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Adaptive Health Financing: Budgetary and Health System Responses to Combat COVID-19

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Adaptive Health Financing: Budgetary and Health System Responses to Combat COVID-19

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Health financing policies are an essential element of health system responses to COVID-19. Sound policies help ensure there are sufficient resources to combat COVID-19, that the resources are disbursed rapidly, and that resources are spent in an effective manner. The effective implementation of such policies depends on budget and health officials working together closely to bring about co-ordinated actions. This policy brief analyses how OECD member countries have adapted health financing policies to combat COVID-19, and how such policies may need to continue to adapt as the pandemic evolves. It reviews how countries have provided additional budgetary resources to the health sector to combat COVID-19. It also maps out the key areas of joint action by budget and health officials to plan, implement and review the necessary health financing measures needed to combat COVID-19.

Key Findings

As of the end of September 2020, central governments of OECD member countries committed on average 245 USD per person to COVID-19 in the health sector. This paper maps out the key areas of **joint action by budget and health officials to plan, implement and review** the measures needed to combat COVID-19.

Analysis draws a distinction between the immediate actions already taken in the response to COVID-19, and medium-term actions that OECD countries are likely to need to consider. These joint actions took place within tight deadlines, shorter than the usual budget cycle, and demonstrated the crucial role that each set of officials performs and the need for ongoing coordination beyond the measures in the budget responses.

In the context of a challenging fiscal environment caused by COVID-19, polices should ensure ongoing investment into health systems, with considerations on how to achieve outcomes within tight constraints. This should include assessments of both operational and capital expenditures to ensure appropriate surge capacity to respond to future emergencies.

The analysis highlighted a range of essential joint actions:

Estimating how much additional funding is needed and where these funds will come from

- Rapid needs assessments were used to establish new health spending needs. These were necessarily approximate. Moving to the medium-term, in-depth assessments will be important to establish more precise estimates of funding needs.
- Supplementary budgets and contingency funds created additional temporary public funds for the health sector COVID-19 response. Such mechanisms are by definition short-term; if longer-term increases are needed, governments will need to assess more fiscally sustainable funding solutions.
- Reprioritising public spending created some fiscal space for the COVID-19 response. Initially, this has been through temporarily postponing lower priority activities (within health and the overall budget); over time some of these temporary postponements may need to be made permanent.

Determining what these additional funds should be spent on

- Boosting the health workforce requires funding to frontline health providers, including funds for hiring additional temporary health workers, and policies to support sustainable workforce planning over the medium to longer term.
- Prioritising health infrastructure and equipment is needed to minimise critical bottlenecks in delivering essential health services.
- Financial barriers to accessing care can undermine the COVID-19 response, so health financing polices should ensure households do not have to pay large sums out-of-pocket for COVID-19 health interventions.

Good budgetary governance helps funds flow quickly to frontline health providers and other priority actions, as well as ensuring such funds are spent effectively and as intended

- Budget structure matters, with programme and performance budgeting providing a robust framework for allocating and tracking COVID-19 expenditures.
- Accelerated procurement procedures to hasten access to personal protective equipment (PPE), medical devices and other essential items are critical for a timely response to COVID-19. By their nature, they open up possibilities for fraud and misspending, but with strong budget processes such risks can be minimised.

- Coordinated responses require clear roles and responsibilities across government agencies and levels of government, and coordinated support to hospitals and other frontline providers.
- Tracking COVID-19 spending is necessary to verify that resources are spent as intended. Over time, performance frameworks will need to be adapted to assess government responses to COVID-19. In this regard, spending reviews can help evaluate the effectiveness of COVID-19 policies in the health sector, by systematically assessing expenditure relative to governments' budgetary objectives and priorities.

Introduction

All OECD countries announced budgetary measures in response to the spread of COVID-19. The response packages were large and phased, responding to the impacts of the virus as new information became available. Most of the budgetary responses were between 5% - 20% of GDP. The health sector was an early recipient, receiving substantial additional resources to provide effective care and relieve health system pressures.

Budgetary responses were through an increase in expenditure for the provision of government services and commitments through guarantees and loans. The increases in health and other government expenditures occurred through four principal channels: (1) supplementary budgets to increase appropriations; (2) transfers between fiscal years to reallocate unused funds from previous years; (3) reprioritised funding from a government's existing budget; and (4) contingency funds for unanticipated events.

Health financing policies are an essential element of health system responses to COVID-19. Sound policies help ensure there are sufficient resources to combat COVID-19 that the resources are disbursed rapidly, and that resources are spent in an effective manner. The effective implementation of such policies depend on budget and health officials working together closely to bring about co-ordinated actions.

The purpose of this Policy Brief is to first highlight the budgetary responses across OECD member countries in the context of the health sector, taking into consideration the co-ordination of responses across levels of government. Findings show that as of the end of September 2020, central governments of OECD member countries committed on average 245 USD per person to COVID-19 in the health sector, ranging from over USD 1 000 per person in the United States, to under USD 100 per person in Iceland, Latvia and the Netherlands.

This Brief also analyses how OECD countries have adapted health financing policies to combat COVID-19, and how such policies may need to continue to adapt as the pandemic evolves. Firstly, it considers relevant aspects of health financing in OECD countries, specifically the budgetary responses across OECD member countries and the co-ordination of those responses in the health system across levels of government. The brief goes on to identify the key areas where joint action by budget and health officials can have a major impact in combatting COVID-19 and can increase future preparedness and resilience for future shocks to health systems. This brief concludes by identifying the role spending reviews can play in upcoming budget processes to assist budget and health ministries demonstrate the extent to which existing appropriations reflect government priorities when making the case for a sustainable level of funding over the medium-term.

Box 1. The OECD Joint Network of Senior Budget and Health Officials

This OECD Joint Network, established in 2011, provides a space for government officials to discuss challenges and solutions to the fiscal sustainability of health systems. The OECD Joint Network has three core activities: annual meetings, cross-country surveys and country case studies. The aim of these activities is to identify and disseminate best practices in managing health budgets, alongside other policies that can ensure fiscal and broader financial sustainability of health systems. Such challenges are even more pressing in light of the COVID-19 crisis – and the subject of this Policy Brief.

Further details on this OECD Joint Network, including recent publications, are available here:

