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Health Financing and Budgeting Practices for Health in Central, Eastern and South Eastern European Countries

2017 Survey Preliminary Results

3rd Health Systems Joint Network meeting for Central, Eastern and Southeastern European Countries

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This report was prepared by Ana Maria Ruiz Rivadeneira, Kholood Farran, Karolina Socha-Dietrich, Ivor Beazley and Chris James. The Survey of Budget Officials on Budgeting Practices for Health for Central, Eastern and South Eastern European Countries was financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria under the Financing Health Care joint programme, extending the work of the Joint Network beyond OECD member countries. Survey design was developed by Ana Maria Ruiz Rivadeneira, Camila Vammalle and Chris James based on the OECD survey of Budget Officials on Budgeting Practices for health, and in collaboration with the WHO. The authors would like to express their gratitude to Anna Nureeva for her help in implementing the survey.

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Table of contents

1. Executive Summary	4
2. Introduction	6
3. Overview of health expenditure and health financing institutional frameworks in CESEE countries	7
3.1. Health expenditure – key facts.....	7
3.2. Overall institutional framework governing health financing.....	9
3.3. Purchasing arrangements	18
4. Budgeting practices	29
4.1. Budgeting practices in the health.....	29
4.2. Budget execution	41
4.3. Budget monitoring and performance	43
5. Conclusions and future work	50
References.....	51

Figures

Figure 3.1. Health Expenditure as a share of GDP, 2006 and 2016.....	7
Figure 3.2. Health Expenditure: Domestic and External Funding Sources, 2016.....	8
Figure 3.3. Relative share of main financing agents in total health expenditure, 2017 (or nearest year).....	9
Figure 3.4. Countries having a specific budget co-ordination body that gathers officials from the CBA and from the Ministry of Health.....	10
Figure 3.5. Healthcare institutional framework and main roles	11
Figure 3.6. Main Healthcare Financing Schemes in CESEE Surveyed Countries.....	13
Figure 3.7. Key purchasers for health services.....	16
Figure 3.8. Countries that receive international development assistance earmarked for health.....	17
Figure 3.9. Location of development assistance management	17
Figure 3.10. Explicit government policy for managing development assistance	18
Figure 3.11. Countries with formal mechanism to evaluate benefits of new medical procedures	20
Figure 3.12. Government intervenes to ensure the provision of basic primary coverage or ensures the provision of health services to high-risk groups.....	21
Figure 3.13. Main provider payment methods	22
Figure 3.14. Countries having caps on total payments to individual hospitals	23
Figure 3.15. Countries having caps on the total volume of services individual hospitals can deliver ..	23
Figure 3.16. Countries having caps on total payments to individual outpatient specialty providers	24
Figure 3.17. Countries having caps on the total volume of services outpatient specialty providers can deliver	24
Figure 3.18. Legal statuses of different health service providers	26
Figure 3.19. Public primary care providers and outpatient specialty and diagnostic centres mainly overseen by one of following institutions	27
Figure 3.20. Autonomy of public providers	28
Figure 4.1. How public health expenditure is included in the central-government budget.....	30

Figure 4.2. Separate budget for social health insurance system.....	31
Figure 4.3. Bases of the social health insurance agency budget.....	31
Figure 4.4. Is the health insurance agency budget submitted for legislative approval?	32
Figure 4.5. Countries planning to increase publicly funded health coverage in the coming years	34
Figure 4.6. Targets included in the plan to increase publicly funded health coverage.....	34
Figure 4.7. Targets and ceilings imposed on the health expenditure growth rate	35
Figure 4.8. Mechanism in place to ensure that new legislative proposals concerning publicly funded health expenditures accounts for the full cost of the initiative	36
Figure 4.9. Countries in which the CBA receives economic evaluations of expected health benefits from new policy proposals suggested by the Health Ministry	37
Figure 4.10. Assessment of health policy proposals (based on economic assessments of their expected benefits) by the CBA.....	37
Figure 4.11. Countries in which the CBA receives evaluations of the expected impact on equity and coverage from new policy proposals.....	38
Figure 4.12. Assessment of the impact of health policies on equity by the CBA	38
Figure 4.13. Years of medium-term estimates for health spending in the budget.....	39
Figure 4.14. Countries with long-term projections for healthcare expenditure.....	39
Figure 4.15. Elements specified in the budget documents	41
Figure 4.16. Number of years with over or under-spending in health between 2005 and 2015.....	42
Figure 4.17. Reasons for underspending in the health sector	43
Figure 4.18. Actor with the main responsibility in monitoring health expenditures	44
Figure 4.19. Central government Health expenditure reporting delay	45
Figure 4.20. Reasons for health expenditure reporting delay.....	45
Figure 4.21. Countries where health implementing agencies/authorities are subject to performance agreements.....	46
Figure 4.22. Decision making responsibility on the performance indicators	46
Figure 4.23. Use of performance information in health sector.....	47
Figure 4.24. Consequences of not meeting performance targets.....	47
Figure 4.25. Countries with an overall cost containment strategy	49
Figure 4.26. Measures undertaken in response to budgets exceeding initially targeted levels	49

Boxes

Box 3.1. Health Reforms in Azerbaijan	14
Box 4.1. The case of deficit and accumulated reserves for the Social Health Insurance Institute in Slovenia.....	33
Box 4.2. Performance based reforms in financial mechanisms to strengthen TB services in Armenia	48

1. Executive Summary

Government revenues are key to achieving the goal of universal health coverage for countries in Central, Eastern and South-Eastern Europe. Many countries in the region are aiming to increase public spending on health in the future. However, rigidities and subdivisions in public finance systems often prevent the optimal use of such resources. Delayed budget execution and rigid public finance rules that limit the budget flexibility given to frontline health providers have adverse effects on service delivery. Health providers do not always have the necessary delegated authority to manage budgets effectively. Improving the capacity of national health authorities to engage more effectively with national budgetary authorities is essential to make progress on critical issues related to both the level of funds to be provided and the flexibility with which such funds can be used – while concurrently ensuring accountability for the use of these funds.

Improving the dialogue and mutual understanding between health and finance officials is the core objective of the OECD Senior Budget Officials-Health Joint Network on Fiscal Sustainability of Health Systems (Joint Network). This report summarises the key results from a survey in the Central, Eastern and South-east Europe (CESEE) region.

Results obtained from the survey offer a unique panorama of budgeting practices for health in the region, and also allow for comparisons with OECD member countries. Key findings from the survey include:

- There is wide variation in the health expenditure levels between the CESEE surveyed countries. Whilst spending by government or compulsory health insurance schemes play a central role, private out-of-pocket payments can still be significant in the region. In some countries, out-of-pocket payments represent more than half of total health expenditure, while in OECD countries the average is 20%. More than two thirds of surveyed countries have a specific plan to increase publicly funded health coverage, implying increases in public spending on health in the coming years.
- In most CESEE surveyed countries there is a single main health financing scheme. Surveyed countries reported to have either a social health insurance scheme or a general government financing schemes. Only two countries have mixed or dual systems. Low levels of fragmentation in the health system enhance coordination and simplify monitoring systems.
- Boundaries between government financing and social health insurance schemes are becoming blurred as the trend in Europe is moving towards mixed revenue sources, with increasing reliance on government budget transfers to health insurance funds (public or private) within a publicly financed system. Regardless of the main healthcare financing scheme, most countries have a wide variety of financing agents reflecting an increased participation of government expenditure in health financing.
- Most health expenditures are included in the central budget process either as direct expenditure on health programmes, goods and services, as transfers to social security institutions, or as transfers to subnational governments. Budget allocations within the health sector tend to be defined at a more detailed level than in OECD countries. This can create challenges in terms of flexibility for managers and reduce efficiency in health spending.

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- There is great variation between the CESEE surveyed countries regarding their expenditure levels. While some countries tend to have rather stable expenditure levels throughout the year, some CESEE surveyed countries tend to have lower or higher expenditure levels than the ones initially programmed in the central public budget.
 - Most CESEE surveyed countries have periodic reporting and monitoring systems in place to oversee budget execution in the health sector. However, cost containment strategies and ceilings to control health expenditure growth rate are not widespread in the region. Most budget agencies have a multi-year vision of health spending. However, long-term projections (more than 5 years) are not common.
 - Overall, the CESEE surveyed countries have full information on the amount of funds committed and disbursed by international institutions and the projects financed. Furthermore, in most countries a large share of these resources is channelled through the regular budget process and the public finance management system. Despite these good practices, institutional set-ups and coordination mechanisms could be further improved.
 - Health service provision and financing is highly centralised in the CESEE surveyed countries. Only one country reported having a system where sub-national government play an important role in healthcare financing and/or provision.

2. Introduction

Government revenues are key to achieving the goal of universal health coverage for countries in Central, Eastern and South-Eastern Europe. Many countries in the region are aiming to increase public spending on health in the future. However, rigidities and subdivisions in public finance systems often prevent the optimal use of such resources. Delayed budget execution and rigid public finance rules that limit the budget flexibility given to frontline health providers have adverse effects on service delivery. Health providers do not always have the necessary delegated authority to manage budgets effectively. Improving the capacity of national health authorities to engage more effectively with national budgetary authorities is essential to make progress on critical issues related to both the level of funds to be provided and the flexibility with which such funds can be used – while concurrently ensuring accountability for the use of these funds.

Improving the dialogue and mutual understanding between health and finance officials is the core objective of the OECD Senior Budget Officials-Health Joint Network on Fiscal Sustainability of Health Systems (Joint Network). The Joint Network was created in 2011 joining efforts between the Health and Budget and Public Expenditures Divisions of the OECD. In particular, the aim is to clarify roles, common goals, policy levers and constraints of all actors involved. To achieve these objectives, in 2013, the Joint Network designed and implemented a survey of budgeting practices for health in 27 OECD countries. The results of this survey were published in September 2015. In addition, the Joint Network organises annual meetings of health and finance officials from participating countries, to identify and share good practices.

The OECD is now expanding the activities of the Joint Network in other regions of the world, in partnership with the WHO, the Global Fund, CABRI, the IDB, the ADB and other international institutions. Among other collaborative work (i.e. regional meetings and case studies), the OECD designed a Survey of Budget Officials on Budgeting Practices for Health, adapted specifically to cover issues relevant for low- and middle-income countries. Its main aim is to obtain an internationally comparable set of data that will allow for comparative analysis and benchmarking of good practices in budgeting for health in different regions of the world and compare this with OECD countries. The survey targets officials working in Central Budget Authorities who focus on health issues and officials in the Ministry of Health who deal with health financing and budgetary issues. In 2016, the survey was implemented in the Latin America and the Caribbean (LAC) region. In 2017, the Survey is being implemented in Asia and in Central, Eastern and South-east Europe (CESEE).

This report summarises the key results from the survey in the CESEE region. The survey was sent to all participating countries of the 2nd Health Systems Joint Network Meeting for CESEE Countries that was held in Tallinn on 1-2 December 2016, including Malta that was invited as a partner country. The survey was answered by 12 countries (Armenia, Azerbaijan, Czech Republic, Estonia, Georgia, Greece, Kazakhstan, Kyrgyzstan, Lithuania, Malta, Slovakia, and Republic of Slovenia) between March and May 2017.

The rest of this report is organised into two main parts: (1) an overview of health expenditure and health financing institutional frameworks; and (2) an in-depth analysis of budgeting practices for health; in CESEE countries. Given that only one country reported to have a system where sub-national government play an important role in healthcare financing and/or provision, multi-level governance of health expenditure has not been addressed in this report.

3. Overview of health expenditure and health financing institutional frameworks in CESEE countries

3.1. Health expenditure – key facts

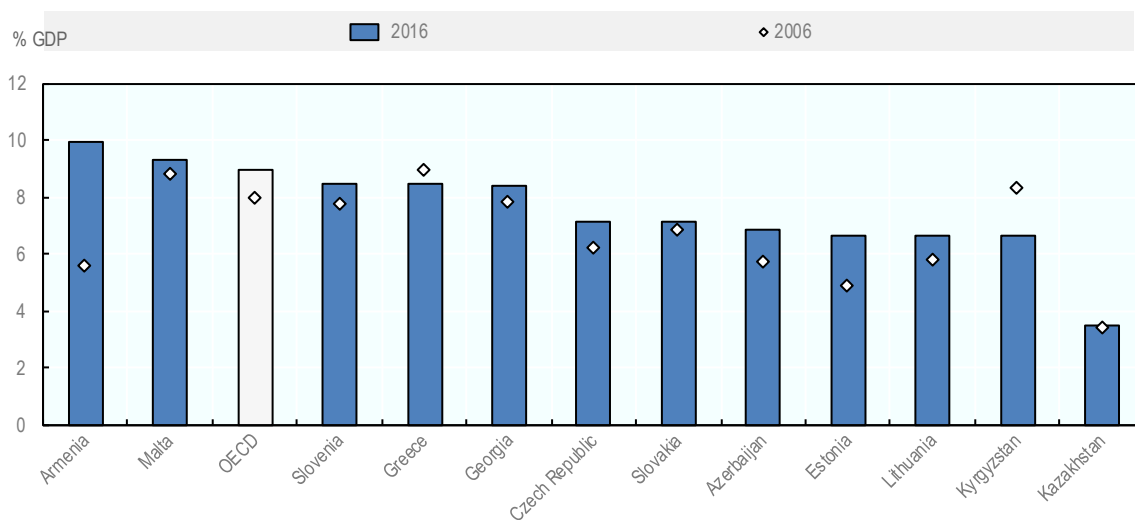
3.1.1. Health expenditure and the national economy

Health spending as a share of GDP

Spending on health in the surveyed CESEE countries has generally increased over time. However, there are three distinct time periods – health spending grew rapidly prior to the global economic crisis of 2007-2008; then during the crisis and for a few years after (2007-2013) health spending growth slowed and was even negative in some countries; before health spending growth recovered in recent years.

To some extent, these trends in health spending have mirrored trends in economic growth. A closer look at the data, though, shows important differences across the surveyed countries. More precisely, health spending has outpaced economic growth markedly in Armenia, with health spending as a share of GDP increasing from 5.6% of GDP in 2006 to 9.9% of GDP in 2016. Health spending has also markedly outpaced economic growth on average in the Azerbaijan, Czech Republic, Estonia, Lithuania over this 10 year period; and to a lesser extent in Kazakhstan Malta, Slovakia and Slovenia. Only in Greece and Kyrgyzstan has health spending as a share of GDP fallen between 2006 and 2016 (Figure 3.1).

Figure 3.1. Health Expenditure as a share of GDP, 2006 and 2016



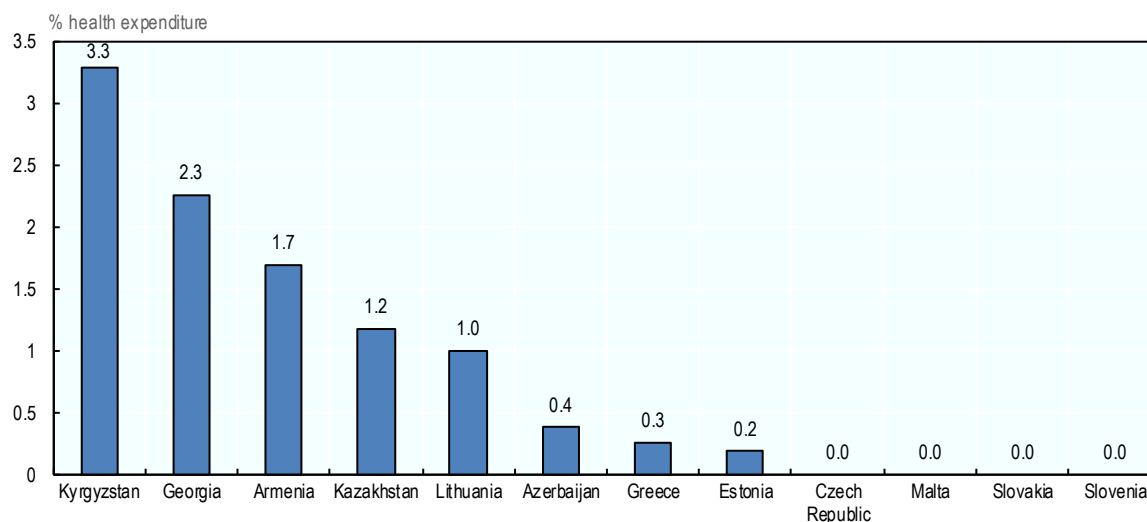
Source: WHO Global Health Expenditure Data base <http://apps.who.int/nha/database/Select/Indicators/en>

External resources for health play a relatively small role in most surveyed CESEE countries

Based on health expenditure data, eight of the twelve surveyed countries (Armenia, Azerbaijan, Estonia, Georgia, Greece, Kazakhstan, Kyrgyzstan and Lithuania) received

some external resources to finance healthcare in 2016. Nonetheless, the relative share of this source of funding is very low: between 0.2% and 3.3% of current health expenditure, and only exceeding 3% of current health expenditure in Kyrgyzstan (Figure 3.2).

Figure 3.2. Health Expenditure: Domestic and External Funding Sources, 2016



Source: WHO Global Health Expenditure Database <http://apps.who.int/nha/database/Select/Indicators/en>

3.1.2. Financing of healthcare

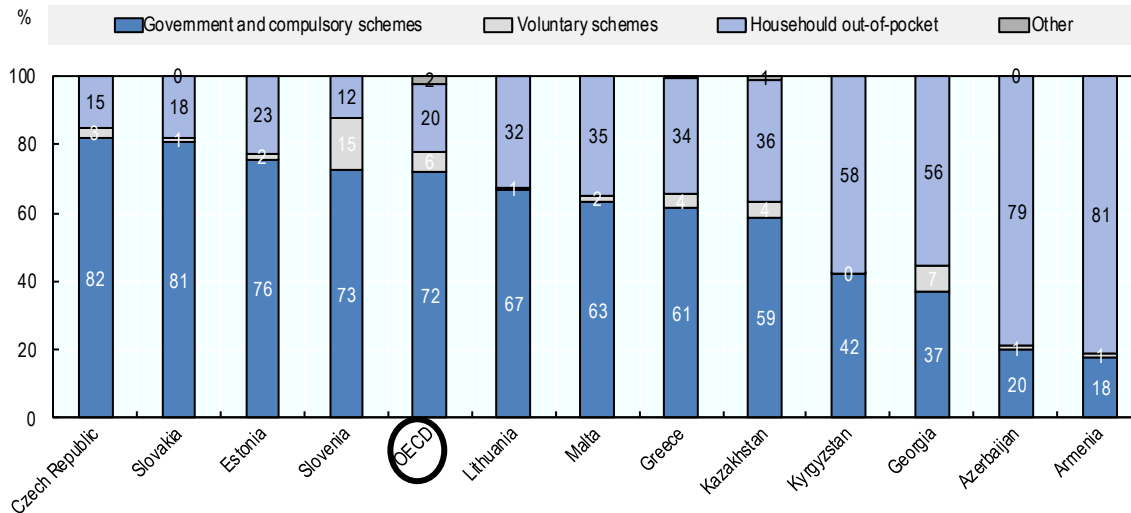
Financial protection and out-of-pocket payments

Health financing schemes vary across the surveyed CESEE countries, with some systems predominantly organised around government schemes and others through compulsory social health insurance. However, boundaries between these schemes are becoming less relevant, as the trend in Europe is moving towards more mixed revenue sources. Section 3.2.2 discusses in detail the different financing arrangements.

Regardless of the main health financing scheme in place, many surveyed countries still have a significant reliance on private household out-of-pocket (OOP) payments to finance health care (Figure 3.3). OOP payments comprised over half of health spending in Armenia, Azerbaijan, Georgia and Kyrgyzstan, noticeably higher than the OECD average of 20%. From a policy perspective, over-reliance on such OOP payments risks causing financial hardship for households – the World Health Organization has shown that when OOP payments make up over 30% of total health spending, there is a serious risk of households facing severe financial hardship (also known as catastrophic health expenditures) because of the costs of healthcare (WHO 2010).

In order to support the health system goals of better health outcomes and adequate financial protection, two thirds of the surveyed countries have a specific plan to increase publicly funded health coverage in the coming years, which would generally imply increases in public spending on health (see Section 4.13).

Figure 3.3. Relative share of main financing agents in total health expenditure, 2017 (or nearest year)



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3.2. Overall institutional framework governing health financing

3.2.1. Co-ordination mechanisms and decision-making

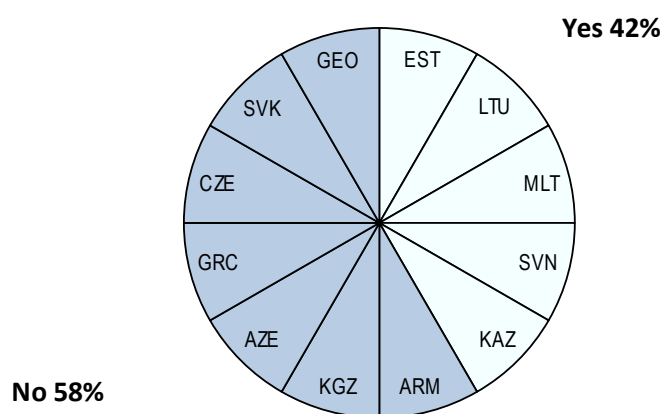
Good institutional and procedural frameworks governing health financing are essential for governments to control health spending and stimulate value-for-money. Of particular importance are co-ordination and co-operation between a Central Budget Authority (Ministry of Finance) and a Ministry of Health in allocating money to health. Central Budget Authorities tend to focus on the macro-fiscal aspects of health spending, i.e. how to reconcile preferences about public spending and taxing, as well as how much to allocate to health relatively to other public services such as education, policing or transport. Ministries of Health in turn focus on which health policies are most effective at improving health outcomes, whilst also considering value-for-money and how investment in health contributes to national economy. Integrating both perspectives can help in choosing between alternatives and making difficult allocation choices. In particular, finding policies that can make health spending more sustainable without compromising important achievements in health requires mutual comprehension and joint efforts between Central Budget Authorities and Ministries of Health.

Therefore, a sound co-ordination mechanism is essential to promote the dialogue between Central Budget Authorities and Ministries of Health. In order to better integrate both perspectives, many OECD countries have formal bodies or less formal teams (or both) composed of officials from both institutions (and sometimes also other social security entities) to discuss together possible solutions to fiscal sustainability challenges in health care and ensure effective policy choices (OECD, 2015^[1]).

Co-ordination mechanisms between the Central Budget Authority and Ministry of Health

Coordination between the Ministry of Health and the Ministry of Finance is still a challenge for the CESEE surveyed countries. Less than half of the surveyed countries have a specific budget co-ordination body that gathers officials from the Central Budget Authority and from the Ministry of Health (Figure 3.4). Some of these co-ordination bodies include informal groups of experts composed by experts from the Ministry of Finance and the Ministry of Health together with the social health insurance agency (Republic of Slovenia), inter-ministerial supervision offices (Czech Republic), health and finance budget commissions (Kazakhstan), institutes for health and financial policy (Republic of Slovenia), or parliamentary committees (Kyrgyzstan). The remaining surveyed countries either have more informal coordination mechanisms such as working groups (Estonia and Lithuania) or informal meetings during the budget formulation process (Malta and Greece), or do not have any mechanism at all (Armenia, Georgia, and Azerbaijan).

Figure 3.4. Countries having a specific budget co-ordination body that gathers officials from the CBA and from the Ministry of Health



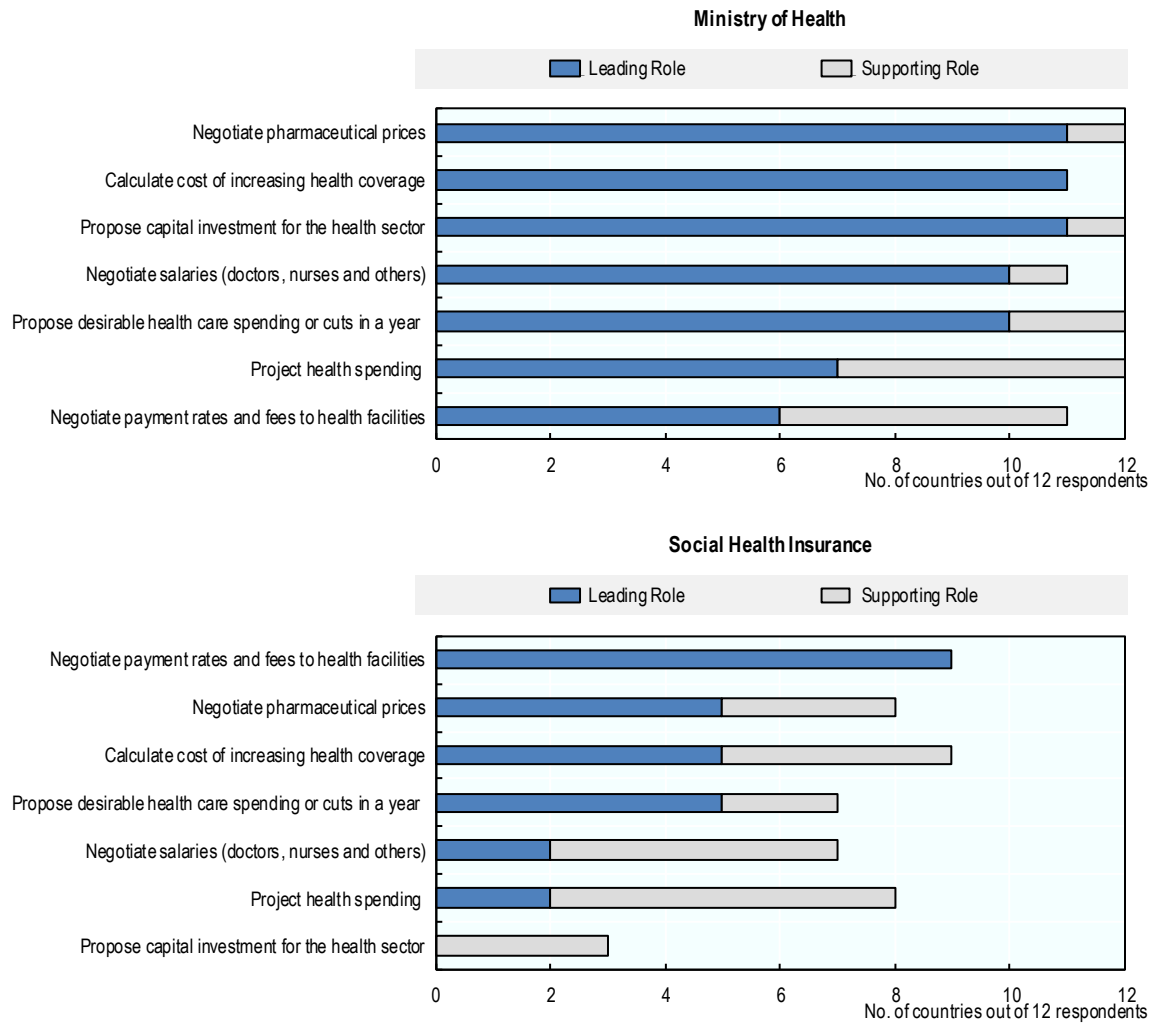
Source: OECD (2017), CESEE Survey on Budgeting Practices for Health (Question 9b)

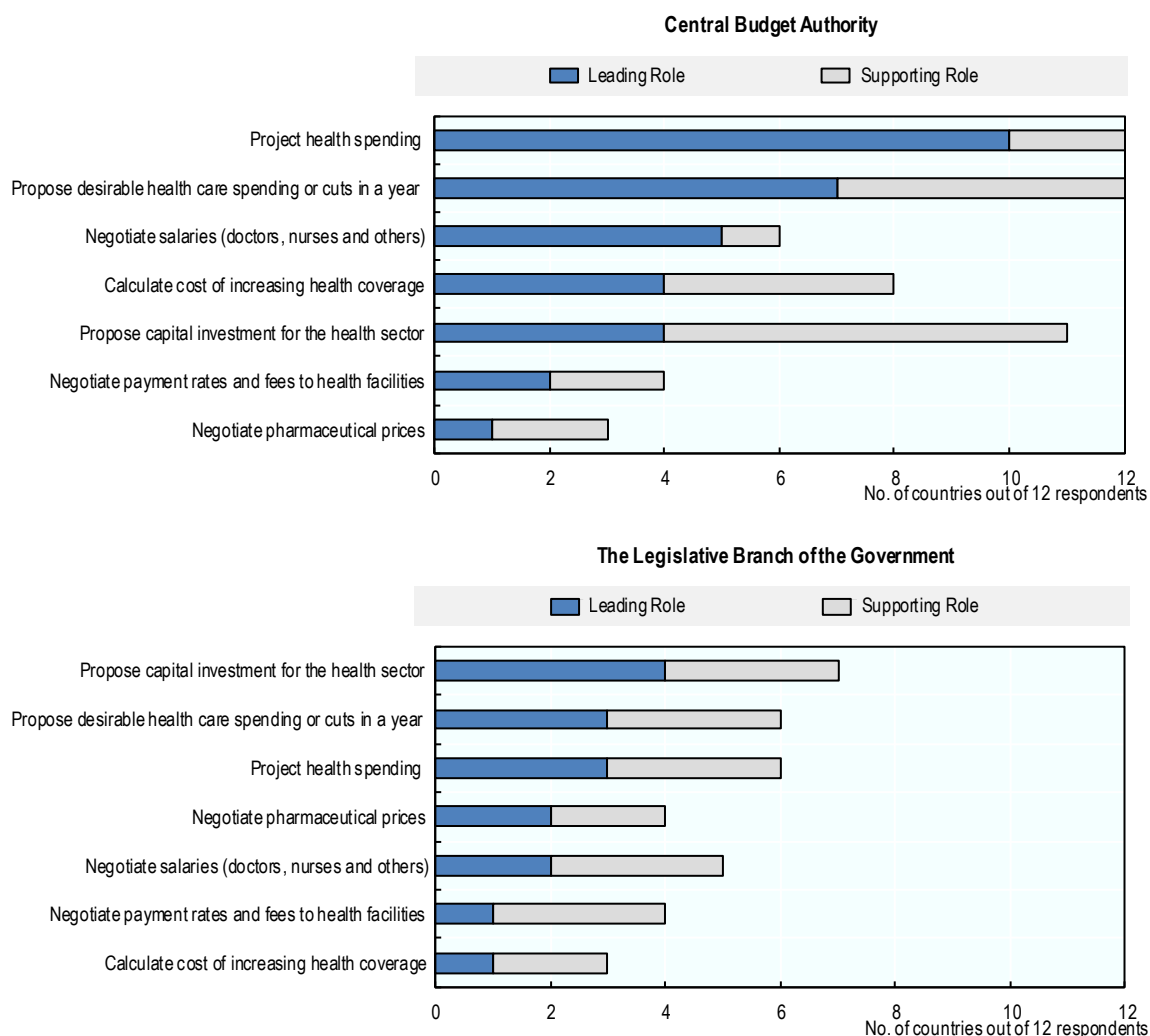
Main roles of Central Budget Authorities, Ministries of Health, and Health Insurance in health budgeting

In all surveyed countries, the Ministry of Health has either a leading or supporting role in almost all surveyed functions, such as: (1) projecting and proposing desirable amounts of healthcare spending, (2) proposing capital investments projects, (3) calculating costs of increasing health coverage, (4) negotiating payment rates and fees paid to hospitals and other health facilities, (5) negotiating salaries paid to doctors, nurses and other individual providers, and (6) negotiating pharmaceutical prices. The role of the Ministry of Finance is also relevant for the functions related with projecting, costing, and proposing healthcare expenditures, but not as much for the negotiation process with facilities, pharmaceuticals, and individual providers. Social health insurance agencies also have a main role across all functions for countries with insurance-based systems. In particular, in such systems, insurance agencies have a leading role in negotiating payment rates and fees paid to hospitals and other health facilities. In around half of the surveyed countries, the legislative branch of the government has a leading or supporting role for most functions. Finally, sub-

national governments, independent fiscal institutions, and other institutions tend to have a rather supporting role for all function and only for about a third of surveys countries (Figure 3.5).

Figure 3.5. Healthcare institutional framework and main roles





Note: Answers with 'no role at all' are eliminated from the graph

Source: OECD (2017), CESEE Survey on Budgeting Practices for Health (Question 9 and 9a).

3.2.2. Health financing arrangements

Health financing arrangements through which health services financed causes budgetary challenges. Most of the surveyed countries finance their health systems predominantly through government schemes or compulsory health insurance. From a budgetary control perspective, each arrangement has specific implications. In government schemes, budget control follows from the allocation of a share of overall government revenues to health, and the subsequent level of service provision based on the management of the allocation

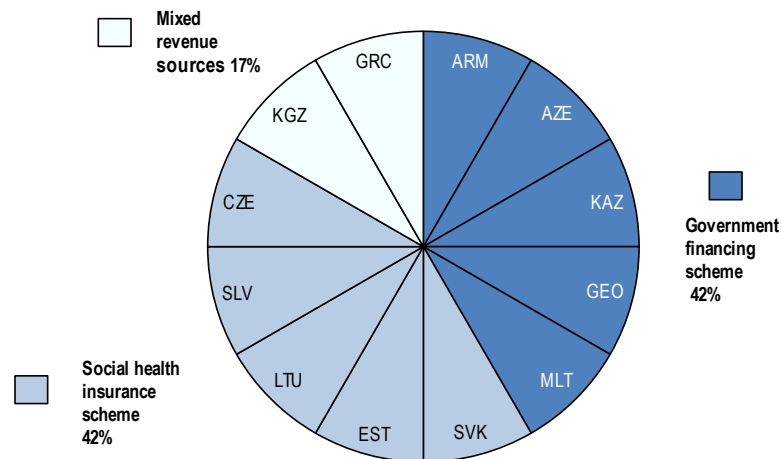
In systems based on compulsory health insurance, it is harder to enforce a total amount of spending in advance, given spending is entitlement-based. Effective budgetary control, though, is dependent on the service payment rules, and service demand. However, such a distinction between these two types of financing schemes is becoming less relevant from a budgeting perspective, since many compulsory health insurance schemes now include direct transfers from general government revenues alongside traditional dedicated funding sources (e.g. payroll taxes). Furthermore, differences between these two types of health

financing arrangements are becoming less pronounced through the use of targets for containing or increasing public spending (as discussed in Section 4.13).

Main health financing schemes

Health financing schemes vary across CESEE countries. For the surveyed countries, 42% have a Government Financing Scheme funded through government budget revenues (mainly taxes), 42% have a Social Health Insurance Scheme with public and private administrators, and 16% have mixed revenue sources, with increasing reliance on government budget transfers to health insurance funds (public or private) within a publicly financed system (Figure 3.6). From the countries with a government financing scheme, only Kazakhstan has a system partially managed by subnational governments. Other surveyed countries with a government financing scheme are fully managed at the central level.

Figure 3.6. Main Healthcare Financing Schemes in CESEE Surveyed Countries



Source: OECD (2017), CESEE Survey on Budgeting Practices for Health (Question 2)

A number of surveyed countries that are former Soviet states, namely Armenia, Azerbaijan, Georgia, Kazakhstan, and Kyrgyzstan, have implemented or are planning to implement structural reforms in the health sector. In particular, some countries are moving towards a health insurance system. In 2016, Azerbaijan begun implementing a mandatory health insurance system starting with a pilot programme in two regions, covering a population of 230,000 (Box 3.1). Likewise, Armenia and Kazakhstan are starting to transition from a government financial scheme to a social health insurance in 2017 and 2018, respectively.