http://www.oecd.org/els/health-systems/sbo-health.htm

Relevant aspects of health financing in OECD countries

Governmental budgetary commitments to COVID-19

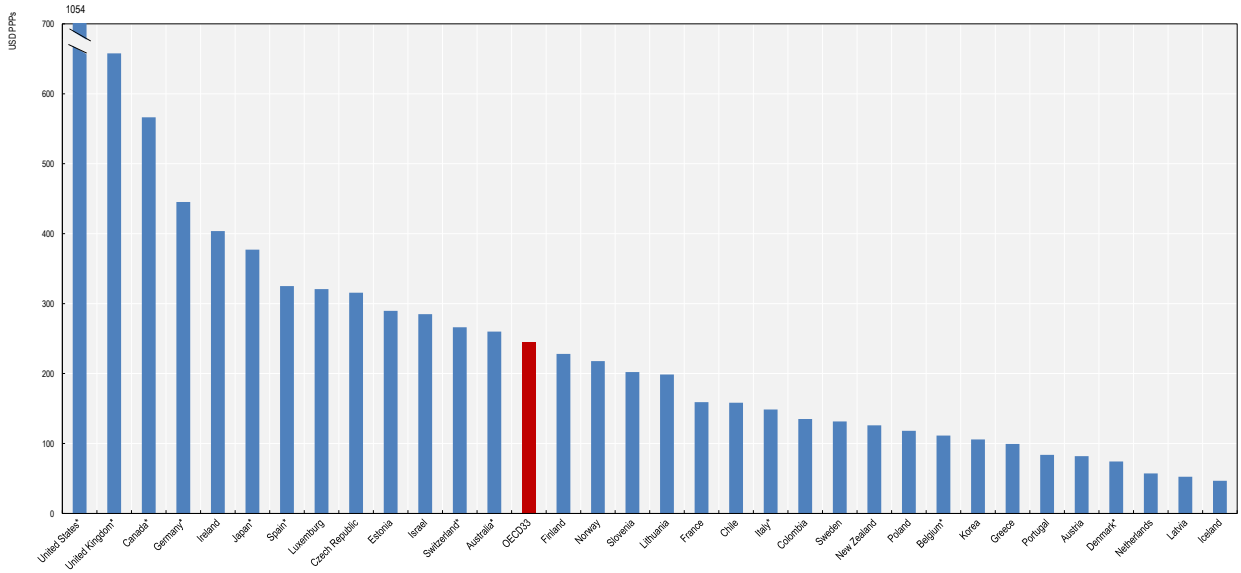
Countries across the world have dedicated unprecedented resources to combatting COVID-19. Response packages announced by governments contain a series of measures designed to mitigate and contain the spread of COVID-19, and treat people who fall ill with the virus. Alongside health system measures, fiscal and balance sheet measures included financial support for workers and vulnerable groups, liquidity support for businesses through tax deferrals, and government guarantees[1]. Further, uncertainty around the development of a vaccine and the potential for future waves of COVID-19 has meant governments have announced successive spending measures. After the fiscal response packages of March, April and May 2020, many OECD countries have tailored the response measures to reflect the structure of their economies and the effects of the virus on communities.

Across OECD members, the size of the budgetary responses has been substantial, notably in some of the countries hit hardest by COVID-19. As of June 2020, Japan and Spain have put in place measures estimated at 15-20% of GDP. The Korean government announced four support packages sequentially totalling KRW 20 trillion, or nearly 11% of GDP. In Austria, Belgium, and the United States have dedicated around 10% of GDP to the immediate COVID-19 response. A number of countries have implemented measures totalling between 5% - 10% of GDP, including Iceland, Latvia, Lithuania and Slovenia, and in Chile, Ireland, Italy and the Slovak Republic responses were up to 5% of GDP (OECD, 2020[1]).

On a per capita basis, central government budgetary commitments to COVID-19 in the health sector ranged from over USD 1 000 per person in the United States and over USD 400 per person in the United Kingdom, Canada, Germany and Ireland, to under USD 50 per person in Iceland (Figure 1). The estimated figures refer to central government spending commitments only and were adjusted for purchasing power parity across the countries. While cross-country differences in the definition of the health system vis-à-vis other COVID-19 spending exist, common response measures included the purchase of medical supplies and equipment for testing or treatment, increases in remuneration of health professionals, support to hospitals and other health providers, and research and development into new vaccines and treatments (Table 1).

[1] For detailed health system responses to COVID-19 see 'Health System Response Tracker'.

Figure 1. Central government additional COVID-19 health spending commitments per capita, 2020 (between March and September 2020)



Note: These figures represent estimates from official announcements of spending measures against COVID-19, as of September 2020. Figures reflect central government spending commitments only, excluding commitments by subnational governments, external donors or private donations. *Denotes countries with a significant budgetary response at the subnational level. PPPs are for Actual Individual Consumption, national currency per US dollar, 2019. Cross-country comparability is limited by differences in the date of the latest available official announcement. See Table 1 for details on the exact timing of official announcements across countries.
Sources: OECD member country Governments

Table 1. Additional central government COVID-19 health expenditure commitments, 2020 (latest available official announcement)

Country	Additional commitment (millions, local currency)	Additional commitment (per capita, USD PPPs)	Main expenditure areas	Source (as of)
Australia	9 423	260	Purchase of PPE, increasing testing capacities, expanding telehealth and hospital services	Government of Australia (as of July 23rd)
Austria	579	82	Purchase of PPE and medical equipment, research	Parliament of Austria (as of May 6th)
Belgium*	1 000	111	Purchase of medical equipment and PPE	Federal Public Service and Policy Support (as of April 20th)
Canada	25 617	566	Increasing testing capacities, vaccine research, purchasing of medical supplies, mitigation efforts	Government of Canada (as of August 11th)
Chile	1 299 780	158	Purchase of medical supplies and equipment, strengthening hospitals	Ministry of Finance, Chile (as of September 1st)
Czech Republic	40 300	316	Health insurance payments, salaries, PPE, medical devices, hospital debt relief	Ministry of Finance, Czech Republic (as of May7th)
Denmark*	3 100	74	Procurement of PPE	Ministry of Finance, Denmark (as of May 29th)
Estonia	213	290	Transfer to Estonian Health Insurance Fund	Parliament of Estonia (as of April 2nd)
Finland	1 087	228	Additional health costs, testing, PPE and medical equipment, research on diagnosis and vaccines	Ministry of Finance, Finland (as of September 24th)
France	8 000	159	Extraordinary healthcare expenses including equipment and masks, staff remuneration	HCFP (as of June 10th)

Germany*	26 790	445	Central procurement of PPE, vaccine development and treatment measures	Ministry of Finance, Germany (as of September 18th)
Greece	610	99	Purchase and distribution of PPE and medical goods, hiring additional health workforce, enhance laboratory capacities	Ministry of Health, Greece (as of September 21st)
Iceland	2 500	47	Hospital services, testing capacities, mental health services, health workforce bonuses	Government of Iceland (as of April 21st)
Ireland	1 800	404	Expand hospital capacity, develop primary and community-based responses, procurement of medical equipment	Government of Ireland (as of May 12th)
Israel	10 000	285	Purchase of ventilators, PPE, and medicines, increasing testing capacity	Government of Israel (as of May 5th)
Italy*	6 312	149	Hiring of medical and nursing personnel, expanded private hospital capacity, purchase of medical equipment	Ministry of Economy and Finance, Italy (as of March 17th)
Japan	4 798 900	377	Disease prevention, medical care provision, PCR testing equipment, distribution of masks, research and development	Ministry of Finance, Japan (as of May 5th)
Korea	4 800 000	106	Disease prevention, expanded diagnostic and treatment facilities, vaccination research	Ministry of Finance, Korea (as of June 3rd)
Latvia	59	52	Health personnel expenditures, procurement of PPE, testing equipment, ventilators, surveillance, laboratory network	Ministry of Health, Latvia (as of September 4th)
Lithuania	249	199	Purchasing PPE, equipment, bonuses and social guarantees for health care workers	Government of Lithuania (as of July 1st)
Luxemburg	194	321	Medical equipment and health infrastructure, testing capacities	Government of Luxembourg (as of April 4th)
Netherlands	800	57	Purchase, distribution and sale of medical devices, contribution to vaccine research, training additional healthcare personnel	Government of Netherlands (as of April 24th)
New Zealand	371	54	Hospital capacity, aged care, primary care	New Zealand Treasury (as of May 29th)
Norway	12 160	218	Expenses for medicines and medical equipment, laboratory expenses, vaccination development	Ministry of Finance, Norway (as of May 12th)
Poland	7 500	118	Creating and equipping infection hospitals, medical transport and additional healthcare services	Government of Poland (as of April 1st)
Portugal	504	84	Health personnel expenditures, acquisition of medical equipment	Government of Portugal (as of June 18th)
Slovenia	247	202	Purchase of medical, protective equipment	Stability programme 2020 (as of August 30th)
Spain*	10 030	325	Ministry of Health support, transfer to regions, research on drugs and vaccines development	Government of Spain (as of July 12th)
Sweden	12 366	131	Public Health Agency, National Board of Health and Welfare, Swedish Medical Produce agency, transfers to municipalities and regions for costs associated with testing and tracking	Government of Sweden (as of September 21st)
Switzerland*	2 910	266	Procurement of medical supplies, PPE, tests, and medications, contribution to CEPI	The Federal Department of Finance, Switzerland (as of August 12th)
United Kingdom*	32 000	658	PPE, Test, Trace, Contain and Enable programme, procurement of additional ventilators	OBR (as of July 8th)
United States	344 900	1 054	Grants to health providers, preparedness and response, vaccine and treatment research	Committee for a Responsible Federal Budget (as of August 28th)

Note: *Denotes countries with a significant budgetary response at the subnational level
Source: OECD member country Governments

Figures constitute only central government spending commitments. So differences in per capita spending levels are attributable in part to the different roles of subnational governments (SNGs) in the COVID-19

response. In Australia, Belgium, Canada, Japan, Spain, Switzerland, and the United States, SNGs have significant dedicated budgetary resources for the health sector. In addition, depending on the coverage of health financing, social health insurance (SHI) plays a significant role in financing emergency responses (See Box 2).