Box 3.1. Health Reforms in Azerbaijan

In 2006, a national health sector reform project was launched in Azerbaijan to transform its healthcare provision and create a national health insurance fund under the Social Security Agency. The reform aims to integrate all National Health Programs in a Mandatory Health Insurance Scheme (MHI) Fund by 2020.

The reform process began as a pilot stage integrating 11 National Healthcare Programs (NHP) that cover specific types of diseases under the social health insurance scheme. Patients who are registered under the NHP are covered for medical consultations as well as treatment and drugs for the selected diseases. The total funding for the National Health Plan in 2015 accounted for around 20% of total health expenditure. In the rollout phase, the programme is designed to transfer gradually the NHP funding to the MHI Fund. The MHI Fund would continue to cover the same benefits to all its registered members. At the final stage, members will continue to have access to the specialised care centers for treatment (as they will become part of the MHI network).

The reform is aiming to improve health outcomes by: (1) increasing access to care - incentivising more private investments into health provision to increase supply-; (2) increasing the quality of care, since stricter provider licensing participation criteria should in return raise quality through the introduction of payment mechanisms which reward quality of care; (3) promoting sustainability of public healthcare expenditure by keeping the share of total government budget needs reasonable; (4) improving transparency, which should generate healthcare data to improve the quality of services.

Source: The State Agency for Mandatory Health Insurance, Azerbaijan, 2017.

Voluntary private insurers also have a presence in the region. Half of the surveyed countries reported to have this form of financing scheme (i.e. Estonia, Azerbaijan, Malta, Republic of Slovenia, and Kazakhstan). In most countries, however, the fraction of the population covered through this scheme is low. The Republic of Slovenia is the only surveyed country where complementary voluntary private insurance covers a large share of the population (78%)¹. In the rest of surveyed countries, the population covered is below 10%. Most surveyed countries reported that private insurance is only available to the high and middle income population, as well as to employees of particular companies (e.g. private oil companies in Azerbaijan and large companies in Kazakhstan).

NGOs represent only a small share of resources. Nevertheless, NGOs and other civil society organizations play a key role in supporting strategic vertical programmes, such as HIV, tuberculosis and malaria. Therefore, articulation with the core programmes of the health system is needed to avoid duplications and ensure these resources are spent in an efficient and sustainable way.

Apart from these schemes, some countries have other health subsystems providing coverage to certain groups of the population and their families; for example, as a legacy of the Soviet period, Kyrgyzstan has parallel health services provided by ministries and agencies other than the Ministry of Health. In a similar way, Azerbaijan has parallel

¹ In the Republic of Slovenia special groups of the population, children and students below 26 are not liable for co-payments. 95% of the population liable for co-payments is covered by a voluntary complementary health insurance, which means that 78% of the total population is covered by this arrangement.

providers in the industry and line ministries with separate healthcare financing schemes offering services to their current or former employees.

Key purchasers of different types of health services

Purchasing of health services plays a central role in advancing health systems and has a direct impact on performance, and thus needs to be addressed strategically in order to advance effectively towards universal health coverage (WHO, 2017). In compulsory health insurance systems, purchasing and provision are separated; this purchaser-provider split has also been introduced in some countries with predominantly tax-funded government schemes.

In the CESEE surveyed countries multiple purchasers exist, who may or may not compete with each other (Figure 3.7). In the majority of surveyed countries, the key purchaser for public health is the central government. Countries with Social Health Insurance systems (e.g. Czech Republic, Lithuania, Estonia, Slovenia, and the Slovak Republic) have the Social Health Insurance agency as the key health service purchaser for all categories of services except for Public health services where the main purchaser is the central government. Public health services are also purchased by regional and local governments in the case of the Slovak Republic. In addition to the Social Health Insurance agencies, in Slovenia and the Slovak Republic, private health insurance companies are also key purchasers for all categories of services. Armenia, being in a transitory period from a government health scheme to a social health insurance scheme, currently has health insurance coverage purchased by the central government and will be serviced by insurance companies once the health insurance system is established.

The CESEE surveyed countries with Government Health Systems have different key purchasers for the different category of services. Malta, for example, has the Central Government as its sole main purchaser for all categories of services. While in Azerbaijan and Kazakhstan, the system is decentralised. In the case of Azerbaijan, the Ministry of Health is the main purchaser/provider of health services in the capital. Regional governments are the main purchasers of health services in the rest of the country. In Kazakhstan, local health authorities purchase outpatient/public health services from the funds transferred from the federal budget for all service categories; to the contrary, acute inpatient care and pharmaceuticals are purchased directly by the central government. In Georgia, the main purchaser is the Social Service Agency (SSA)² for all categories of services except for preventive services and public health. Acute inpatient care and pharmaceuticals are also purchased by private health insurance and by the National Centre for Disease Control. The latter is also the main purchaser of public health. Georgia has undergone reforms and transferred responsibility for purchasing healthcare services from private insurance companies to the Social Service Agency (SSA) under the Ministry of Labour, Health and Social Affairs (MOLHSA), thus putting in place a platform to shift from passive to active purchasing.

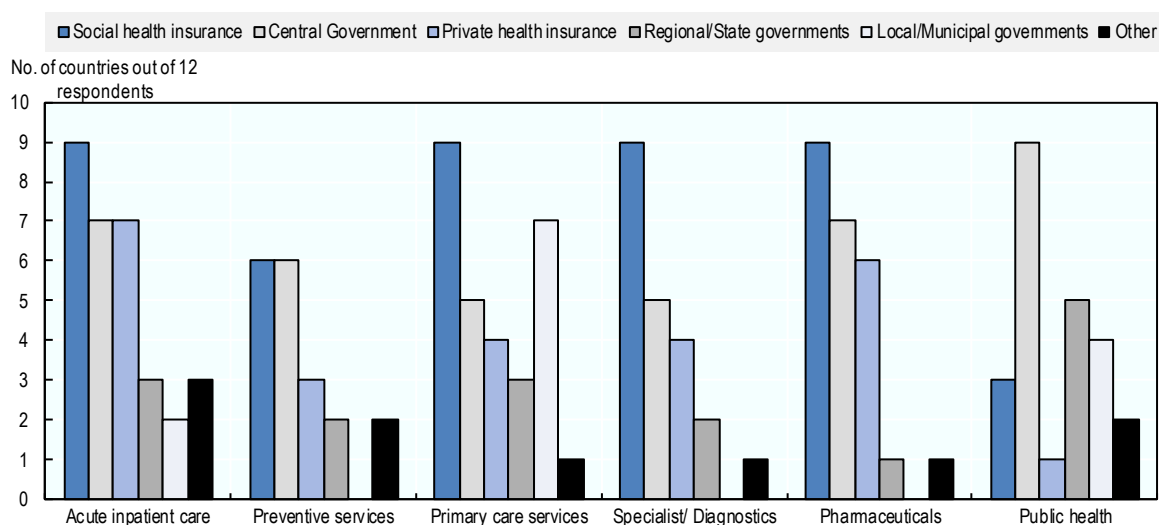
Having mixed systems, Greece and Kyrgyzstan have the central government, the social health insurance fund, and private health insurance funds as key purchasers for almost all categories of services. In both Greece and Kyrgyzstan, the social health insurance does not purchase preventive nor public health services. Similarly, private health insurance in

² As the sole purchaser of services for the UHC Program, Georgia has given the SSA the power to purchase services to enable it to be more strategic and manage costs effectively. It includes: managing revenues and expenditures; contracting; paying providers and setting the right incentives; monitoring provider performance, service and quality. A key element of the UHC reform was to transfer responsibility for purchasing publicly financed services from private insurance companies to the SSA.

Greece does not purchase pharmaceuticals or public health, while in Kyrgyzstan preventive services and specialist/diagnostics are not purchased by the private health insurance.

In addition to the social health insurance, Estonia also has the National Institute for Health Development as purchaser for preventive services along with the central government and the social health insurance. The central government also purchases pharmaceuticals along with the social health insurance and the national institute for health development. In Lithuania, acute inpatient care is provided by different purchasers including the Central Government, regional and local governments, the social health insurance, and the private health insurance.

Figure 3.7. Key purchasers for health services



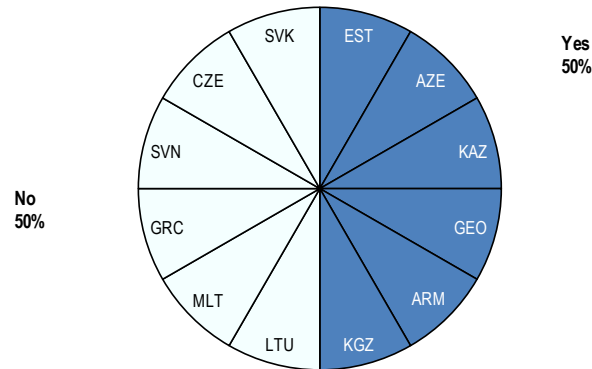
Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (question 14)

3.2.3. Management of development assistance for health

Countries receiving development assistance for health

Half of the CESEE surveyed countries (Armenia, Azerbaijan, Estonia, Kazakhstan, Kyrgyzstan, and Georgia) report receiving international development assistance earmarked for health or benefits from direct financing of health programmes and facilities (Figure 3.8). All countries that receive international development assistances reported to have complete information on the amount of funds committed and disbursed by international institutions and the projects financed. Most of these countries reported that more than 75% of the total international development assistance for health is channelled through the regular budget process and the public finance management system. In the case of Georgia and Kyrgyzstan, however, this share represents only between 0%-25%, and in Armenia between 51%-75%.

Figure 3.8. Countries that receive international development assistance earmarked for health

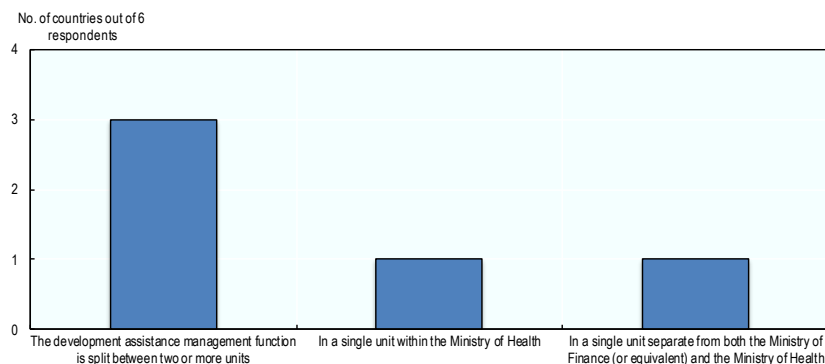


Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 44)

Management of external resources for health

Even though all surveyed countries that receive external funds have one or more units responsible for the management of development assistance, institutional setups and coordination mechanisms could be further improved. Most countries report to have multiple units responsible for managing these resources, which can create challenges in terms of coordination and accountability (Figure 3.9). Estonia and Kazakhstan, for example, have departments in both the Ministry of Health and the Ministry of Finance to manage development assistance. In addition, Georgia has one unit in the Ministry of Finance and another unit directly under the government administration that manages the Global Fund Program. On the other hand, Azerbaijan and Armenia both have a single unit to manage international development assistance. This unit in Azerbaijan is located within the Ministry of Finance (or equivalent) named Country Coordinating Mechanism on HIV/AIDS, TB, and Malaria Control; in Armenia it is a Health Project Implementation Unit, which is a State Agency in the Ministry of Health Programs Coordination Group.

Figure 3.9. Location of development assistance management

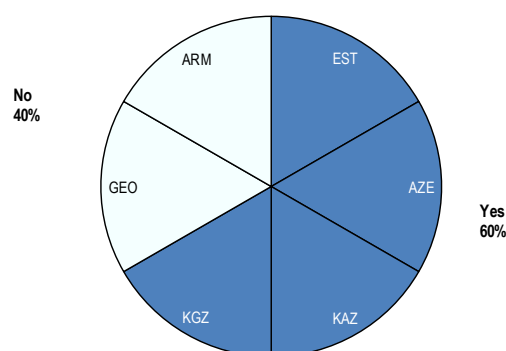


Note: Kyrgyzstan answer to this question is “other”

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 50)

While Estonia, Azerbaijan, Kyrgyzstan, and Kazakhstan have an explicit policy for managing development assistance, Georgia and Armenia do not have any. These policies include the distribution of aid management responsibilities within Government, rules or guidelines for donors when dealing with Government, general preferences for aid types (e.g. grants or loans), and requirements for the provision of information by donors. In particular, in the case of Estonia and Azerbaijan these policies also include general preferences for aid types (e.g. project aid or programme aid), more specific guidelines for each aid modality (e.g. project aid), monitoring and evaluation arrangements for the implementation of the aid management policy, and a specific agreement on development cooperation in the health sector (such as memorandum of understanding or compact) on how aid will be managed in health (Figure 3.10). Does the government have an explicit policy for managing development assistance?

Figure 3.10. Explicit government policy for managing development assistance



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 51)

In Estonia, Azerbaijan, and Georgia, the development assistance management unit keeps a database of incoming aid flows for health. The information on incoming aid flows for health is freely available in Estonia and upon request in Armenia and Azerbaijan. In Kazakhstan, Kyrgyzstan, and Georgia the use of this information is reserved only for internal Government purposes. In Kyrgyzstan, the database includes the terms of each project or programme (i.e. whether it is a loan or a grant), the total value of each project or programme, co-financing requirements, a detailed budget according to Government classification system, actual disbursements for previous fiscal years, expenditure commitments for the current fiscal year, actual disbursements for the current fiscal year, expenditure commitments for the forthcoming fiscal year, and budgets for the next 2-3 years.

3.3. Purchasing arrangements

3.3.1. Evaluating the benefit package

All of the surveyed countries have their own process for making decisions on the range of benefits (goods and services) covered by the public health system schemes or compulsory health insurance. The main challenge is, however, to base these decisions on adequate methodologies and data, so that the benefits basket prioritises interventions that are more

cost-effective and/or or equity enhancing. On top of building upon reliable evidence, the decision-making process need to be transparent, timely, and cost-effective in itself.

To meet these challenges, many OECD countries use Health Technology Assessment (HTA) to inform priority-setting decisions for their benefits packages: for the selection and coverage of medicines and development of standard treatment guidelines most commonly, and increasingly, for non-drug technologies, programmes, and services. The bodies responsible for HTA are independent (but publicly funded) and base their assessments on cost-effectiveness analyses and other best-practice economic evaluation methods. Information on the process of and criteria for decision-making (including HTA guidelines laying out data requirements) along with results of the assessment and the rationale for coverage decisions are publicly available. Moreover, increasing support for international collaboration contributes to better data availability, timeliness, and avoids duplication of these costly efforts (Auraaen et al., 2016^[2]).

Evaluating new healthcare services

The surveyed CESEE countries are planning or still building their institutional capacity to undertake HTA based on best practice in economic evaluation and to ensure transparency and timeliness of the coverage decisions. Furthermore, the evaluation of benefits is typically limited to assessing new (rather than existing) health interventions.

The majority of the surveyed countries (75%) reported to have a formal mechanism in place to evaluate some or all of new medical procedures, medicines, or medical devices, and consequently to decide whether to include them in the public health benefits basket (Figure 3.11).

Estonia, for example, has standardised the procedure by establishing an independent public body, namely the Estonian Health Insurance Fund (EHIF), with the main responsibility to define the benefits packages in collaboration with other stakeholders. The benefit package is then agreed upon by both the EHIF and the Ministry of Social Affairs, before being endorsed by the government, who then gives each item in the list a reimbursement price. This process takes place on a yearly basis, where around 100 applications are issued. Similarly, in Kazakhstan, the Republican Centre assesses new services for Healthcare Development (RCHD) backed with evidence-based research. The National Centre for Expertise of Drugs assesses new pharmaceuticals, which directs findings to the Joint Quality Commission (consultative platform with representatives of different stakeholders). Finally, the Ministry of Health (Medical-Economic Board) approves the technology or drug, taking into account recommendations from the Joint Quality Commission.

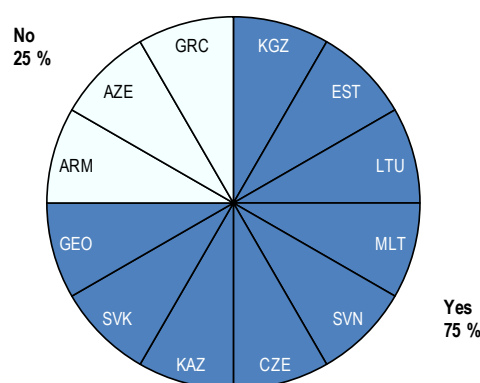
Lithuania, on the other hand, has a number of assigned public health institutions to evaluate the health benefits package (HBP). The Public Health Technology Centre conducts research on public health gaps and carries out assessments on public health technologies. It also develops and tests innovative interventions in the public healthcare practice. The State Health Care Accreditation Agency has the authority to assess and accredit new health technologies, while the State Medicines Control Agency is the government body that is responsible for evaluating and supervising pharmaceuticals.

Slovenia, Czech Republic, and Slovakia have some form of a formalised process to assess HBPs but not for all medical processes and technologies. Slovenia, for example, conducts health technology assessments for new medical and diagnostic procedures and evaluates pharmaceuticals used by the Health Insurance Institute of Slovenia (HIIS). It is looking into improving the process, however, by placing standardisation on health equipment and by

introducing technical guidelines for that purpose. The Czech Republic has the State Office for Drug Control (SUKL), which registers and performs quality control over pharmaceuticals. However, it does not have a formal process to conduct health technology assessments. Also, the Ministry of Health in Slovakia has started a new initiative to achieve better health technology assessment procedures with price referencing in various areas (medical devices, special health material, and medical equipment).

Those who reported not to have a formal mechanism in place (Armenia, Azerbaijan, and Greece) are either planning to establish one, such as Greece, or in the process of assigning a particular body to conduct evaluations on HBP's such as in Azerbaijan.