Of note is that quantifying the additional resources for the health sector does not allow for statements referring to the optimal, or desired, level of resources dedicated to combat COVID-19. Beyond the policy responses implemented, differences in the prevalence of COVID-19 across member countries, along with the state of health systems in each country, contribute to expenditure variances.

Co-ordinating COVID-19 responses across levels of government

Subnational governments (SNGs) are key players in addressing the COVID-19 pandemic. In the health sector, SNGs are often responsible for a significant share of public expenditure on health, regional and local authorities are delivering critical short-term containment measures, and ensuring health systems have the capacity to respond.

The provision of health services represents a significant portion of SNGs budgets in many countries. For example, in Italy, health represents 48% of SNG total expenditure. In Australia, Austria, Colombia, Denmark, Finland, Spain, Sweden and the United States, health expenditures represent over 20% of SNG budgets (OECD, 2020[2]). Looking beyond the share of expenditure, the decision-making powers across levels of government can illustrate potential co-ordination challenges between central government and SNGs (Beazley et al., 2019[3])Many central governments across OECD countries have implemented measures to mitigate the impact of the COVID-19 crisis on SNG budgets. This included an increase in central government transfers to offset expenditure and revenue pressures of SNGs, as well as those dedicated specifically to the health sector. In particular, as at June 2020, 15 of 37 central governments in OECD member countries provided transfers to SNGs for COVID-19 related health expenditures (Table 2). This included central government in decentralised systems, such as Canada, Finland, Norway, Spain, and Sweden, where SNGs usually have the responsibility of financing health services to compensate for expenditure pressures. While in Korea, the central government provided special support for Daegu City and the North Kyeongsang Province, the hardest-hit areas, to fund infrastructure and disease prevention. For the remaining 22 OECD countries that do not provide direct budgetary transfers to SNGs, the response measures reflected a more centralised pooling of budgetary resources to combat COVID-19.

Table 2. Transfers to subnational governments for COVID-19 related health expenditures

Country	Federal or Unitary	Transfers to SNGs	Notes
Australia	Federal	✓	The Commonwealth is to pay half of all additional costs incurred by states and territories in diagnosing and treating patients with COVID-19, and disease containment efforts.
Austria	Federal	✗	
Belgium	Federal	✗	
Canada	Federal	✓	The central government provided resources to provinces and territories for critical health system needs preparedness and mitigation efforts.
Chile	Unitary	✗	
Colombia	Unitary	✗	
Czech Republic	Unitary	✗	
Denmark	Unitary	✓	The central government is to provide compensation to regions for extraordinary expenses for COVID-19-related measures
Estonia	Unitary	✗	
Finland	Unitary	✓	The central government is to provide support to municipalities, including reimbursement of COVID-19 related costs to hospital districts.
France	Unitary	✗	

Germany	Federal	✗	Transfers to public health offices at district level to expand tracing capacities.
Greece	Unitary	✓	Supplementary transfers granted to regions and municipalities to provide the initial response.
Hungary	Unitary	✗	
Iceland	Unitary	✗	
Ireland	Unitary	✗	
Israel	Unitary	✗	
Italy	Federal	✗	
Japan	Unitary	✓	Transfers to local governments for COVID-19 related measures.
Korea	Unitary	✓	Special support for Daegu City and North Kyeongsang Province, the areas hit hardest area for disease prevention and treatment.
Latvia	Unitary	✗	
Lithuania	Unitary	✗	
Luxemburg	Unitary	✗	
Mexico	Federal	✓	States will receive transfers through The Health *Institute for* Wellbeing.
Netherlands	Unitary	✗	
New Zealand	Unitary	✗	
Norway	Unitary	✓	Support tor Regional Health Authorities and Municipalities.
Poland	Unitary	✗	
Portugal	Unitary	✗	
Slovak Republic	Unitary	✓	Transfers to regional public health authorities.
Slovenia	Unitary	✓	The government is providing additional lump sum payments to municipalities.
Spain	Quasi-federal	✓	Advance transfer to the regions for the regional health services.
Sweden	Unitary	✓	The state will retrospectively compensate municipalities and regions for extraordinary measures and additional costs in the health system.
Switzerland	Federal	✗	
Turkey	Unitary	✗	
United Kingdom	Unitary	✓	Transfers to devolved governments (Scotland, Wales and Northern Ireland).
USA	Unitary	✓	Federal transfers to state to address coronavirus-related expenses, measured by the number of positive tests for the COVID-19 disease.

Source: Authors.

In some countries where SNGs have large responsibilities for health, additional appropriations have already been allocated to health expenditures, notable examples include Australia, Belgium, Canada, Japan, Spain, Switzerland and the United States. In Australia, every state and territory government has announced a spending response to the COVID-19 crisis. Of this, approximately 28% is dedicated to hospitals and health care, including Intensive Care Unit (ICU) capacity, COVID-19 testing, ventilators, medical equipment, and respiratory clinics (Grattan, 2020[4]). In the United States, most states have increased their appropriations for health and/or created special appropriations to respond to the COVID-19 crisis. In Belgium regional governments have announced significant budgetary measures directed towards the health system, for example, Walloon set an envelope of EUR 115 million earmarked to help the health and social sector (Walloon Government, 2020[5]).

Other than direct resource transfers to combat COVID-19, central governments have supported SNGs through other targeted measures and co-ordinated responses with insurance schemes. One targeted measure was the centralised procurement of medical supplies for distribution across regions (Italy, Switzerland). On insurance schemes, Box 2 illustrates the scope of co-ordination within four country examples.

Box 2. Co-ordinating the policy response with health insurance schemes

The role of compulsory health insurance funds to co-ordinate and deliver a response to COVID-19 depends on the financing scheme. Compulsory health insurance schemes are the dominant source of health financing in 21 OECD countries. For example in France, Germany, Japan, Luxembourg and the Netherlands, compulsory health insurance covers around three-quarters of all health spending.

As such, Social Health Insurance (SHI) funds are at forefront of the COVID-19 response across these countries – and includes responsibility for testing strategies, organising and financing COVID-19 related health services, and ensuring protection to vulnerable groups. For example:

- **Germany**, health insurance funds, together with the federal government, are contributing EUR 5 billion towards a Protective Shield for hospitals, to mitigate revenue shortfalls and higher costs.
- **Korea**, the National Health Insurance Fund has committed over KRW 10.4 billion to the COVID-19 response. This includes reimbursement to providers, prevention activities and the coverage of COVID-19 diagnosis and treatment costs.

At the same time, increases to unemployment can reduce employment-related health contributions as a result of lower income, while health spending will be similar or increase. This can result in fiscal deficits or the need to raise contributions rates and/or diversify the sources of financing compulsory health insurance systems. To compensate for this, central governments have provided transfers to SHI funds as part of the overall response package to COVID-19:

- **Austria**: The federal government provided a flat-rate subsidy to the Austrian Health Insurance Fund of EUR 60 million for the additional expenses incurred by the COVID 19 crisis.
- **Estonia**: The state supplementary budget provided transfers to the Estonian Health Insurance Fund (EHIF). The purpose was to cover the costs related to COVID-19 and the state emergency. However, the rigid legislation applied to COVID-19 related costs does not allow the EHIF to use the supplementary funds to cover its revenue shortfalls.

Source: Authors

Joint actions by budget and health officials

Mapping joint actions against COVID-19 across key strategic phases

In the short-term, health financing policies contribute to the health system's response to short-term needs during the coronavirus pandemic. Additional resources to combat COVID-19 must be made available quickly, which requires the rapid execution of funds, making it possible to boost the health workforce, procure medical equipment and supplies, and expand hospital capacity, among other measures.

In the medium-term, health financing policies can help ensure health systems emerge stronger and more resilient to future waves of COVID-19 and other health shocks. In the context of a challenging fiscal environment post-COVID-19, polices should ensure ongoing investment into health systems, with considerations on how to achieve outcomes within tight constraints. This should include assessments of both operational and capital expenditures to ensure appropriate surge capacity to respond to future emergencies. In mapping the main joint actions by budget and health officials, three key phases can be identified:

- **Plan** the response to COVID-19.

- **Implement** the announced responses.
- **Review** which policies worked well and which have not, before planning an updated response.

Table 3 below maps joint actions to these three phases, including how they link to the budget cycle and the emergency management cycle. The budget cycle characterises the way in which a government's budget is produced, specifically, budget strategy, budget formulation, budget execution, and budget review. The emergency management cycle characterises, specifically, preparedness, mitigation, response, and recovery.

This section analyses the joint responses by ministries of finance and health in relation to the three actions of plan, implement and review. The analyses draws a distinction between the immediate actions already taken in the response to COVID-19 and medium-term actions that OECD countries are likely to need to consider. The analyses include examples from OECD countries.

Table 3. The health financing response – joint actions from budget and health officials

Phase	Joint Responses	Short-term actions	Medium-term actions
PLAN *Links to phases of:* Budget cycle Budget strategy Budget formulation Emergency cycle Mitigation Preparedness	Estimate resource needs for health system response	• Conduct rapid needs assessment to estimate new spending needs and indicative budget envelope	• Conduct more in-depth assessments to establish medium-term expenditure requirements
	Reprioritise public spending	• Postpone lower priority spending (within health and the overall budget)	• Reprioritise overall government budget • Reprioritise health budget
	Identify basis of additional funds	• Allocate additional temporary funds to the health sector, using supplementary budgets or contingency funds	• Assess feasibility and desirability of: o Increasing government revenues o Private financing options
	Revise budgetary modalities	• Create or modify budgetary programmes to reflect COVID-19 activities	• Deepen implementation of programme and performance budgeting
IMPLEMENT *Links to phases of:* Budget cycle Budget execution Emergency cycle Response Recovery	Boost surge capacity (staff, supplies, space)	• Staff: mobilise additional health workers, adapt roles of existing staff, prioritise health staff for social support services • Supplies: accelerate procurement procedures (without compromising integrity) • Space: repurpose non-medical space, transfer patients to localities with spare capacity	• Staff: revise health workforce planning to account for future surges, including the creation of a reserve of personnel • Supplies: reform procurement, including potential domestic production of some essential supplies • Space: evaluate health infrastructure within capital budgeting framework
	Adapt cost recovery policies to support groups vulnerable to COVID-19	• Suspend user fees and co-payments related to COVID-19	• Reassess cost recovery policies
	Ensure a co-ordinated response across government	• Clarify roles and responsibilities of different government agencies • Co-ordinate support to hospitals and other frontline health providers	• Revise payment modalities and financing regimes for additional on-going COVID-19 costs
REVIEW *Links to phases of:* Budget cycle Budget review Emergency cycle Recovery Mitigation	Adapt accountability requirements	• Adapt tracking and reporting measures prior to release of funds	• Revise accountability rules to include budget codes for COVID-19 expenditure
	Evaluate effectiveness of government policies in response to COVID-19	• Conduct rapid assessments focused on safety and efficacy • Adapt performance budgeting frameworks to COVID-19	• Expand scope of evaluations to include cost-effectiveness analysis • Revise programme and performance budgeting frameworks • Conduct Spending reviews

Joint responses against COVID-19 during the 'Plan' Phase

Rapid-needs-assessments were used to quickly establish how much additional funding was needed

Due to the rapidly evolving situation, estimating health resource needs for the COVID-19 response represents a significant challenge. Joint action requires the rapid assessment and costing of policy proposals – such as the cost of hiring additional health workforce, and the purchase of specialised medical supplies, including personal protective equipment (PPE) – to establish budget envelopes and spending limits. At the same time, previously budgeted expenditures may fall, as countries take actions such as the postponing or cancellation of elective surgeries, budget should respond accordingly.

In the medium-term, budget allocations must find a balance between providing sufficient resources to enable health systems to respond, while ensuring the sustainability of public finances. More in-depth assessments based on data from the first wave may help to refine estimates of the ongoing resource needs, thereby providing a more accurate estimate of medium-term expenditure requirements. Such needs assessments should include all critical components of the supply chain in the health system, including research and development.

Box 3. Country examples of supplementary budgets

Across OECD countries, budget envelopes for COVID-19 responses refer specifically to additional resources for the health sector, for example:

- **Estonia**: An explanatory memorandum to the Supplementary Budget Act contains revised expenditure projections and limits for the 2020 budget. The memorandum includes revised expenditure and revenue projections and the updated budget position for the Estonian Health Insurance Fund. Projections estimate the loss in revenue from health insurance payments, and COVID-19 related costs for primary care, ambulance services, specialist care, hospital care, and pharmaceuticals (Rahandusministeeriumi, 2020[6]).
- **Iceland**: A supplementary budget contained estimates of the additional costs incurred in the health system, and in particular the additional cost for each specialised hospital, due to COVID-19 (Althingi, 2020[7]).
- **Netherlands:** The supplementary budget included cost estimates for various emergency measures, which formed the basis for adjustments to expenditure ceilings. Previously budgeted expenditures are also adjusted (up or down) using revised estimates (Rijksoverheid, 2020[8]).

Source: Authors.

Reprioritising spending created some fiscal space for the COVID-19 response

Identifying areas of low-priority spending for reprioritisation – both within and outside the health budget – can create some fiscal space for COVID-19 related spending. Joint action between health and finance ministries can ensure the appropriate identification of low-priority health spending items. In contrast, blanket cuts, implemented by finance ministries alone, can damage the ability of health systems to respond to COVID-19 as well as disrupt the continuity of non-COVID-19 related care.

In the short-term, the focus across OECD countries has been to temporarily postpone spending on non-essential services. Common measures included postponing elective care procedures or re-specifying hospital discharge criteria. Alternative delivery modalities, notably telemedicine, have been scaled up to

help offset the postponements to care. In many countries, this has been facilitated through the relaxation of regulation (OECD, 2020[9]).

Looking to the medium-term, lessons from temporary reprioritisation efforts may help to inform efforts to tackle wasteful spending in health. For example, policymakers may explore whether a permanent increased use of telemedicine offers value-for-money. In addition, as non-COVID-19 care returns to post-pandemic levels, policymakers may use this new reality to identify the extent to which cuts were a correction for the wasteful utilisation of care, versus a cut in essential services. More broadly, finance and health ministries may look together at the viability and desirability of increasing prioritisation of health within the overall government budget. The fiscal and social consequences of postponing non-essential services should also be considered. In particular, health providers paid through activity-based funding mechanisms will face revenue shortfalls when such services are not provided. Governments may therefore have to provide temporary financing to such health providers, which would reduce or cancel out any short-term cost savings from postponing care.