Figure 3.11. Countries with formal mechanism to evaluate benefits of new medical procedures



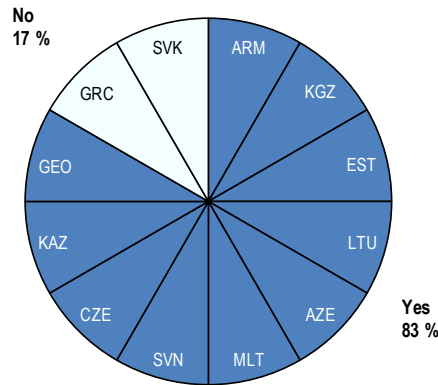
Source: OECD (2017), Survey of Budget Officials on Budgeting Practices for Health in CESEE countries (Question 5)

Ensuring provision of basic coverage to high-risk groups

With the exception of Greece and Slovakia, governments in the CESEE surveyed countries intervene to ensure the provision of basic primary coverage or ensure the provisions of health services to high-risk groups (e.g. seniors, disabled, people with specific diseases such as HIV, TB, cancer, etc.) (Figure 3.12).

In Slovenia, for example, the government regulates premiums to promote access to insurance for high-risk groups (e.g. community rating). In addition, in Slovenia and Estonia, the government subsidises (via direct subsidy, tax credit, or other tax incentive) the purchase of basic health insurance. Moreover, in Estonia, Slovenia, Czech Republic, and Georgia, high-risk patients are entitled to public health coverage through dedicated programmes that subsidise public or private provision. Finally, in more than half of the surveyed countries (Armenia, Kyrgyzstan, Azerbaijan, Malta, Slovenia, Kazakhstan, and Georgia), the government funds and manages a dedicated programme for treating people with specific diseases that are considered major such as TB or HIV. Otherwise, those countries directly provide free healthcare services to high-risk patients.

Figure 3.12. Government intervenes to ensure the provision of basic primary coverage or ensures the provision of health services to high-risk groups



Source: OECD (2017), Survey of Budget Officials on Budgeting Practices for Health in CESEE countries (question 6)

3.3.2. Provider payments

As discussed in Section 3.3.1, ensuring benefit baskets exclude cost in-effective interventions is crucial for stimulating value-for money in health. The evaluation of the benefits package must be combined with efforts to guarantee appropriateness of care. In all systems, underuse and overuse tend to co-exist as low-value care or inappropriate use of medicines, tests, imaging, screening, or even surgeries can be incentivised by payment systems. Therefore, aligning payer and provider incentives is essential for health systems sustainability (OECD, 2017^[3]).

The structure of provider payments is one of the key policy levers that countries have to drive health system performance. They are a core element for influencing providers' behaviour, and can create incentives to improve quality and deliver care more efficiently (WHO, 2007). Payment systems too often do not pay for improvements in health outcomes. Health providers are still predominantly paid in traditional ways – through fee-for-service (FFS), capitation, salary, global budgets or more recently diagnosis-related groups (DRGs) (see glossary for definitions). These payment methods can give incentives for undesirable behaviours, for instance over-provision of services or inattention to clinical needs (OECD, 2016^[4]).

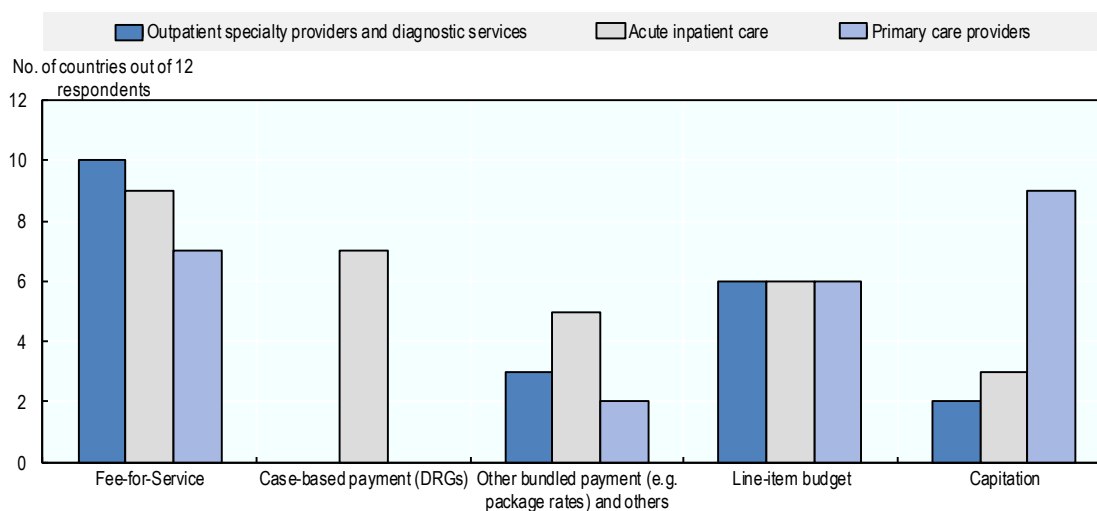
Experiences of OECD countries show innovative payment methods can be successful in improving some aspects of the quality of care, health outcomes and/or reducing the costs of care provision. For example, add-on payments are used in different domains of care for co-ordination or to reward an achievement. Bundled payments for episodes of care or for chronic conditions have improved quality of care. Population-based payments in which groups of health providers receive payments based on the population covered, with built-in quality and cost-containment requirements, result in slower health spending growth. At the same time, such innovative payment methods have not always been successful, and can be costly to implement and monitor.

Main provider payment methods used

The CESEE surveyed countries pay providers through payment methods that can give incentives for undesirable behaviours, such as over-provision of services or inattention to clinical needs. More should be done to align payer and provider incentives so that payment is based on delivering value to patients (OECD, 2016^[4]).

Fee-for-service is the most common payment method for outpatient specialty providers, diagnostic services, and acute inpatient care. In the case of primary care providers, the most common payment method is capitation, but fee-for-service and line-item budgets are also used by at least half of the surveyed countries (Figure 3.13). Some countries have started using more innovative payment systems such as case-based payments and other bundled payments but only for acute inpatient care.

Figure 3.13. Main provider payment methods



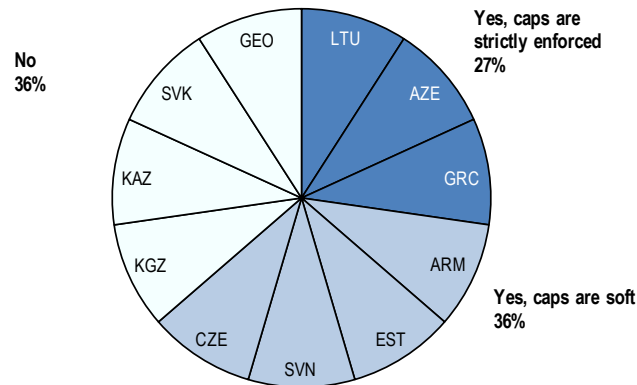
Note: The information on this graph aggregates all different level of providers (Central government, social health insurance, regional/state government, local municipal government, or private health insurance.)

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 19 to 21)

Hospitals: caps on payments and service volumes

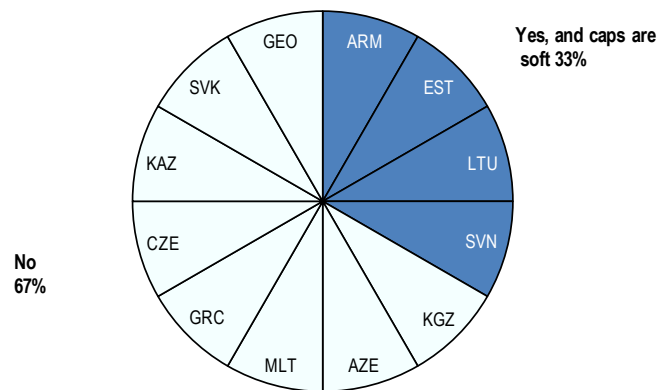
More than half of the CESEE surveyed countries place caps on the total payment to individual hospitals. Only 27% strictly enforce them, however, while 36% use soft caps. The rest, 36% reported to have no caps on those total payments (Figure 3.14).

Countries differ in how these caps are set and how strictly they apply them. In the Czech Republic, for example, caps on payment to hospitals are set as a percentage increase relative to the previous accounting period. On the other hand, since hospitals in Azerbaijan are financed via line-items based on the previous year's budget, hospitals cannot spend more than their line-item budget. While in Greece, caps are not set in terms of payments that can be made but in terms of new liabilities (accrual expenditure) that can be accrued in the annual budget. That envelope is the ceiling on the new obligations that each unit can undertake during a fiscal year and is monitored on a monthly basis.

Figure 3.14. Countries having caps on total payments to individual hospitals

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (question 19.a,19.a.1)

Only 33% of the CESEE surveyed countries have caps on the total volume of services individual hospitals can deliver (Figure 3.15). Lithuania and Armenia, for example, set these caps using a specific contract.

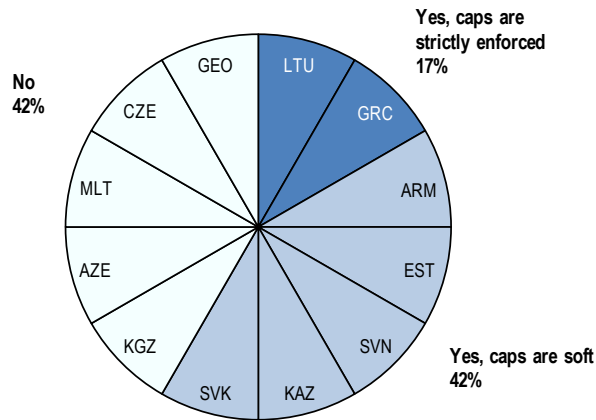
Figure 3.15. Countries having caps on the total volume of services individual hospitals can deliver

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (questions 19.b and 19.b.1)

Outpatient speciality providers: caps on payments and service volumes

More than half of the CESEE surveyed countries (58%) place caps on the total *payment* to individual outpatient speciality providers; 17% enforce them strictly (Figure 3.16). These caps are enforced differently according to each country. In Kazakhstan, for example, there are no limits set on these caps. While in the Slovak Republic and in Greece, the Health Insurance Companies (HICs) and the social health insurance service (EOPYY), respectively, set payment limits for specific periods. In Slovenia, caps are placed for specific health programmes (e.g. with long waiting times) where overruns are paid.

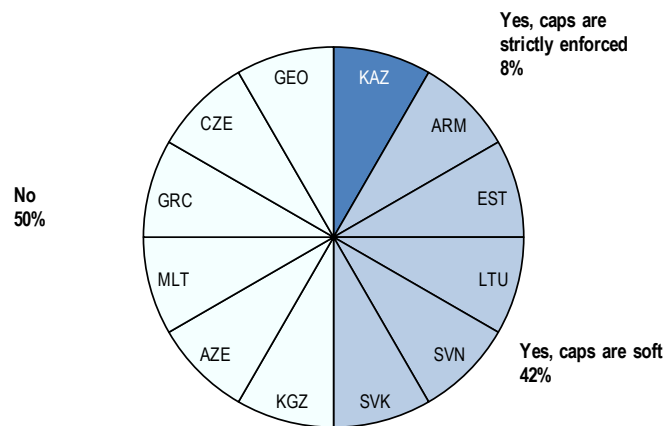
Figure 3.16. Countries having caps on total payments to individual outpatient specialty providers



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (questions 20.a and 20.a.1)

Half of the CESEE surveyed countries reported to place caps on the total *volume* of services outpatient speciality providers can deliver; 8% enforce them strictly (Figure 3.17). The enforcement methods vary greatly across the surveyed countries. In the Slovak Republic, for example, caps are set by the health insurance companies (HICs) who set volume limits for specific periods where service limits are in place. Armenia on the other hand sets these caps by contract.

Figure 3.17. Countries having caps on the total volume of services outpatient specialty providers can deliver



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (20.b and 20.b.1)

3.3.3. Governance of health providers

As discussed in Section 3.2, separating purchasing function from the provision of health services and encouraging selective contracting can potentially help promote efficiency. If providers of health services are legally independent from purchasers of health services, or

at least enjoy a high degree of autonomy over the use of the allocated funds, they should be more motivated to improve efficiency and cut unnecessary costs of their services.

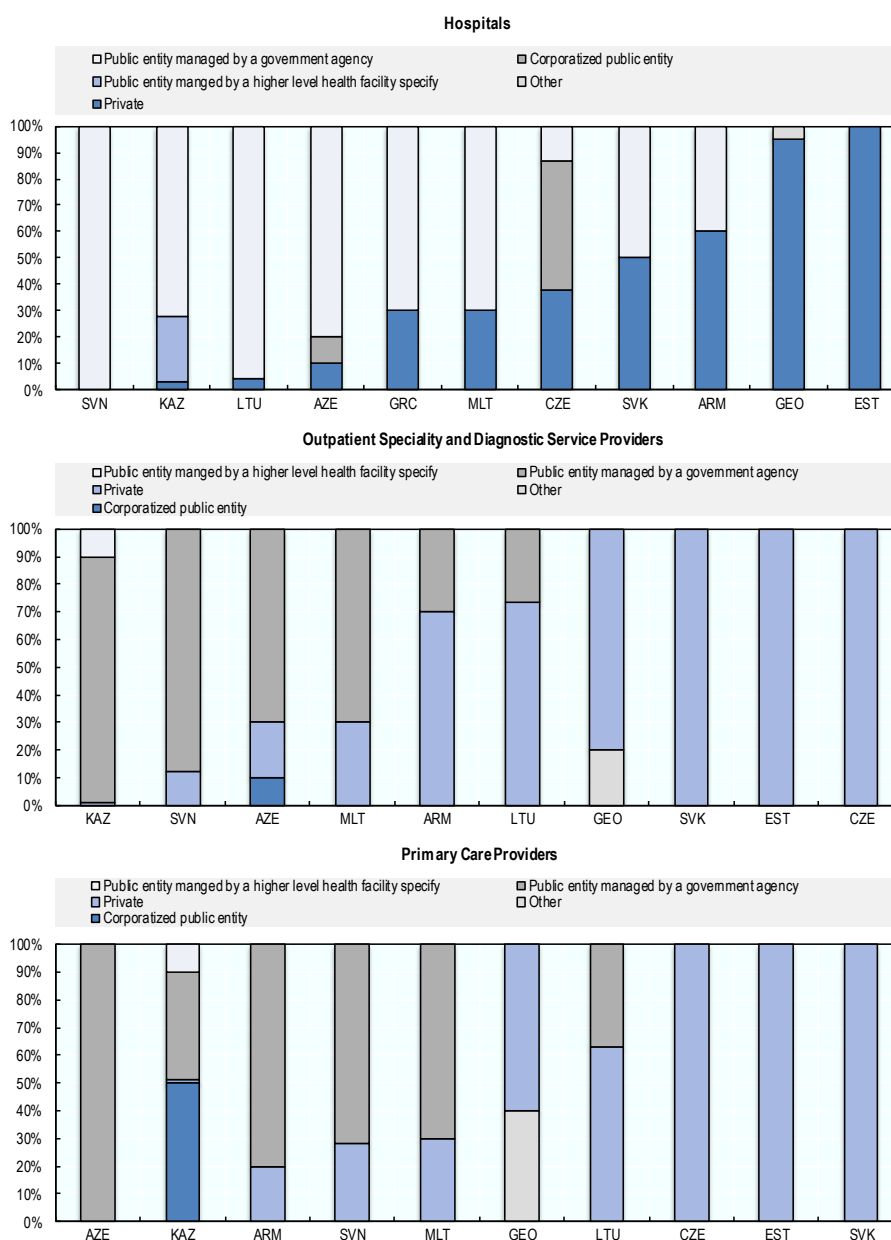
Increased autonomy, however, comes at the cost of losing direct management tools for providers – e.g. the ability to implement process efficiencies through sanctioning. In addition, control of spending on and maintenance of physical capacity (e.g. equipment purchases) can be easier if it is managed and financed from a centralised capital budget; autonomous providers might tend to underfund capital in order to maintain operational funding. The range of instruments available for controlling providers' behaviour is much wider within hierarchies than for purchasers trying to influence autonomous organisations (OECD, 2015^[1]). Many OECD countries have moved away from direct management of providers and focused on strengthening the oversight capacity instead. The exceptions are capital investments budgets, over which the providers still frequently do not have autonomy.

The legal status of health service providers (hospitals, outpatient speciality and diagnostic service, and primary care) vary greatly across the CESEE surveyed countries. In two out of twelve surveyed countries (16%), namely Estonia and Georgia, hospitals are almost 100% privately owned. At the other end, hospitals in Lithuania and Slovenia (16%) are almost 100% public. Hospitals in four of the CESEE surveyed countries (33%) are 70% or more publicly owned and 30% or less privately owned (Azerbaijan, Greece, Kazakhstan, and Malta). In the Czech Republic and Armenia, hospitals are 40% or less public. The Slovak Republic is the only country that has hospitals that are 50% public and 50% private. In Kyrgyzstan, hospitals are 99.8% public, managed by a higher-level health facility, and in Kazakhstan 25% of them are under this category. Corporatisation of hospitals in the Czech Republic is more prominent than in other countries in the CESEE region with around 49% corporatised hospitals. To a lesser extent, in Azerbaijan, around 10% of hospitals are corporatised (Figure 3.18).

Outpatient speciality and diagnostic service providers in the CESEE surveyed countries are a mixture of privately and publicly owned entities. These service providers tend to be more privatised in half of the surveyed countries: 100% private in the Czech Republic, Estonia and the Slovak Republic, and at least 70% or more private in Armenia, Georgia, and Lithuania. On the other hand, outpatient speciality and diagnostic service providers are at least 70% or more public in the other half of the surveyed countries (Azerbaijan, Malta, Kazakhstan, and Slovenia). In Kyrgyzstan, very few service providers are private and the majority are public and managed by a higher-level health facility, while in Kazakhstan 10% are under this latter category.