Box 4. Country examples of reprioritising existing expenditure

Many of the supplementary budgets and contingency funds enacted by OECD countries identified how spending could be reduced, for example:

- **Estonia:** The supplementary budget reduced expenditure by EUR 141 million, including a temporary suspension of state payments to the mandatory pension scheme (for those born after 1982) (Rahandusministeeriumi, 2020[6]).
- **Hungary:** Funding for the new Pandemic Protection Fund (equivalent to about EUR 2 billion) comes in part from reallocated budget items, notably subsidies to political parties and tax revenues that normally go to municipalities (Bloomberg, 2020[10]).
- **Latvia:** The government requested all ministries to review expenditures for activities cancelled due to COVID-19, and divert unused funding to combat the pandemic. As of September 2020, the process of identification and reprioritisation of funds is still ongoing. The process leads to a reduction and reallocation of appropriations between the ministries and other central government authorities.

Source: Authors.

A number of budget constraints were relaxed in health ministries

While reprioritisation efforts can free up some resources, these are unlikely to be sufficient to respond to COVID-19, particularly in the short-term. Therefore, many OECD countries implemented emergency budgetary measures to rapidly identify sources of additional public funds. While finance ministries were responsible for the identification of such funds, ministries of health provided invaluable input through the contribution of spending amendments or proposals for the health sector response to COVID-19.

Supplementary budgets and contingency funds were the main budgetary mechanisms used to authorise the use of additional funds.

- **Supplementary budgets** are proposed amendments to the annual budget, used to authorise additions or changes in allocations that were not foreseen at the time of the original budget. They typically require parliamentary approval, but can be subject to simpler legislative procedures (OECD, 2018[11]). To ensure transparency and consistency with good budgetary principles,

supplementary budgets should explain the basis for the supplementary budget measures and show the effect on fiscal policy objectives (OECD, 2020[12]).

- **Contingency funds** can provide immediate funding on a limited timescale. Established to finance unanticipated emergencies, the use of the funds do not require parliamentary approval beyond the approval of the annual budget. Nearly all OECD countries have a contingency reserve for unforeseen expenditure (OECD, 2018[11]).

In the medium-term, if resource assessments indicate the need for permanently higher health spending to combat COVID-19, various financing options should be explored. Reprioritising government spending can free up some funds, but this may not be sufficient. Therefore, the feasibility and desirability of mobilising additional resources to increase government tax revenues or to increase private financing should be assessed. In the context of SHI systems, after experiencing COVID-19 related-costs and lower revenues, insurance funds may need to reassess the sustainability of funding structures. Options may include adjusting the contribution rates of employees/employers, although this should be considered as part of the impact on labour taxes, or finding alternative sources of income, ultimately leading to a more diverse funding structure.

Box 5. Country examples of sources of additional funds

Many OECD countries introduced supplementary budgets to raise additional funds for COVID-19. As of June 2020, examples include:

- **Estonia, Finland, France, Germany, Greece, Korea, Netherlands, Sweden and Switzerland**: Such measures were typically temporary in nature – for example, in Sweden, while support measures directly affecting the government balance amount to about SEK 95 billion (1.9% of GDP), only SEK 12 billion of these funds will affect the balance from 2021.
- **United Kingdom:** Enacted the Contingencies Fund Act 2020 to fund the COVID-19 response. Under this Act, the available contingencies not requiring parliamentary approval increased from a limit of 2% of spending in the preceding financial year to a limit of 50%.

Source: (OECD, 2020[1]).

Programme budgeting provides a framework for allocating and tracking COVID-19 expenditures

The budget classifications used to formulate public budgets affect the flexibility of line ministries to respond to COVID-19. Budgets detailing expenditures by inputs offer limited flexibility, as reallocations between inputs require parliamentary approval. When programmes form the basis of appropriations, decision makers have flexibility – within a defined programme – to redirect spending to priorities without further parliamentary approval.

In the medium-term, programme budgeting offers the flexibility to continue to respond to COVID-19 based on changing needs. This is while still being grounded within a core accountability framework for public resources, through expenditure and performance tracking mechanisms.

Box 6. Country examples of programme budgeting frameworks

Many OECD countries have programme budgeting frameworks in place. In the context of COVID-19:

- **France**: Created new budgetary programmes as a means of allocating expenditures to the COVID-19 response. Following the framework of the annual budget, the supplementary budget contained a new budgetary mission 'Contingency plan for the health crisis', divided into two new programmes and related actions (Republique Francaise, 2020[13]).
- **New Zealand**: Utilised its programme budgeting framework as a basis for allocating COVID-19 related expenditures. As part of the 2020 budget, the Government established the COVID-19 Response and Recovery Fund (CRRF) to support a response to and recovery from COVID-19. For the health sector, it provided a framework for the Ministry of Health to manage expenditure flexibly within the budgeted envelope (New Zealand Government, 2020[14]).

Source: Authors.

Joint responses against COVID-19 during the 'Implement' Phase

Boosting health workforce numbers and supporting sustainable workforce planning

Health professionals are at the frontline of combatting COVID-19. OECD countries have enacted a range of health workforce policies to boost overall numbers, including mobilising medical students, recently retired staff and bringing in personnel from the private sector and army. The roles of existing medical staff have also been adapted to treat COVID-19 patients, and governments have prioritised health workers for receiving social support such as childcare. These measures, while necessary, are costly. Consequently, finance ministries have allocated significant shares of supplementary budgets or emergency funds to mobilise the workforce, including overtime pay and providing bonus payments.

Lessons learned from these short-term responses to the COVID-19 crisis should feed into discussions around sustainable workforce planning for the medium-term. Issues include ensuring sufficient doctors and nurses, the mix of professions, and the ways in which the health sector can attract and retain workers to build future resilience. Creating a reserve of personnel can offer a flexible response to any future surges in COVID-19 cases. For countries with chronic workforce shortages, joint action between budget and health ministries can ensure sustained investments into the workforce beyond the initial outbreak, notably through improved pay and working conditions.

Box 7. Country examples of boosting health workforces

Examples of public employment and management practices in the health sector included:

- **Austria**: Implemented measures to support workers from nearby Eastern European countries, which the health and long-term care sectors rely on heavily. These included bonus payments, and also flights and non-stop trains to transport workers between their home country and their patients in Austria, despite border closures (Sozialministerium, 2020[15]).
- **Chile, France, Hungary, Ireland, and the Netherlands:** Are examples of countries that introduced new flexibilities for hiring health workers, including hiring retired professionals, qualified jobless health workers and allowing students in advance stages of medical and nursing training to start practising.
- **Italy:** The government decree 'Cura Italia' contains measures to hire an additional 20,000 health workers for the health system and support overtime (Ministero dell'Economia e delle Finanze, 2020[16]). To support hiring, the government created rapid recruitment tracks, and released more freelance contracts for doctors and nurses not yet listed under the Medical Register (Ministero

della Salute, 2020[17]). They also promoted psychological support services for health professionals during the emergency.

Note: For further examples from the OECD see 'Health System Response Tracker', and 'Workforce and safety in long-term care during the COVID-19 pandemic'.
Source: Authors.

Accelerated procurement procedures were critical for a timely response to COVID-19 but should not compromise integrity

Ensuring the sustained availability of the medical supplies needed to diagnose and treat patients has been a major concern during the ongoing outbreak (see (OECD, 2020[18]), from which this analysis is drawn, for further details on procurement challenges during COVID-19). Countries are not only in competition for the same resources at an international level, but central governments may also be in competition with regions, municipalities, and even individual hospitals for the same supplies. For the short-term responses, policies focused on implementing emergency contracting frameworks for urgent purchasing needs of health related goods or services, which provides exemptions and flexibilities to the general rules on open and competitive tendering practices. Specific actions included permitting public buyers to negotiate directly with potential contractors, no prior publication requirements, no time limits, no minimum number of candidates to be consulted, or relaxation of procedural requirements.

Other policy initiatives for the short-term response should focus on incentives to increase collaborative and co-ordinated approaches for procurement strategies. The centralised purchasing of medicines and other health products can help avoid the duplication of stock and internal competition for supplies. Moreover, co-ordination at the international, national and regional levels can prevent competing requests being sent to the market and resulting in suppliers inflating prices.

Emergency contracts facilitated the governmental response to the radically different purchasing environment. However, even when the general rules on procurement frameworks are suspended, joint action must ensure that government spending remains transparent. Ex-post transparency and ex-post auditing requirements help maintain the integrity of emergency contracts. Explicit initiatives include the rapid publication of all COVID-19 related emergency contracts as quickly as possible, and publishing reports on the execution of these contracts. E-procurement platforms can record transactional information on emergency procurements to analyse bidding patterns and identify potential integrity threats. Finally, setting up a central price and supplier tracking system for key medical supplies and other health products helps to identify red flags in procurement contracts, excessive pricing strategies, counterfeits and other misconducts. Supply chains should also be revisited in the medium-term, including assessing the costs and benefits of producing certain essential supplies domestically.

Box 8. Country examples of accelerating public procurement

Country examples:

- **Colombia:** Excluded the procurement of medical devices and PPE needed for the fight against the coronavirus (COVID-19) from the general public procurement regime, and allowed public buyers to purchase these items without any formal tender procedures. However, the government reinforced transparency and monitoring rules for contracts that fall outside of the normal procurement framework.

- **France:** The government took emergency measures in public procurement, removing requirements for prior advertising and competitive tendering for limited items in the health sector (Ministère de l'Économie et des Finances, 2020[19]).
- **Italy:** Centralised and simplified its procurement process. CONSIP, the national procurement agency owned by the Ministry of Economy and Finance, is responsible for the emergency procurement process for medical devices and ventilators related to COVID-19 (CONSIP, 2020[20]).

Source: Authors.

Prioritising health infrastructure and equipment to make responses to future crises more effective

COVID-19 highlighted the need for the adequate capacity of hospital beds, particularly ICU beds, to address sudden surges in seriously ill patients. The pandemic showed that countries needed to be flexible and creative to boost infrastructure capacity. Repurposing non-medical space to create temporary field hospitals or testing centres; and the safe and timely transfer of patients from overrun localities to other areas with spare capacity have been two effective strategies to meet sudden spikes in COVID-19 cases.

Looking to the medium-term, governments should reassess the capacity of health infrastructure to respond to potential future waves of COVID-19. This includes balancing the need for an adequate supply of ICU beds while avoiding excess idle capacity. The geographic distribution of these beds, and strategies for repurposing non-medical space for treatment and testing are also critical. A sound capital budgeting framework can help evaluate infrastructure proposals. Such a framework can establish consistency between capital investment plans with health sector priorities, and the prudent assessment of costs and benefits of such investments.

Box 9. Country examples of prioritising health infrastructure

Country examples of prioritising health infrastructure:

- **France:** The intensive care capacity in the Eastern part of the country was overstretched and a military camp was set up to boost the number of ICU beds. The military also transferred patients across regions from those operating at nearly full capacity to those with spare capacity (OECD, 2020[9]).
- **Korea:** Pioneered the approach of drive-through centres together with network of 96 public and private laboratories. More than 50 drive-through centres boosted the capacity to identify cases quickly with around 20 000 tests conducted daily (OECD, 2020[9]).
- **United Kingdom:** Temporary field hospitals were built in seven major cities to provide additional ICU capacity. The London Nightingale hospital became operational on 3 April, with capacity to treat 4 000 patients, with 500 beds equipped with ventilators and oxygen (NHS, 2020[21]).

Source: Authors.

Countries removed financial barriers to accessing care to ensure a more effective COVID-19 response

Although nearly all OECD countries provide universal health coverage, gaps persist in some countries. Population coverage for core services remains below 95% in seven OECD countries, and is lowest in Mexico, Poland, and the United States. A critical task for health systems confronted with the spread of COVID-19 was to protect the health of citizens, requiring that diagnosis, testing and appropriate care should be readily available, affordable and provided in a safe environment (OECD, 2020[22]).

Across the OECD, it was common for the government budget to provide transfers or subsidies to health systems to cover certain population groups, for example retirees, children below a certain age, students, soldiers, disabled people, and unemployed populations. However, expanding the subsidies to suspend user fees and co-payments requires joint action from finance and health ministries to guarantee the corresponding budget resources. This should cover transfers, subsidies, or direct payments to ensure full coverage for testing, diagnosis and treatment for COVID-19. Persistent gaps in coverage undermines the health system response, with failures to be tested or diagnosed for COVID-19 due to costs damaging efforts to limit transmission.

Although a key aspect of resilience is the ability to provide a proactive short-term response, health systems can evolve based on lessons learned during the crisis. In the medium-term, countries should reassess coverage and identify gaps to build resilience for future pandemics.

Box 10. Country examples of financial barriers

Country examples of lowering and/or removing financial barriers to access health services.

- **Ireland:** Although coverage for services in public hospitals is universal, less than half of the population is covered for the cost of GP visits. However, during the COVID-19 crisis, regardless of coverage status, the Health Service Executive will finance the provision of remote consultations by GPs for patients who may have contracted COVID-19.
- **Poland:** The National Health Fund is to fully cover health services combating the COVID-19 outbreak for the uninsured as well as the insured, including testing and access to medication. Funding comes from the state and extends coverage to the uninsured, or those without a Polish citizenship (Sejm, 2020[23]).
- **United States:** Increased access to diagnostic testing and treatment by the federal government, state governments, and private insurers. One step included the elimination of cost sharing for COVID-19 testing under Medicare and Medicaid (the federal programmes providing health insurance to the over 65s, disabled, and low income populations). This has been funded through the federal supplementary appropriation enacted in March 2020 (Tolbert, 2020[24]).

Source: Authors.

Coordinated responses require clear roles and responsibilities across government

There were multiple actors – both within the health sector and beyond – that are charged with combatting COVID-19. At the outset, the various government agencies needed clarity about the roles and responsibilities of the agencies in the COVID-19 response. Co-ordination mechanisms were critical to ensure the response to COVID-19 was rapid, targeted to localities with the most pressing needs; and also to ensure consistency in policy decisions and response strategies across different stakeholders.

Of note is the co-ordination across levels of government, for example, even in countries with decentralised governance, supplementary budget funds tend to be centralised. Joint collaboration between finance and health ministries can help identify particularly vulnerable regional or local governments to prioritise resources. Following large transfers of additional resources to SNGs also requires the corresponding transfer in monitoring and accountability standards. Beyond the management of additional funds, SNGs need to be at the heart of policy decisions, given that they are closer to the frontline of the COVID-19 response. Effective co-ordination can ensure the alignment of priorities across levels of government, the implementation of joint policy actions, and allow for rapid information sharing.

As countries move towards medium-term strategies, joint action should prioritise a co-ordinated recovery across government agencies and levels of government. In particular, targeted action to address any asymmetric impact of the crisis across regions can help prevent lasting territorial impacts. Further, countries should review the effectiveness of multi-level co-ordination mechanisms for crisis management.

Box 11. Country examples of roles and responsibilities

A number of OECD countries have provided additional budget support to subnational governments.