Primary care in the Czech Republic, Estonia, and the Slovak Republic is 100% privatised. In addition, two countries (Georgia and Lithuania) have at least 60% private primary care services. On the other hand, three countries reported to have at least 70% public primary care services (Malta, Slovenia, and Armenia), while primary care services in Azerbaijan are 100% public. In Kyrgyzstan, 99.8% are public managed by a higher-level health facility, and the remaining 0.2% are private. Lithuania reported to have 40% of these services as public entities with private management. In Kazakhstan 50% of primary care services are corporatised while 10% are public and managed by higher-level health facility (Figure 3.18).

Figure 3.18. Legal statuses of different health service providers



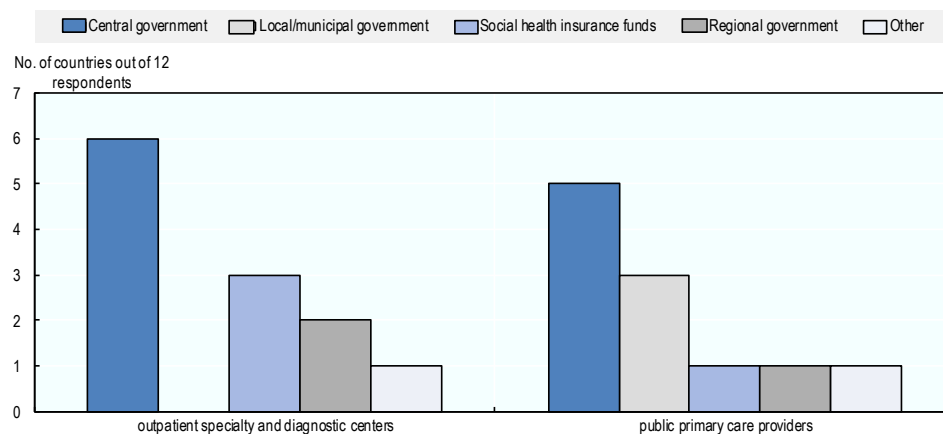
Note: 1. "Other" for Georgia refers to – Public entity with private management
 2. Greece had no information for outpatient speciality and diagnostic service providers, and for primary care providers.
 Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (question 15)

Oversight of public providers

Half of the surveyed CESEE countries reported to have *outpatient speciality and diagnostic centres* overseen by the central government. Other countries, such as Slovenia, Greece, and the Czech Republic have the Social Health insurance funds oversee these centres. Elsewhere they are overseen by regional governments, such as in Kazakhstan and Armenia. Only one country, Georgia, has reported that its outpatient specialty and diagnostic centres are overseen by the private sector (Figure 3.19).

Public *primary care providers* are also mainly overseen by the central government in CESEE countries. Some countries reported that public primary care providers are often overseen by regional or local/municipal governments (Armenia, Kazakhstan, Lithuania, and Slovenia), while only the Czech Republic has delegated the responsibility to the Social Health Insurance fund. On the other hand, the private sector in Georgia carries the responsibility of this task (Figure 3.19).

Figure 3.19. Public primary care providers and outpatient specialty and diagnostic centres mainly overseen by one of following institutions



Notes: 1. Slovakia has no public primary care providers
2. Georgia's public primary care providers and outpatient specialty and diagnostic centres are mainly overseen by the private sector

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (question 16-17)

Autonomy of public providers

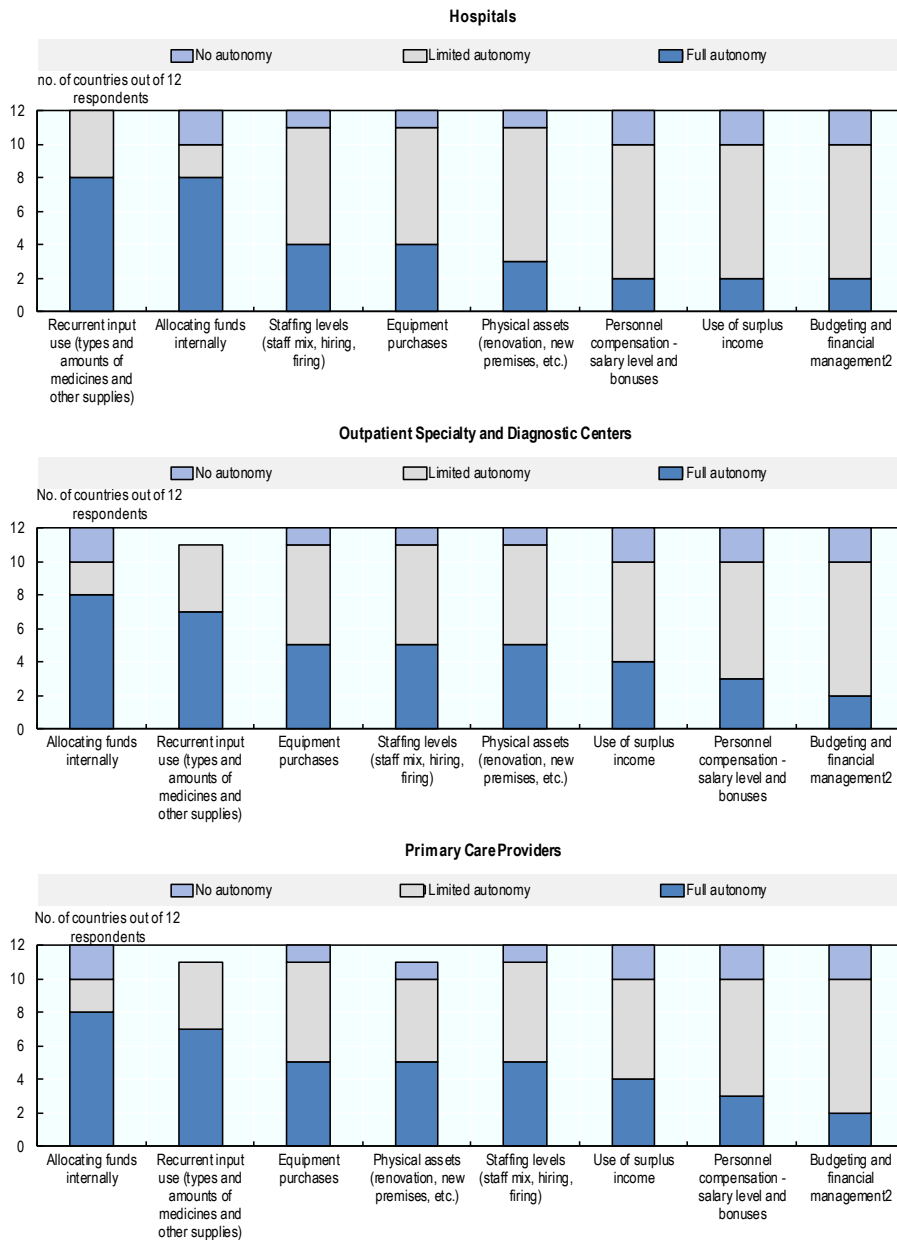
Hospitals have full autonomy in the majority of the CESEE surveyed countries when it comes to activities such as allocating funds internally and on recurrent input use (types and amounts of medicines and other supplies). In a few countries, such as Lithuania and Azerbaijan, hospitals have no autonomy at all on these same activities. On the other hand, more than half of the surveyed countries have reported hospitals have limited autonomy on equipment purchases, personnel compensation – salary level and bonuses, physical assets (renovation, new premises, etc.), staffing levels (staff mix, hiring, and firing), use of surplus income, and on budgeting and financial management. (Figure 3.20)

Similarly, *outpatient specialty* and diagnostic centres have full autonomy in the majority of the CESEE surveyed countries when it comes to allocating funds internally and on recurrent input use (types and amounts of medicines and other supplies). In 50% or more of these countries, however, centres have limited or no autonomy for activities related to equipment purchases, personnel compensation – salary level and bonuses, physical assets (renovation, new premises, etc.), staffing levels (staff mix, hiring, and firing), use of surplus income, and on budgeting and financial management. Particularly, only two out of the twelve surveyed countries (Estonia and the Czech Republic) have full autonomy on budgeting and financial management within outpatient and diagnosis centres.

Primary care providers in CESEE countries also show a similar distribution when it comes to autonomy. In the majority of countries, providers are fully autonomous to allocate funds internally and use recurrent input (types and amounts of medicines and other supplies). At

the same time, in the majority of these countries providers have limited or no autonomy on equipment purchases, personnel compensation – salary level and bonuses, physical assets (renovation, new premises, etc.), staffing levels (staff mix, hiring, and firing), use of surplus income, and on budgeting and financial management.

Figure 3.20. Autonomy of public providers



Note: Georgia did not give an answer for outpatient speciality diagnostic centres and primary care providers on Recurrent input use. Lithuania did not give an answer for physical assets for primary care providers
Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (question 18)

4. Budgeting practices

4.1. Budgeting practices in the health

4.1.1. Budget formulation and planning

How is public expenditure on health included in the central-government budget?

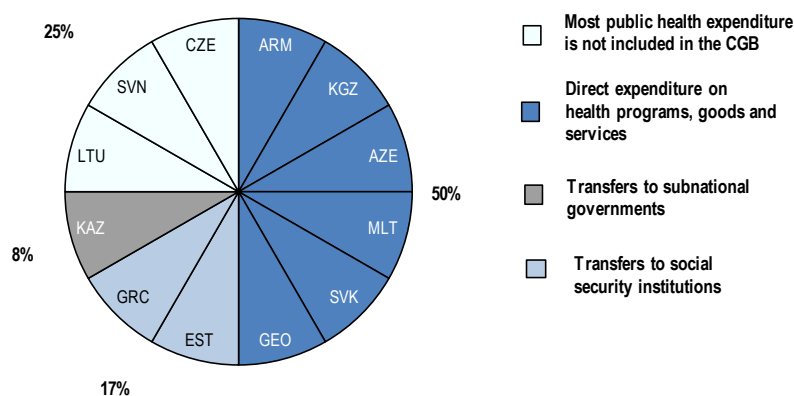
Budgeting practices for health differ depending on the type of health system in place, including the way health expenditures are incorporated in the different public budgets (central, subnational, and health insurance funds, when applicable). In all countries, however, some health spending is included in the government budget – even in countries with independent social security or insurance funds, or where health is responsibility of sub-national governments. Therefore, the government’s budgetary process is an important tool in determining overall spending and achieving policy objectives. Moreover, of particular importance is the alignment of the legislative review processes and timeline for budget formulation between the government budget and the budgets of the independent social security or insurance funds, or the sub-national governments (Section 4.1.2).

In the majority of the CESEE surveyed countries, most types of health expenditures are included in the central budget process either as direct expenditure on health programmes, goods and services, as transfers to social security institutions, or as transfers to subnational governments.

When health expenditures are included in the central budget process, these expenditures normally go through the regular formulation process led by the Central Budget Authority (CBA) and are discussed by the parliament during the central budget approval phase. This is the case for 75% of the survey’s countries. The type of resources that goes through this process, however, varies from country to country. Half of the surveyed countries include health expenditure as direct expenditure on health programmes, goods, and services; 17% include them as transfers to social security institutions; and only one country, namely Kazakhstan, includes them as transfers to subnational governments (Figure 4.1).

The remaining 25% of surveyed countries reported that most of their public health expenditure is not included in the budget of the central government. These countries have a separate budget process for the health insurance system where most health revenues and expenditures are directly included (see Section 4.1.2 for more details).

Figure 4.1. How public health expenditure is included in the central-government budget



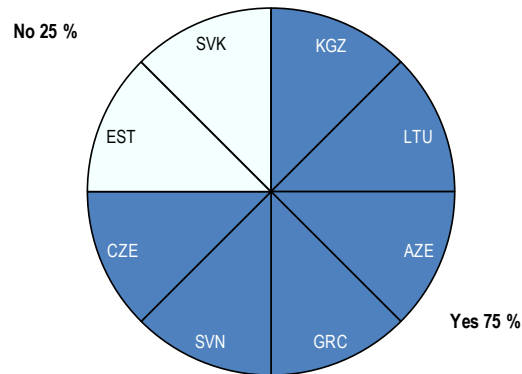
Source: OECD (2017), CESEE Survey on Budgeting Practices for Health (Question 7 and 7a).

4.1.2. Budget formulation for social health insurance

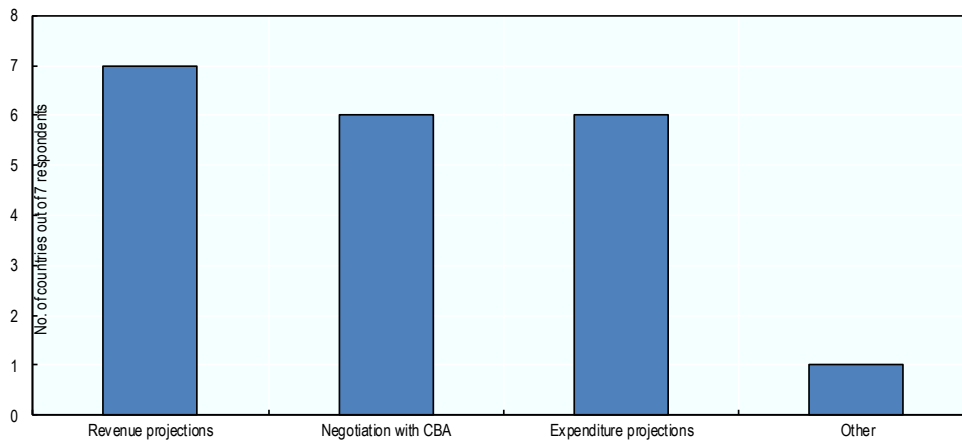
SHI and degree of integration with the central-government budget

As mentioned in Section 3.1.2, 42% of the surveyed countries have a Social Health Insurance Scheme, while 16% have mixed sources for healthcare financing. This subsection explores the details of the budget formulation process and approval for social insurance funds/agencies. Most surveyed countries with a social health insurance scheme have a separate budget to manage its resources. Despite this, negotiations with the central budget authority play a major role when preparing the social health insurance agency budget.

Around 75% of the surveyed countries with a social health insurance scheme have a separate budget to manage resources (Figure 4.2). Only Slovakia and Estonia reported to have the budget of the social health insurance system integrated with the central-government budget. In Slovakia, the Ministry of Health acts as the main regulator and is the only stakeholder in the main health insurance company (General Health Insurance Company) with a delegate in the advisory board from the Ministry of Finance. Therefore, it also serves as a budget regulator despite the fact that the main authority to approve the budgets is the Healthcare Surveillance Authority (Figure 4.3).

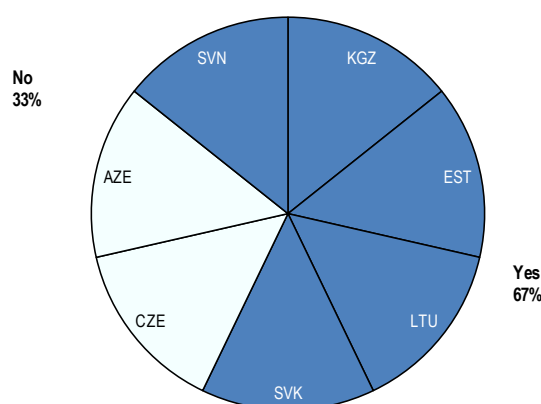
Figure 4.2. Separate budget for social health insurance system

Note: This question was only answered by countries that have a social health insurance scheme.
Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 8)

Figure 4.3. Bases of the social health insurance agency budget

Notes: 1. This question was only answered by countries that have a social health insurance scheme
 2. For the Czech Republic, “Other” refers to Negotiations with the Ministry of Health
Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 41)

Most surveyed countries reported that the budget of their health insurance system is approved by the parliament, either as part of the central budget process or with a different parallel approval process. In Greece, the social health insurance agency budget is subject to legislative approval as part of the total annual General Government budget and of the Medium Term Fiscal Strategy (MTFS), which are both submitted and approved by the Parliament. Only in Slovenia and Azerbaijan, the social health insurance budget does not require legislative approval (Figure 4.4). In some countries, the Ministry of Health (e.g. Slovakia) or the supervisory board of the health insurance fund (e.g. Estonia) also have a main role in the approval phase of the budget document.

Figure 4.4. Is the health insurance agency budget submitted for legislative approval?

Notes: This question was only answered by countries that have a social health insurance scheme.

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 41.a)

Budget transfers to SHI

All CESEE surveyed countries have transfers from the central government to the social health insurance system. Most of these transfers are insurance contributions paid by the government on behalf of some non-contributing groups (e.g. retirees, children below a certain age, students, soldiers, and unemployed). Only in Greece, these transfers are general subsidies to the scheme.

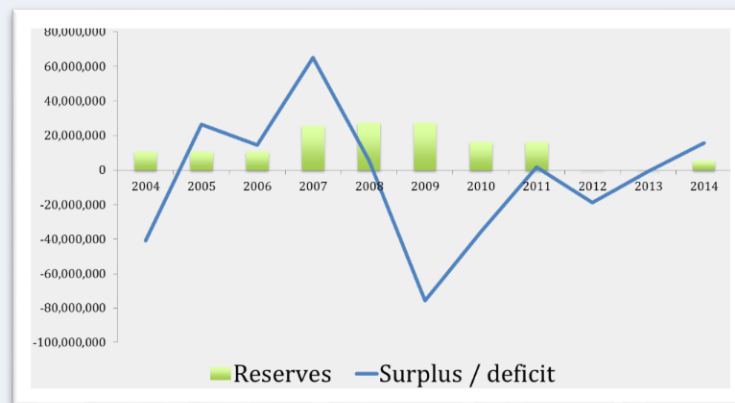
The percentage of resources transferred and the way to calculate it vary between the CESEE countries. In the case of Lithuania, the amount of the contribution per person insured by the State is defined by the Law on Health Insurance. In 2016, the state budget contributions were almost 30% of the total revenue of the Compulsory Health Insurance Fund Budget. In Greece, the state grant contributions is transferred directly from the central government budget to the budget of Greece's National Organization for the Provision of Healthcare Services (EOPYY). In 2017, this grant represents 7% of the total social health insurance system budget. In Slovenia, transfers represent around 18% of the social health insurance system's total budget, consisting of contributions from central and local budgets, reimbursement of co-payment to complementary health insurance for social protected groups of population, and contributions for prisoners as well as war veterans. In Slovakia, the transfers are for those that are considered economically inactive and it constitutes approximately 23% of overall contributions. Finally, in the Czech Republic, transfers for insurance contributions for non-contributing groups represent around 24% of the social health insurance budget.