- **Australia:** The National Cabinet assumed responsibility for decision-making and leadership during the crisis. The Cabinet comprises of the prime minister and all state and territory premiers and chief ministers, it brings together information to help implement co-ordinated decisions across Australia (The Conversation, 2020[25]).
- **Canada:** The Federal Government increased budget transfers for health services to provinces and territories. Co-ordination is facilitated through a federal-provincial-territorial Special Advisory Committee (SAC) on COVID-19. The SAC advises Deputy Ministers of Health across Canada on the co-ordination, public health policy, and technical content related to COVID-19 (Government of Canada, 2020[26]).
- **Denmark:** The current budget law sanctions municipalities if they overspend budgets. However, due to the expected rise in health costs due to COVID-19, the government is planning to grant an exemption for the pandemic (OECD, 2020[27]).
- **Greece:** The Ministry of Health has co-ordinated with the National Centralised Procurement Agency (EKAPY), in an attempt to allocate resources efficiently. It has set up a Digital Registry which monitors stock and utilisation of all COVID-19-relevant equipment (gloves, masks, protective gear for medical personnel etc.), as well as hospital and ICU bed capacity and occupancy in real-time. The data is utilised to forecast future needs (WHO/EC/European Observatory, 2020[28])
- **Korea:** Adopted a supplementary budget that includes support for Daegu City and the North Kyeongsang Province, two of its hardest hit areas.

Source: Authors.

Coordinated support to hospitals and other frontline providers is also needed

Irrespective of the degree of decentralisation across levels of government, hospitals and other health providers merit special attention. Factors such as boosting surge capacity, procuring medical supplies, and establishing testing capabilities, drive up health provider costs. On the other hand, depending on payment modalities, postponed or cancelled elective surgeries, restrictions on face-to-face consultations, and strict lockdown measures can cause a significant drop in revenues.

Joint action should ensure co-ordinated support for health providers during the pandemic. Direct central or SNG resource transfers can help stabilise provider revenues. Other more targeted measures include the adjustment of payment modalities reflecting COVID-19 activity costs, or providing financial incentives to expand capacity. Further, establishing co-ordination mechanisms between providers allow for information sharing regarding the status of resources such as medical supplies, ICU capacity and share emerging practice. Financial support for health workers merits special attention. Joint action is necessary to avoid 'double coverage' for health workers, eligible for coverage under short-term worker government schemes, and through health providers that have received compensation for revenue reductions.

In the medium-term, countries should continue to revise payment modalities and financing regimes to support providers where necessary. This includes making adjustments that are more permanent to payment systems to reflect COVID-19 related activity beyond the initial outbreak, such as hygiene and decontamination costs, and on-going testing initiatives. Other funding adjustments may include support to providers facing a backlog of patients due to postponement in planned care.

Box 12. Country examples of co-ordinated support

Country examples of co-ordinated support measures:

- **Germany:** Implemented measures at the federal level to support hospitals and expand ICU capacity, funded through federal transfers. Measures included a compensation payment for loss of earnings due to a lower utilisation of beds. It also included a bonus for additional ICU capacities (amounting to EUR 50,000 for each ICU bed with mechanical ventilation and surcharges for additional costs) (Rong, 2020[29]). Germany has sought to improve co-ordination across hospitals, with the Robert Koch Institute, the German Hospital Association (DKG) and the German Association for Intensive and Emergency care (DIVI) setting up a website where each hospital provides a daily update on available capacity with respiratory support (DIVI, 2020[30]).
- **New Zealand:** A new initiative in the central government's budget provides funding to address increases in waiting lists and waiting times incurred during the crisis and the follow-on period. This spending initiative is to be funded until the budget year 2022/2023 (New Zealand Government, 2020[14]).
- **Portugal:** The COVID-19 crisis led to a change in the governance for hospitals, from a model of almost total regulation and centralisation, to that of autonomy. Prior to the crisis, hospitals could not make multi-year expenditure commitments or invest beyond certain thresholds without authorisation from the ministries of finance and health. Since the crisis, the government has given hospitals an 'exceptional expenditure authorisation regime for the response to the pandemic'. The Central Administration of the Health System and the Directorate-General for Health have been delegated powers to approve expenditures with a view to responding more quickly to purchase goods and services. Hospitals also have increased flexibility to make direct adjustments to expenditures (Diário da República, 2020[31]).
- **United Kingdom:** Simplified the financing regime and created greater certainty on the flow of money to reduce the burden on hospitals, and helps NHS Trusts support the economy by paying suppliers promptly. Hospitals are guaranteed minimum income through block contracts, and are able to claim monthly top-ups, depending on the additional cost of COVID-19 treatment (Brown and Ward, 2020[32]). In addition, the government rid more than 100 NHS hospitals of historic debt, freeing financial space to invest in infrastructure improvements.

Source: Authors.

Joint responses against COVID-19 during the 'Review' Phase

Tracking COVID-19 spending helps verify that resources were spent as intended

Countries are allocating unprecedented levels of public resources to combat COVID-19. With a rapid response, funds are identified and released much more quickly than in the normal budget process. Governments have granted additional degrees of flexibility within the rules governing the use of funds. This means maintaining sound budgetary governance practices are as crucial in assuring the proper use of resources and maintaining financial accountability. Tracking and reporting on COVID-19 spending helps to verify if resources have been spent as intended.

Finance ministries have a lead role in ensuring financial compliance and enforcing effective control of budgetary expenditures. And, health ministries are critical in implementing reporting rules and procedures for additional COVD-19 funding.

In the medium-term, countries should adapt mechanisms to control and track the execution of new spending measures. Through the creation of dedicated budget programmes, codes or funds for COVID-19, government officials can be held accountable over the use of funds during the crisis. Finance ministries should uphold transparency when modifying existing rules to grant additional degrees of flexibility to health officials, ensuring clear criteria over the use of funds.

Box 13. Country examples of tracking COVID-19 expenditure

Country examples of tracking and monitoring expenditure:

- **Austria:** The Ministry of Finance has emphasised the need for transparency during the crisis – with separate accounts for COVID-19 expenditure set up to facilitate ongoing monitoring. The information will be published by the Ministry of Finance in a monthly report to parliament, with a separate section on 'Corona Measures', detailing the list of all measures and costs related to COVID-19 (Parliament of Austria, 2020[33]).
- **New Zealand:** The Controller and Auditor-General is to monitor COVID-19 spending and report to the public and parliament on the government response. This includes examining the systems in place for the Government on the authorisation and use of COVID-19 related expenditures.
- **United Kingdom:** The government has asked the NHS to account for the resources it has used to tackle COVID-19. Using unique COVID-19 cost centres and budget codes, the NHS hopes to capture all COVID-19 related costs, including capital costs and opportunity costs, for example, the costs of staff moved to work on COVID-19 from other areas (HFMA, 2020[34]).

Source: Authors.

Adapt performance frameworks to assess government responses to COVID-19

OECD governments have implemented unprecedented policy measures to contain and mitigate the effects of COVID-19. Ex ante and ex post analyses can help governments assess the relative effectiveness and efficiency of policies. In the short-term, such analyses will need to be rapid, and likely focused on safety and efficacy. But over time they should become more comprehensive, closer in nature to traditional Health Technology Assessments (HTA) that review the cost-effectiveness of different interventions. Such assessments can provide invaluable input into preparation for ongoing and any future waves of the virus.

Beyond policy evaluation, performance budgeting frameworks can be adapted to COVID-19, in terms of objectives and key performance indicators. This can give parliaments and citizens a clearer picture of what

public services are actually being delivered, to what standards of quality and with what degree of efficiency. In the medium-term, spending reviews are a key tool to help ministries of health and finance identify resources that can support priority goals.