Whether the accumulation of debt or producing deficit in off-budget public health insurance agencies is permitted varies between the CESEE countries with health insurance schemes. In the Czech Republic and Greece, for example, public health insurance agencies have a strict mandate not to accumulate debt without financing assistance by the government. In Kyrgyzstan and Slovakia, public insurance agencies have the objective of not accumulating debt, and the government takes measures to finance deficits. Estonia's health insurance agencies are allowed to accumulate debt if the annual budget law permits it. In Lithuania, the public health insurance agencies must not have any deficit. Slovenia's health insurance

agency can only record the deficit to the amount of the accumulated reserves from the previous years (Box 4.1).

Box 4.1. The case of deficit and accumulated reserves for the Social Health Insurance Institute in Slovenia

Insurance Institute of Slovenia (HIIS) records the deficit to the amount of the accumulated reserves from the previous years. In order to ensure a balanced cash flow in the period between 2011 up to 2013, HIIS liability payments arising from one year were postponed until the year after. In that case, in 2011, euros 41 million were passed on to be paid in 2012. Similarly, in 2012 deficit was to be paid the year after (euros 64 million), while the 2013 deficit was to be paid in 2014 (euros 49 million). Finally, in 2014, HIIS paid all liabilities without having to transfer any expenditure to 2015.



Source: Slovenia Ministry of Health

4.1.3. Use of targets for coverage and spending

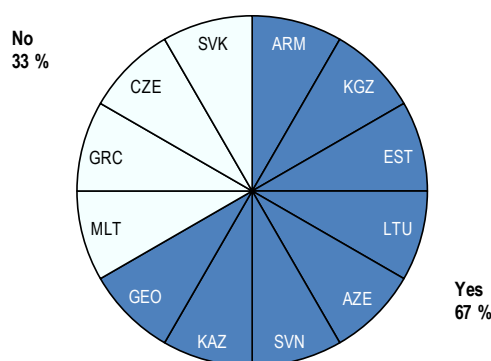
Targets for coverage/spending or ceilings for spending as well as medium-term projections are other crucial tools that allow verifying whether objectives have been achieved and controlling health expenditure. Their effectiveness depends on how far health-specific compared to purely economic factors are used in determining them. Moreover, their meaningfulness is determined by the timeliness and reliability of information available to the key institutions responsible for health financing, as discussed in Section 4.3.

The majority of the CESEE surveyed countries reported to have health systems that cover 100% of the population. These coverages, however, may only include a segment of basic services and provisions. The Armenian healthcare system, for example, covers the whole population for outpatient and primary healthcare services, while only 30-40% of the population is covered for inpatient services. In Kazakhstan, certain health services do not reach remote areas of the country due to low population density.

Consequently, two thirds of the surveyed countries have a specific plan to increase publicly funded health coverage in the coming years, which would generally imply increases in public spending on health (Figure 4.5). In particular, most countries have a plan to increase population coverage (Armenia, Kyrgyzstan, Estonia, Lithuania, Azerbaijan, Republic of Slovenia, and Kazakhstan), service coverage (Armenia, Kyrgyzstan, Lithuania, the

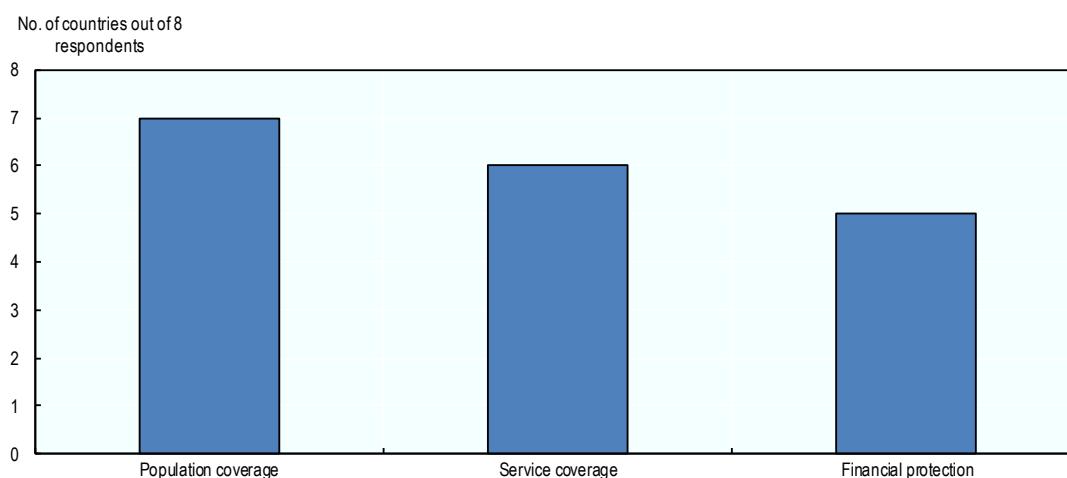
Republic of Slovenia, Kazakhstan, and Georgia) and financial protection (Armenia, Kyrgyzstan, Slovenia, Kazakhstan, and Georgia) (Figure 4.6).

Figure 4.5. Countries planning to increase publicly funded health coverage in the coming years



Source: OECD (2017), CESEE Survey on Budgeting Practices for Health (Question 4)

Figure 4.6. Targets included in the plan to increase publicly funded health coverage



Source: OECD (2017), CESEE Survey on Budgeting Practices for Health (Question 4a)

Targets for increasing or containing public spending on health

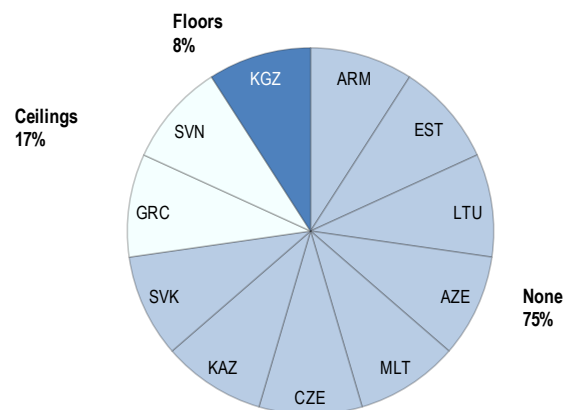
Since one of the main concerns for OECD member countries is to control health expenditure growth rate, most of them use some kind of budget ceiling for central government's expenditure on health. In fact, in 80% of OECD countries, budget agencies developed a desired maximum level of spending for health, and this target was reached in about two-thirds of cases (OECD, 2015^[1]).

In other regions of the world, the objectives are not necessarily the same. For example, in the LAC region many countries are aiming to increase public health expenditure to reach universal healthcare coverage in the following years. Consequently, along with ceilings to

control health spending, 42% of the surveyed countries in this region have minimum targets (floors) to ensure health spending increases.

On the other hand, 75% of the CESEE surveyed countries reported that they do not set specific floors or ceilings for the growth rate of central government budgeted health expenditure (Figure 4.7). Despite existing plans to increase publicly funded health coverage in the region, only Kyrgyzstan reported to have floors for the growth rate of central-government budgeted health expenditure. The most important factors when setting these floors are the share of health spending in total public spending, the estimated GDP growth, and historical budgets. In a similar way, only the Republic of Slovenia and Greece reported to have ceilings. Similar to the trend perceived in OECD countries, the most important factors when establishing such ceilings are: objectives for fiscal position, expenditure estimates, estimated total government revenues, GDP growth, and historical budgets.

Figure 4.7. Targets and ceilings imposed on the health expenditure growth rate



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 11)

4.1.4. New projects and longer-term planning

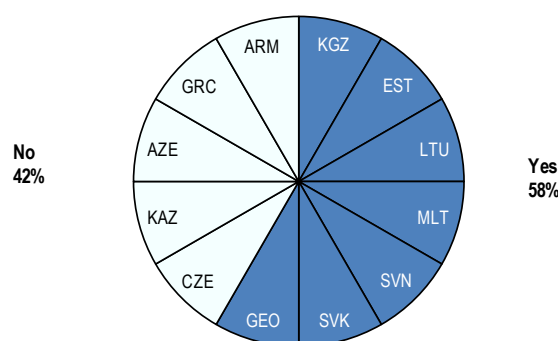
Longer-term planning and well-designed procedures for assessing new legislative proposals concerning publicly funded initiatives are required to effectively guide the budgetary institutions as health needs and economic circumstances evolve. While in many surveyed countries, budget authorities receive evaluations of the expected developments in health needs and the corresponding health benefits from new policy proposals suggested by the Ministry of Health, these are not always considered in the prioritisation of policies. Such findings have also been observed in the earlier survey of OECD countries.

The main challenge in surveyed countries appears to be limited capacity of the central budget authorities to assess policies proposed by the Ministries of Health. The latter indicates a need for further strengthening of the coordination mechanisms (Section 2.1) between the two key institutions. Similarly, longer-term planning is needed to improve adequacy and continuity of health programmes, especially to secure political agreement underpinning their continuous provision.

How are new health proposals evaluated by the central budget authority?

The majority of the CESEE surveyed countries have a mechanism in place to ensure that new legislative proposals concerning publicly-funded health expenditures account for the full cost of the initiative by including cost estimates in the short, medium, and long-term (Figure 4.8). In Estonia, for example, the Ministry of Social Affairs provides cost estimates for new legislative proposals; in Slovakia, these estimates are included in the Government programmes and the spending review targets defined in 2016; in Slovenia, estimates are included in the Financial Plan of the Health Insurance Institute of Slovenia for two years and in their Strategic Plan for five years.

Figure 4.8. Mechanism in place to ensure that new legislative proposals concerning publicly funded health expenditures accounts for the full cost of the initiative

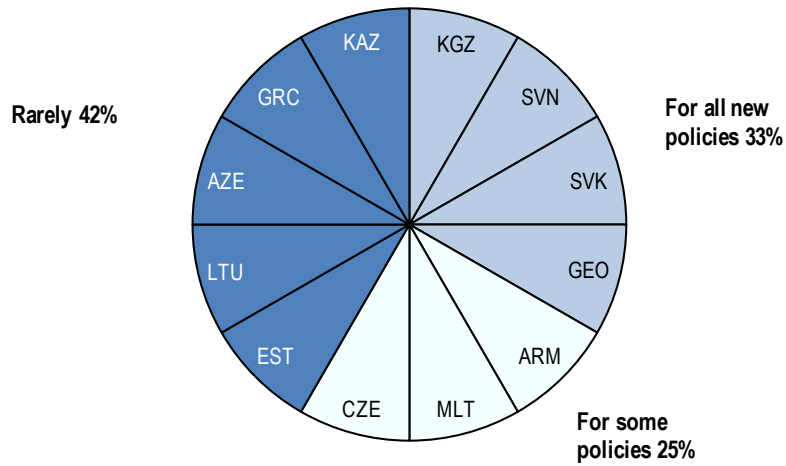


Note: In Malta, these mechanisms are only used for Public Private Partnership (PPP) projects

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 35)

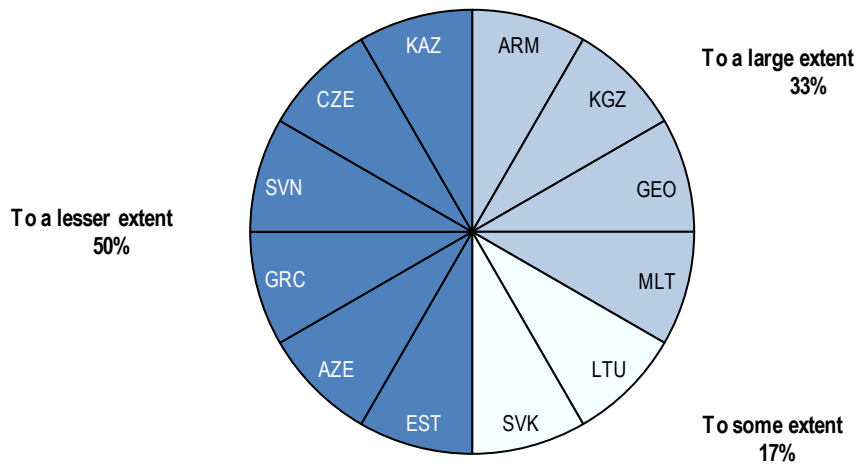
Around 58% of budget agencies noted that they receive economic evaluations (cost-benefit or cost-effectiveness analysis) from Health Ministries for all or some policy proposals (Figure 4.9). They also noted, however, that these assessments count “to a lesser extent” in their assessment of policy proposals (Figure 4.10). Only in Armenia, Malta, Georgia, and Kyrgyzstan are these evaluations often used by the CBA, for prioritising and supporting policy proposals based on some quantification of expected health benefits to the population ahead of all other factors. This suggests a lack of connection between the economic evaluations being conducted within Health Ministries (and academic health policy circles) and their perceived utility to budget agencies. This trend is similar in OECD countries, where 70% receive economic evaluations but only 30% use them to a “large” or to “some extent”. Similarly, in 75% of the CESEE surveyed countries budget authorities receive evaluations of the impact of health policies on equity, but in 50% of the countries this type of analysis is not fully used by the CBA during the assessment of policy proposals (Figure 4.11 and 4.12).

Figure 4.9. Countries in which the CBA receives economic evaluations of expected health benefits from new policy proposals suggested by the Health Ministry



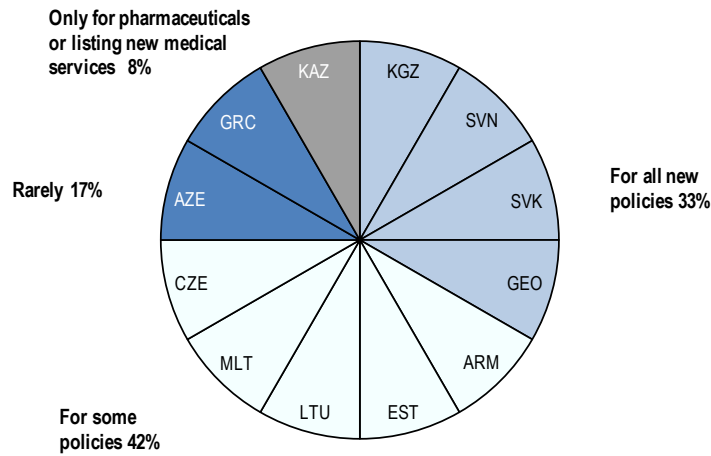
Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 36)

Figure 4.10. Assessment of health policy proposals (based on economic assessments of their expected benefits) by the CBA



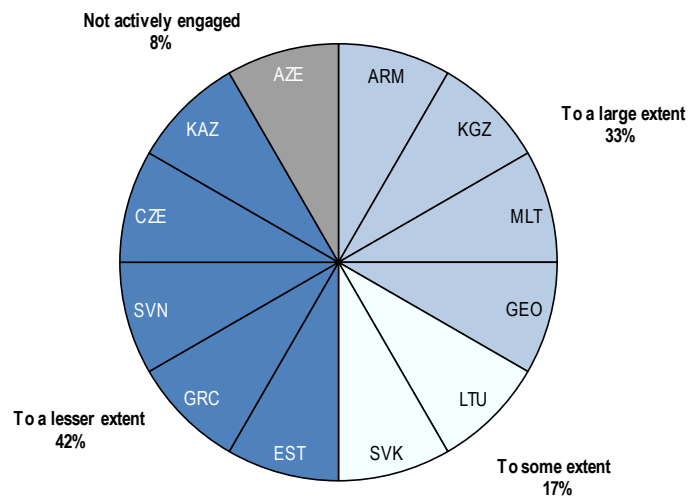
Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 36a)

Figure 4.11. Countries in which the CBA receives evaluations of the expected impact on equity and coverage from new policy proposals



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 37)

Figure 4.12. Assessment of the impact of health policies on equity by the CBA



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 37a)

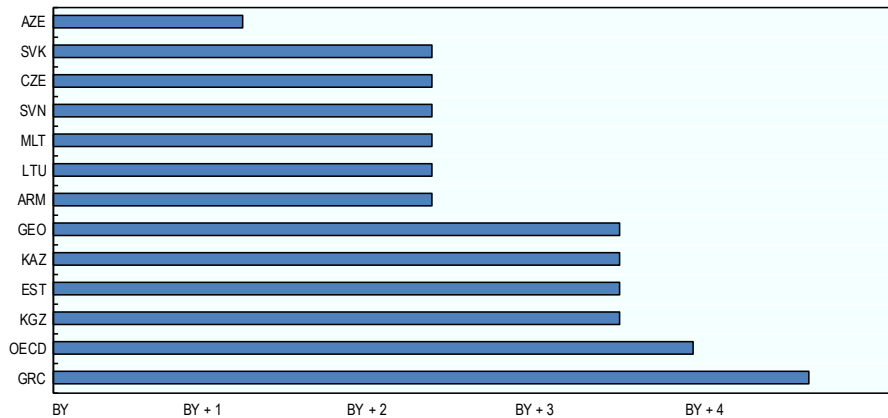
Longer-term planning: projecting health expenditure

Most budget agencies in the CESEE region have a multi-year vision of health spending, including estimates for public spending for more than one year in the budget document. While the majority of countries provide four-year estimates for medium-term projections, the length of the time intervals ranges from two (in Azerbaijan) to five years (in Greece) (Figure 4.13).

On the contrary, long-term projections (more than 5 years) are not common in the region (Figure 4.14). Less than half of the surveyed countries (Estonia, Lithuania, Malta, Slovenia, and Kazakhstan) reported to have such types of projections, neither are they always

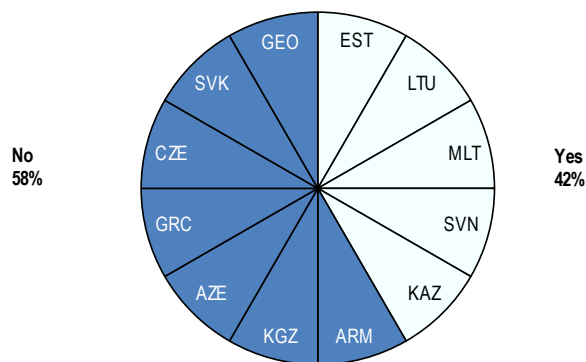
produced for all areas of health expenditure. In Malta, these projections are only produced for PPP projects. In Estonia, Lithuania, and Kazakhstan these projections are done on a yearly basis; while in Kazakhstan, long-term projections are produced every three years. This panorama contrasts with OECD practices, where 85% of countries produce long-term projections of health spending and are generally publicly available. In the majority of cases (62%), projections cover 31 to 50 years.

Figure 4.13. Years of medium-term estimates for health spending in the budget



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 38)

Figure 4.14. Countries with long-term projections for healthcare expenditure



Note: In Malta, these projections are only made for Public Private Partnership (PPP) projects

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 39)

4.1.5. Budget allocation decisions within the health sector

The central budget authorities of the OECD member countries tend to leave the allocation of spending and its scrutiny to a combination of Ministries of Health and social insurance agencies. Since the 1990s, the prevailing trend across OECD countries has been a shift towards “top-down” budgeting practices where the executive determines aggregate public finance targets (spending and revenue levels) given medium term fiscal objectives and prevailing economic conditions. The detailed allocation decisions are then usually delegated to the individual line ministries. Top-down budgeting marks a shift in budgetary

roles away from a more controlling budget agency and provides line ministries with relatively greater responsibility for resource allocation and for supervising spending. This shift towards a supervisory role is evident in the extent to which budget agencies do not allocate budgets on the basis of achieving specific health objectives nor towards sub-categories within health spending (OECD, 2015^[1]).

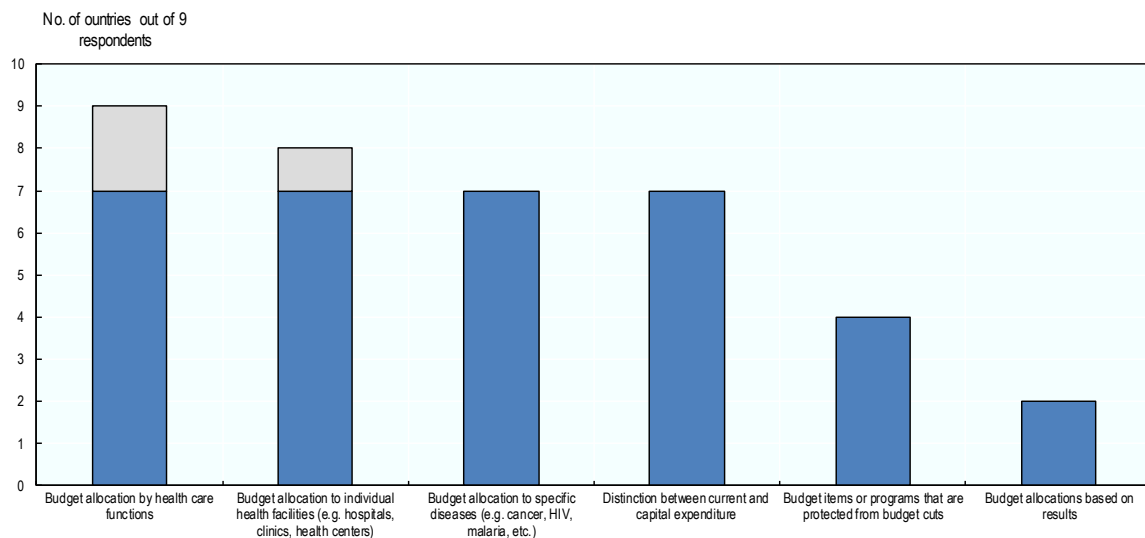
Budget allocations mechanisms within the health sector of the CESEE surveyed countries also differ from OECD trends; the majority of the CESEE surveyed countries include specific budget allocation by healthcare functions, individual health facilities, and specific diseases. This approach limits the flexibility of health sector institutions, from the level of the Ministry of Health down to the level of individual providers, to adjust spending strategies as health needs and health technology evolve. In consequence, this rigidity might create obstacles for timely adoption of initiatives enhancing efficiency.

In contrast with recent OECD trends, the majority of the CESEE surveyed countries include budget allocation by healthcare functions (e.g. curative care, medical goods, preventive care, etc.), individual health facilities (e.g. hospitals, clinics, health centres), and specific diseases (e.g. cancer, HIV, malaria, etc.). In the majority of surveyed countries, these categories form the basis of appropriation, and only a few countries use them for informative (non-binding) purposes (Figure 4.15).

More than half of the surveyed countries also make a distinction between current (operating) and capital expenditure. The shares between these types of expenditure vary between 73% operating and 27% capital in the Czech Republic and 97% and 3%, respectively, in the Republic of Slovenia.

Only one third of the surveyed countries have budget items or programmes that are protected from budget cuts. In particular, salaries (Azerbaijan and Kyrgyzstan) and state contribution for the Compulsory Health Insurance Fund (Lithuania) are some of the budget lines that are protected. In some countries like Georgia, the entire budget line for the state health programme is protected from budget cuts.

Finally, only two countries allocate the budget based on results. In the case of Lithuania, only primary healthcare allocations are based on results, while in Georgia, this type of allocation is used for all healthcare programmes.

Figure 4.15. Elements specified in the budget documents*Notes:*

Light colours denote countries where these categories are only used for informative (non-binding) purposes.
 In Estonia, budget allocation by sub-category of healthcare function is specified in the Estonian Health Insurance Fund budgeting process and budget document
 In Greece, budget allocations by healthcare are explicitly considered in the budget only for EOPYY (Hellenic Organization for the provision of Health Services).
 In Czech Republic, answers refer to the budget of the Ministry of Health in the Central-government budget
 Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 13)

4.2. Budget execution

A crude measure of the success of the accuracy of the health budget estimates is the extent of budget overruns and underspending. Overruns often lead to unplanned savings demand at the end of the budgetary year, which might effectively cease access to some health goods or services. Similarly, underspending usually means that some health services were not provided to populations that might have needed them. In particular, underspending is symptomatic of inaccuracy in the mechanisms of budget allocation within health sector. Indeed, common reasons behind underspending are underlying conditions linked transfers and narrow definitions of spending categories.

Some difference between the actual health spending and the budgeted expenditure is unavoidable but in a well-designed system of monitoring tools, such as early warning mechanisms, should minimise them. Section 4.3 elaborates in more detail on the health expenditure reporting and monitoring system.

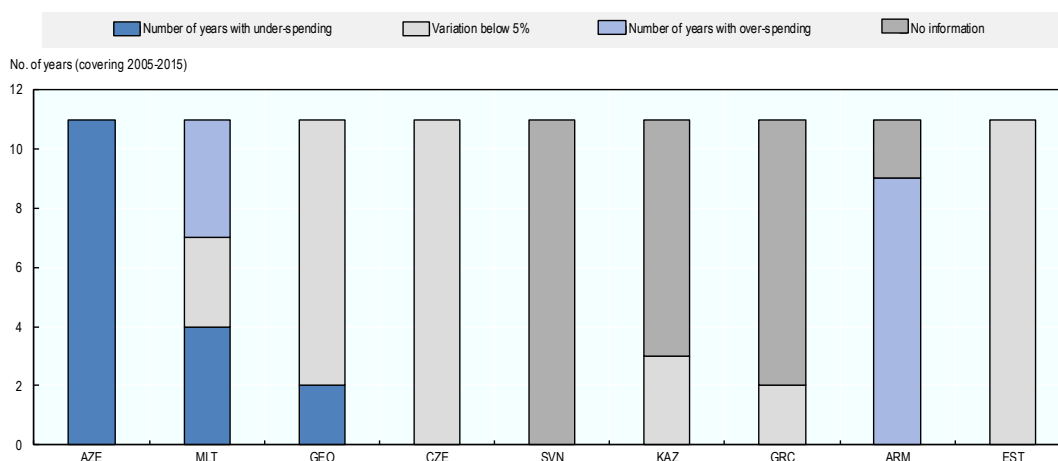
There is great variation between the CESEE surveyed countries regarding expenditure levels. Some countries tend to have lower and others higher expenditure levels than the ones initially programmed in the central public budget, while other countries have more stable expenditure levels throughout the year.

In OECD member countries, budget overruns in health remain common and often lead to deficit or unplanned savings requests to spending units at the end of the year. This contrasts with the experience of some regions of the world (e.g. LAC region), where countries tend to have lower expenditure levels than the ones initially programmed in the budget.

Figure 4.16 compares initial budget approved and actual budget spent. Three of the CESEE countries reported to have underspending in at least two of the last ten years (Malta, Georgia, and Azerbaijan), while two countries reported to have at least two years of overspending during the same period (Armenia and Malta). Six countries (the Czech Republic, Estonia, Kazakhstan, Georgia, Malta, and Greece) reported to have at least two of the last ten years without overruns or underruns (variations of less than 5%).

The particular financing flows and budgetary rules that each country has in the health sector have a strong effect on the expenditure levels. In the case of Slovenia, for example, health expenditure is included in the central budget as transfers to the health insurance fund. Since law determines these transfers each year, overruns or underruns never occur. In a similar way, Kazakhstan has a strict budget system that prevents overspending. On the contrary, the Czech Republic allows carryovers in the budget of the Ministry of Health. Therefore, budget overruns are only possible in the case of underspending in the previous periods.

Figure 4.16. Number of years with over or under-spending in health between 2005 and 2015



Notes:

Figures compare the initial budgeted expenditure with actual expenditure in a given year.

Variations below 5% were not considered as under or over-spending

Kyrgyzstan, Slovak Republic, and Lithuania did not answer this question

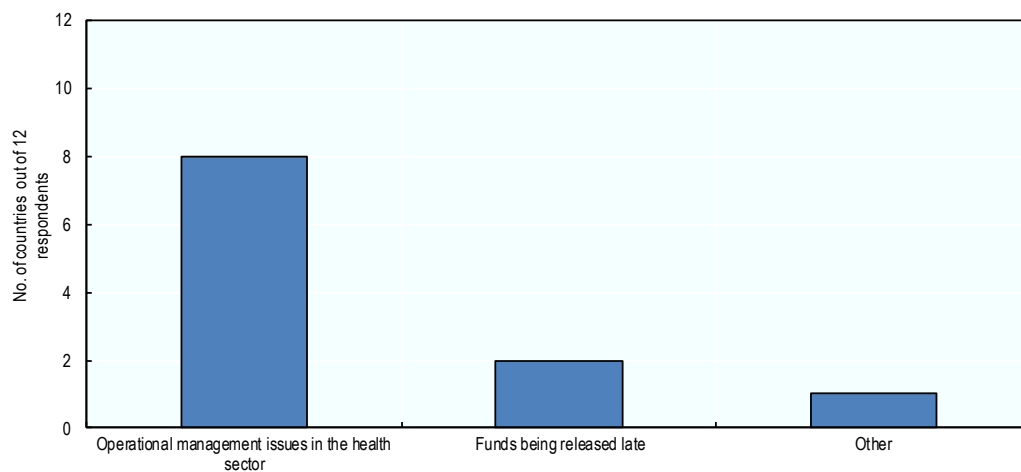
Slovenia's answer to this question is under the category "Not Applicable" since the initial budget planned and the actual budget spent are calculated with a different methodology and is not comparable.

Public expenditures for (Czech Republic, Estonia) that have a health insurance scheme come from the social health insurance budget

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 27)

4.2.1. Main reasons for underspending of budget

Operational management issues in the health sector (e.g. excessive bureaucratic procedures, narrow definitions of spending categories, and strings attached to transfers within the health sector) are one of the main reasons behind under execution (Figure 4.17). Only Kazakhstan and Kyrgyzstan reported that the late release of funds was a relevant cause for under-spending. In the case of Malta, underspending in capital expenditure occurs due to a delay in the tendering process and invoicing.

Figure 4.17. Reasons for underspending in the health sector

Note: In Malta, “other” refer to delay in the tendering process and invoicing for certain projects being carried out

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 27a and 27b)

Gathering information about central-government health expenditure is a rather complicated task. Some countries such as Kyrgyzstan and Lithuania did not answer this question, while other countries such as Greece, Armenia, and Kazakhstan had information available only for recent years.

4.3. Budget monitoring and performance

4.3.1. Health expenditure reporting and monitoring systems

As discussed above, budget overruns or underspending often means that some health services were not provided to populations that might have needed them. Therefore, timely information on spending trends is crucial.

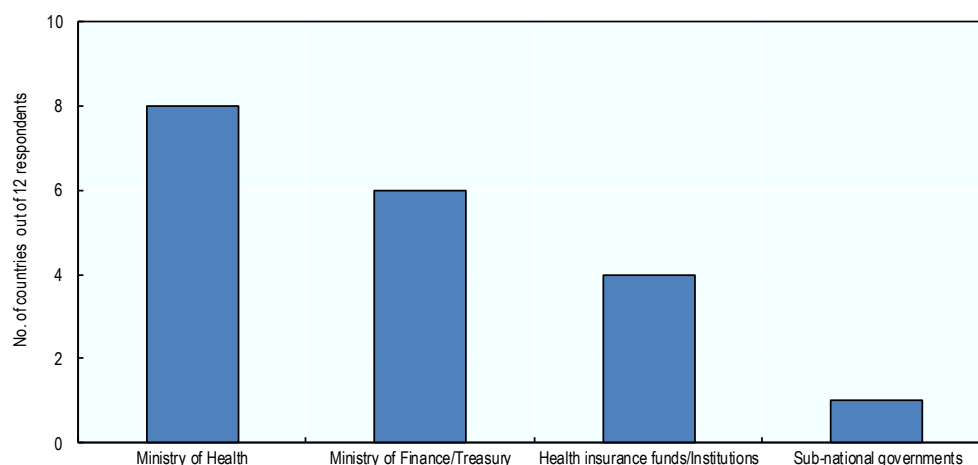
Agency with main responsibility for monitoring health expenditures

There have been initiatives to introduce periodic reporting and monitoring systems in CESEE countries. Except for Estonia, all surveyed countries have a mechanism in place to monitor budget execution in the health sector (e.g. regular reporting on spending by relevant institutions to avoid over- or under-spending). Some countries such as Armenia, Lithuania, Greece, Georgia, Slovenia, and Kazakhstan use periodic reports revealing expenditure levels in the health sector. Other countries such as the Czech Republic use integrated information systems reporting to the central budget authority. This allows for timely information to monitor and control health expenditure.

In most CESEE surveyed countries, the Ministry of Health is the actor with the main responsibility in monitoring health expenditures and signalling when there is a risk of spending above/below the approved limit. These results contrast with other regions of the world where the Ministry of Finance always has the main responsibility for monitoring health expenditure (e.g. LAC). In the CESEE region, the Ministry of Finance only has an active monitoring role in half of the surveyed countries and health insurance funds/agencies have an active role in more than half of the countries that reported to have that type of

system (Figure 4.18). Only in Lithuania, subnational governments have a monitoring responsibility.

Figure 4.18. Actor with the main responsibility in monitoring health expenditures



Note: Estonia does not have a monitoring system in place.

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 24a)

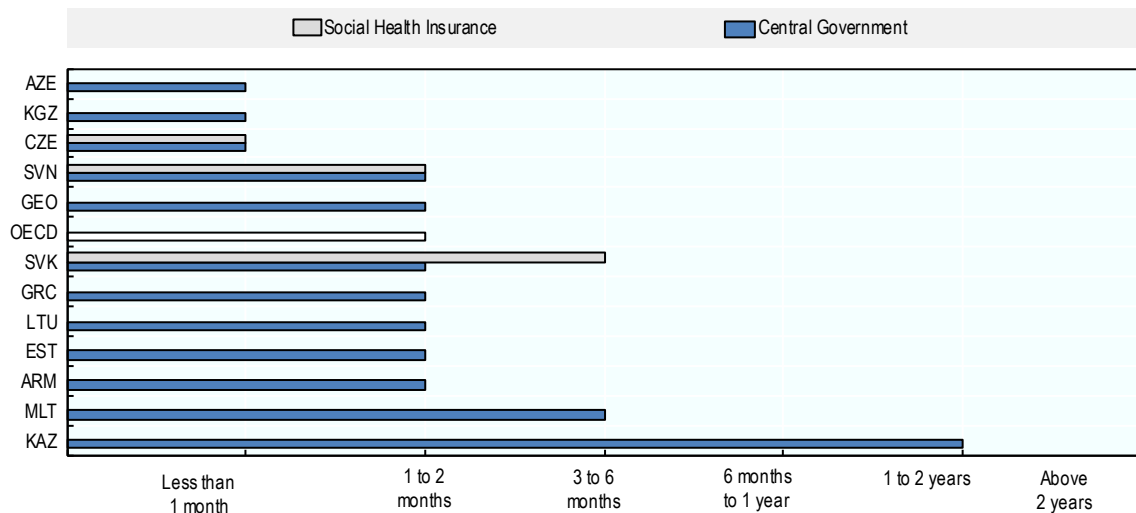
Timeliness of information on health expenditures

A prerequisite for effective monitoring and control of health expenditure is to have timely information. This might be a challenge for countries where health expenditure is not fully included in the central budget document. For example, before 2012, the Greek Central Budget Authority did not have any information on hospitals, the Social Health Fund, or the local governments' health expenditure. After the fiscal crisis, Greece made changes in the system to ensure that the Central Budget Authority can monitor and control all health expenditures.

Overall, the CESEE surveyed countries have timely information available for central government health expenditure. In most surveyed countries, the central budget authority receives information from one to two months after the spending occurs. In Slovakia, information from the social insurance agency is available in 3 to 6 months. Furthermore, in some countries such as Azerbaijan, Kyrgyzstan, and the Czech Republic³, this information is available with less than a month delay (Figure 4.19). In some countries such as Greece, legally binding penalties are imposed on failing to report. These penalties can include the suspension of the State budget transfers and public disclosure of those units that failed to report.

Some of the main challenges faced by the CESEE countries to have timely information on health financing are reporting delays by healthcare providers (50%), the Ministry of Health (30%), and insurers (16%). Other less common challenges are a lack of appropriate technology to process data and reporting delays by subnational governments and other institutions (Figure 4.20).

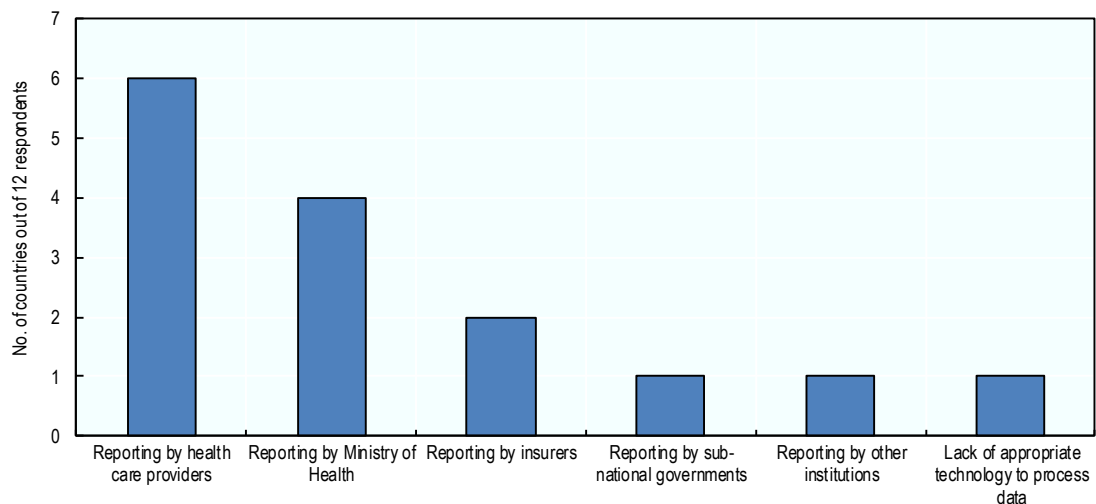
³ The Czech Republic receives information on total cash incomes and expenditures on a monthly basis, for the account balance in less than a month, and for liabilities in less than two months. These reports are then used to quickly estimate and keep track on the healthcare financing throughout the year. More detailed statements are received on a quarterly basis. The health insurance fund submits statements on a quarterly basis.

Figure 4.19. Central government Health expenditure reporting delay

Note: 1. OECD average refers to both social insurance and central government health expenditure

2. In Czech Republic, reporting on Social Health Insurance expenditures go through two stages, one that is received at the CBA in less than 1 month for a quick overview, and a detailed statements is received on quarterly basis

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 25)

Figure 4.20. Reasons for health expenditure reporting delay

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 26)

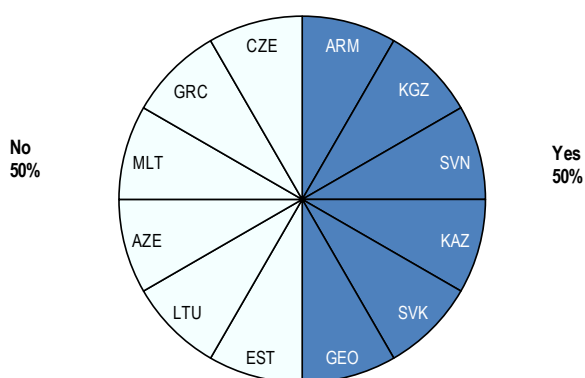
4.3.2. Performance agreements and use of performance information

In addition to providing timely information on the general volume of spending, the monitoring mechanisms also need to shed light on health system performance. Designing well-functioning performance indicators is challenging but through incremental improvements, surveyed countries continuously develop their monitoring capacity in this area. The development of effective accountability mechanisms appears to be more challenging, however.

Performance agreements

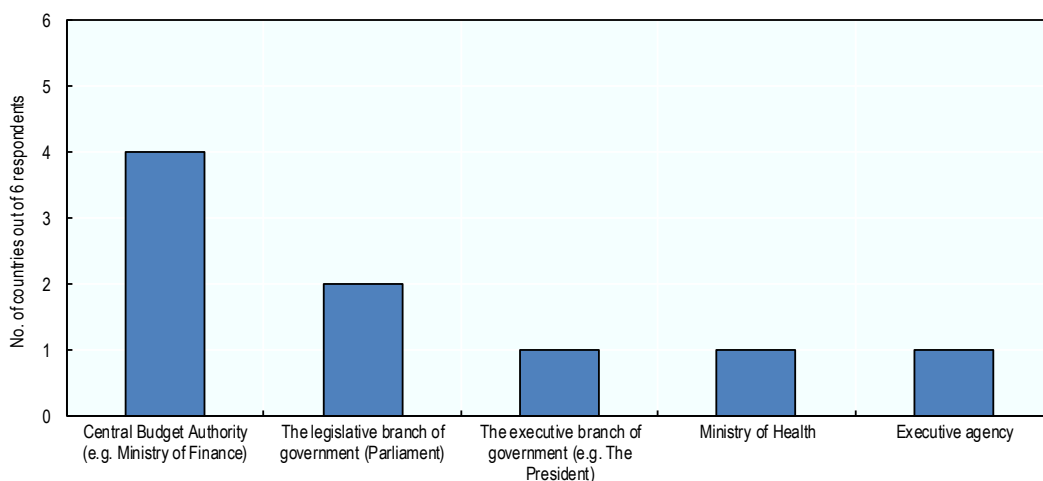
Half of the CESEE surveyed countries reported to have performance agreements with implementing agencies/authorities (Figure 4.21). With the exception of the Republic of Slovenia and Georgia, all countries with performance agreements reported the central budget authority to have a leading role in deciding the performance indicators used to implement such agreements (Figure 4.22). Other institutions that also play a leading role in some countries are the legislative branch of government, the executive branch of government (president or a line ministry), and executive agencies.

Figure 4.21. Countries where health implementing agencies/authorities are subject to performance agreements



Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 28)

Figure 4.22. Decision making responsibility on the performance indicators



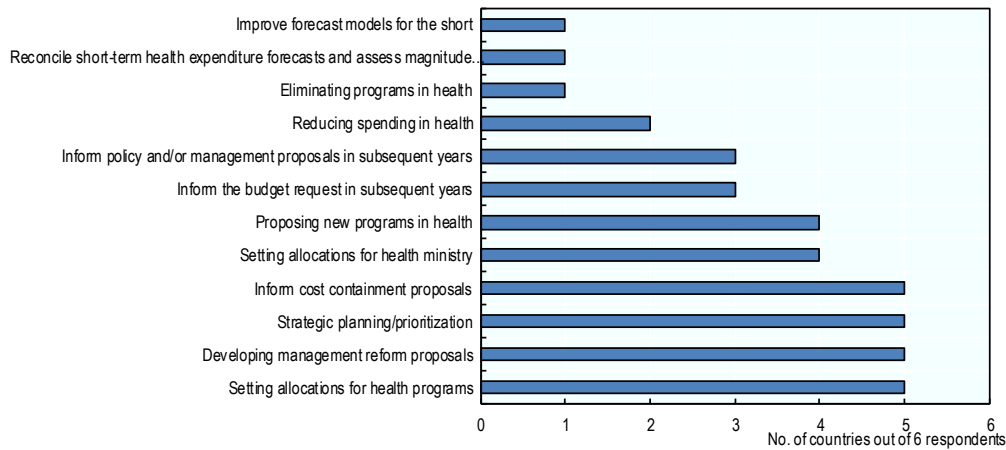
Source: OECD (2017), Survey of Budgeting Practices for Health in CESEE countries (Question 29)

Use of performance information

Some of the most common uses of performance information in health expenditure are: setting allocations for the health programme, developing management reform proposals,

using it for strategic planning/prioritization, informing cost containment proposals, setting allocations for the health ministry, and proposing new health programmes (Figure 4.23). The most common consequence when performance targets are not met is to increase monitoring efforts in the future. Only one or two countries adjust the budget, eliminate programmes, and make poor performance public as a consequence for not achieving performance targets (Figure 4.24).

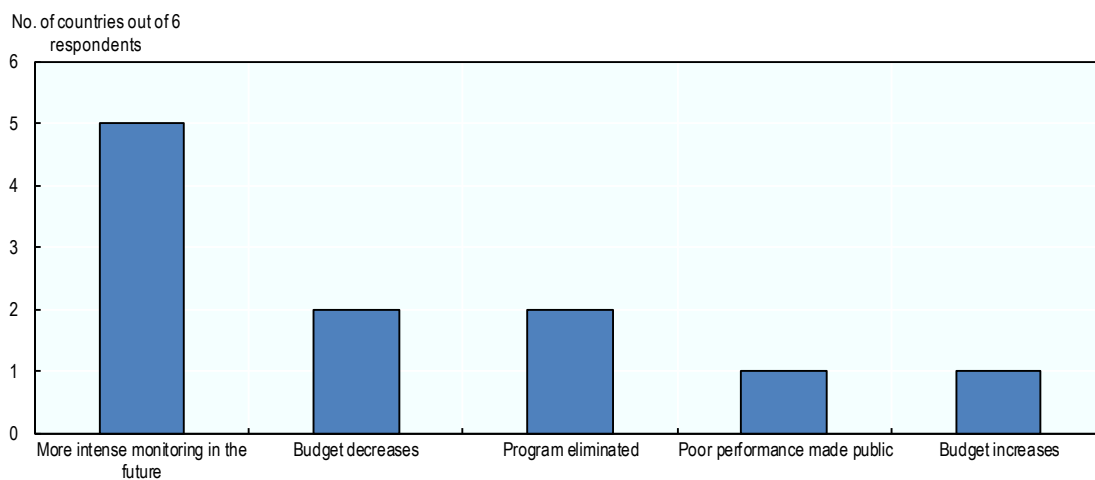
Figure 4.23. Use of performance information in health sector



Note: Information in this graph only includes countries that have performance agreements

Source: OECD (2017), *Survey of Budget Officials on Budgeting Practices for Health in CESE countries (question 30)*

Figure 4.24. Consequences of not meeting performance targets



Note: Information in this graph only includes countries that have performance agreements

Source: OECD (2017), *Survey on Budgeting Practices for Health in CESEE countries (Question 31)*

Box 4.2. Performance based reforms in financial mechanisms to strengthen TB services in Armenia

Armenia went through a process of revamping its tuberculosis (TB) financing mechanisms by introducing performance incentives to strengthen its services. This need came as Armenia realised that more than 65% of TB cases were detected in inpatient care, and almost 95% of all TB patients were admitted to hospitals during the intensive phase of chemotherapy.

Previously, outpatient TB service payments were based on the size of the population served (capitation standard rate). This resulted in a lack of incentive to improve on performance. On the other hand, inpatient payments were based on the number of beds/days, which included staff salaries, the cost of treatment and medications, etc. This in turn incentivised maximising the duration of the stay. In addition, 80% of TB funding was for inpatient services and 20% was for outpatient services. This has resulted in an underestimation of the role of outpatient services in TB diagnosis, treatment, and prevention and the underutilization of its potential.

Armenia, as a result, built a new structure within its inpatient TB services based on a fixed cost (provision of facility maintenance costs such as wages, utilities, etc.) and a variable cost (medicine and food based on the number of discharged patients). This change was intended to neutralise the incentive of health providers to keep the patient hospitalised for longer periods. For outpatient TB services, the cost in the new structure is based on the number of the served population (per capita) and a Performance-Based Incentive Payment that depends on the achievement of certain indicators. This was intended to improve TB services by providing quality incentives.

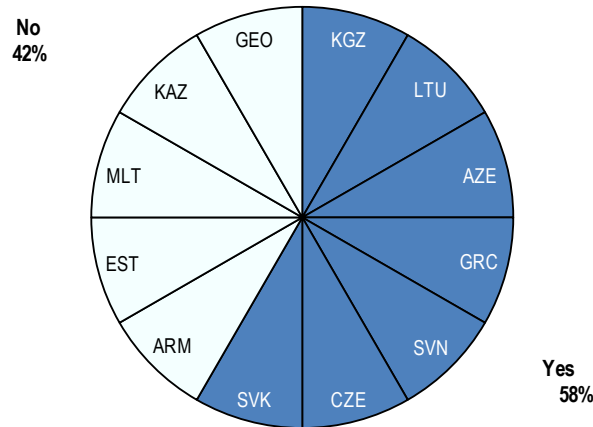
Source: Presentation by Armenia for the 2nd Health Systems Joint Network Meeting for CESEE Countries. Tallinn, 1-2 December 2016.

Cost containment strategies

Overall strategy to ensure health spending stays within initial budget allocations

Over a half of the CESEE surveyed countries reported to have an overall cost containment strategy ensuring that publicly-funded health expenditure stays within the initially allocated amounts (Figure 4.25), and that new legislative proposals concerning publicly-funded health expenditures account for the full cost of the initiative. In most countries, the Ministry of Health and the Ministry of Finance have the leading role for proposing measures of readjustment of health expenditures.

Figure 4.25. Countries with an overall cost containment strategy

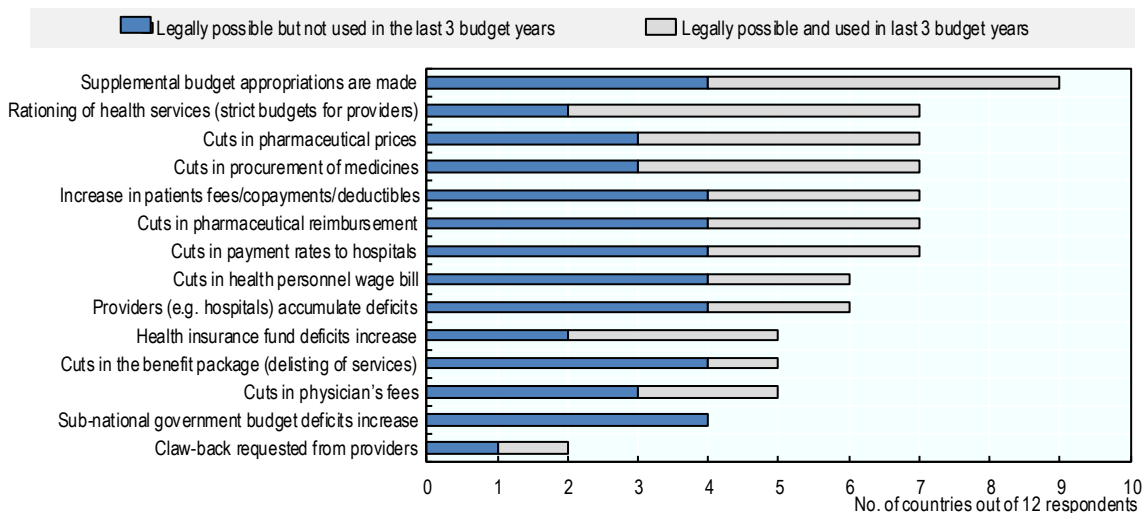


Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 33)

Measures undertaken in response to budget over-spend

Some of the measures that are most likely to be regularly undertaken in response to budgets exceeding initially targeted levels include making supplemental budget appropriations and rationing of health services (strict budgets for providers). These are not only legally possible in the majority of surveyed countries but 40% of countries used them in the last three budget years. Other common practices are cuts in pharmaceutical prices, procurement of medicines, payment rates to hospitals, pharmaceutical reimbursement, health personnel wage bill, and increase in patients fees/co-payments/deductibles (Figure 4.26).

Figure 4.26. Measures undertaken in response to budgets exceeding initially targeted levels



Note: In Georgia, it is not legally possible to conduct supplemental budget appropriations. Nevertheless, this has been used in the last 3 budget years.

Source: OECD (2017), Survey on Budgeting Practices for Health in CESEE countries (Question 34)

5. Conclusions and future work

Improving the capacity of national health authorities to engage more effectively with national budgetary authorities is essential to make progress on critical issues about the level of funds to be provided, the quality and efficiency of health public spending and the flexibility with which such funds can be used, while concurrently ensuring accountability for the use of these funds. Efficiency in health expenditure requires good practices during the entire budget cycle: effective allocation mechanisms during the budget formulation phase, good operational management practices, coordination mechanisms, measuring and evaluating results, and reporting and monitoring tools are essential to ensure that resources are spent in an efficient way and following the lines mapped in the initial budget.

The Survey on Budgeting Practices for Health for Central, Eastern, and South-eastern European Countries found that most CESEE surveyed countries have well integrated health financing systems and they use some interesting budgeting tools to monitor health expenditure at different levels (central budget, social health insurance budget, and external funds). Other budget practices, however, such as cost containment strategies, budget flexibility, and long-term projections for healthcare could be further improved.

Further research for the CESEE Joint Network on the fiscal sustainability of health systems could be carried out in the following areas that link healthcare and budgeting practices in the region: budget rigidities and mechanisms to increase flexibility; reasons behind under-spending in healthcare and possible ways to overcome this situation; and effectiveness and challenges of using performance budgeting tools for health.

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