Box 14. Country examples of performance budgeting frameworks

Several OECD countries are utilising HTAs to gather and assess COVID-19 related information:

- **Canada:** The Canadian Agency for Drugs & Technologies in Health (CADTH), conducts 'Rapid Response Reports', which bring together evidence on prevention, infection control, screening and testing, mental health issues, and ethics surrounding COVID-19 (CADTH, 2020[35]). Other agencies conducting similar tasks includes the National Institute for Health Care and Excellence (NICE) in the United Kingdom, and the Austrian Institute for Health Technology Assessment (GmbH).
- **France:** The amended budget law has created a new budget mission and two new budgetary programmes on COVID-19. Following the performance framework of the general government budget, the budget annex contains details of the new created programmes. This includes the programmes strategy, outlining planned spending measures within the programme and the overall aim. Following this are a set of programme objectives, with the success captured by a number of quantitative indicators.

Source: Authors.

Spending reviews can support joint actions by budget and health officials

The medium-term issues in this section identify the challenges facing the budget and health sector officials following the outbreak of COVID-19. Many of these challenges are not new but emphasise the scarcity of resources at a time when many areas of the public sector will likely to seek additional funding through a government's budget processes.

The health sector is well placed to articulate the challenges it faces in a budget process. On the one hand, the health sector has responded rapidly to the frontline of COVID-19, adopted new functions, such as test and trace, and displaced existing activities by prioritising the responses to COVID-19. On the other, the crisis has identified health resources that were not fit-for-purpose and services that were not unduly missed when they were deprioritised. Both sets of factors contribute to a high awareness of the need to adequately finance the health sector if it is to achieve long-term health outcomes.

Of the tools available to budget and health officials to demonstrate the challenges and the effectiveness of the existing allocation of resources in governmental budgets, spending reviews are a readily available option. Spending reviews have been used since the 1970s. Examples of countries that have pioneered the use of spending reviews include the Netherlands, where the first government-wide spending review was implemented in 1981. The purposes of a spending review include creating fiscal space, improving a government's control over aggregate expenditure, prioritising expenditure in a sector, and managing potential risks.

Following the 2008 Global Financial Crisis, spending reviews were used for fiscal austerity purposes. While that purpose can still apply today, in the past 12-years OECD countries have also used spending reviews to identify capacity constraints relative to government priorities and to foreshadow risks that could affect

future budgets (Box 15). The track record from using spending reviews in these ways helps to establish it as a durable tool across budget and health officials ahead of the 2021 and 2022 budget processes.

The reviews able to be deployed quickly, have an established link to budget processes and are used by nearly all OECD countries. Such reviews are able to be completed faster than a sector-wide evaluation, which increases the relevance of the tool for political decision-makers in a time of ongoing crisis.

Box 15. Spending reviews

A spending review is an examination of the efficiency and effectiveness of the government's existing expenditure. Rather than a budget, which focuses on new expenditure, spending reviews analyse baseline expenditures. Health ministries can opt to implement a spending review within the health sector to help identify areas of wasteful, inefficient or outdated spending. A spending review can also be used to demonstrate the extent to which expenditures align to a government's priorities. Doing so can increase the profile and priority of implementing health policies and bring awareness to the budgetary constraints and sustainability challenges facing ministries of health.

Nearly all OECD member countries have conducted a spending review of all or part of government expenditure, with the main objective to improve spending efficiency over the medium-term (OECD, 2018[11]).

In the health sector, spending reviews occur on a whole-of-ministry basis or for an identified area of expenditure. The **United Kingdom** carries out a whole-of-government spending review approximately every three years, to set budget allocations for departments, including for the NHS, as well as to review the consistency of spending relative to government priorities (HM Treasury, 2020[36]). The Value-for-Money team in the **Slovak Republic** conducts spending reviews identified areas of expenditure, with the health spending review focussed on achieving patient outcomes (Government of the Slovak Republic, 2019[37]).

Source: Authors.

Conclusions

Governments across OECD member countries committed significant budgetary resources for the health sector response to COVID-19. The identification of budgetary resources occurred on a rapid time scale, supported by a series of planning actions by health and finance ministries. The rapid estimation of resource requirements and costing of policies provided direction to set resource envelopes. Alongside supplementary budgets and contingency funds, planned reprioritisation efforts helped identify fiscal space for the health sector. A number of countries with programme budgeting frameworks used the inherent flexibility of the frameworks to allocate or redirect expenditures to COVID-19 responses.

Furthermore, governments adapted health financing arrangements to support a swift execution of budgetary funds to implement response measures. Increasing the size of the health workforce and investing in infrastructure allowed health systems to respond to the demand surge that resulted from the spread of COVID-19. Governmental measures to relax aspects of public procurement requirements facilitated the purchase of PPE, medicines, and other medical equipment. In some countries, reducing the financial barriers to health care improved access to testing and treatment for COVID-19. Finally, countries implemented measures that provided financial assistance to hospitals and other health providers during the crisis, which supported a coordinated whole-of-government response.

Given the extent of the measures, health and finance ministries across OECD countries adapted budgetary mechanisms to review response measures. Monitoring and reporting systems were designed to account for COVID-19 expenditures. In addition, some countries adapted the performance frameworks to review the effectiveness of COVID-19 expenditure measures.

Looking beyond the immediate response, health and finance ministries need to focus on the recovery and aftermath of COVID-19. The focus should turn to the efficiency and value for money across the health sector given that COVID-19 has changed underlying cost-structures. Resources should be made available to the health sector as necessary for COVID-19 related activities, without losing sight of the efficiency of public spending.

Confronted with these challenges, health budgeting systems will need to demonstrate the effective use of public spending when seeking additional resources. Conducting in-depth assessments of health sector expenditure requirements can inform parliament of the expected outcomes over the medium term, thereby strengthening the case for sustainable financing in the health sector. Secondly, reprioritisation efforts within the health sector in light of COVID-19 can help to eliminate ineffective or wasteful spending. Deepening the implementation of programme budgeting offers the flexibility to continue to respond to COVID-19 based on changing needs while providing a framework for performance assessment and accountability over budgeted outcomes.

With COVID-19 reshaping health sector priorities, health financing policies need to ensure existing resources are allocated to the areas of greatest need. Revising health workforce planning to ensure future resilience, including through the creation of a reserve of personnel, may help to estimate the future needs of the workforce. Reforming procurement, including potential domestic production of some essential supplies will prevent shortages and stock-outs during future pandemics. Comprehensive capital budgeting frameworks that include assessments of future need and contingency planning for health crises can help identify appropriate levels of public investment, such as hospital ICU beds. In addition, payment modalities and financing regimes may need to be revised to account for additional on-going COVID-19 expenses to prevent financial hardship for health care providers.

Due to the distribution of health financing responsibilities across levels of government and agencies, health and finance ministries should assess the institutional mechanisms to improve co-ordination across the health sector in light of COVID-19. Such mechanisms, employed during a crisis, helped to facilitate the allocation of responsibilities across the health sector, reducing overlap and ensuring consistency of policy measures. During COVID-19, this included the use of executive federalism and centres of government to co-ordinate the response, as well as the centralisation of activities such as procurement.

Taking stock of the COVID-19 policy measures will be a momentous task for health and finance officials. Permanent adjustments to budget and accounting frameworks to track COVID-19 related expenditure will help policymakers understand the overall impact on health expenditure. A key challenge will be ensuring international comparability of COVID-19 accounting to allow for cross-country comparisons. Looking forward, cost-effectiveness analysis of alternative policy measures to address COVID-19 will also be invaluable to inform health and finance officials of the best use of resources.

Following the pressures on health systems from COVID-19, spending reviews are a readily available option for budget and health officials to demonstrate the challenges and the effectiveness of the existing allocation of resources in governmental budgets. Reviews in the health sector are able to be completed faster than a sector-wide evaluation, which increases the relevance of the tool for political decision-makers in a time of ongoing crisis. The results from a spending review are instrumental to the health sector, by helping to create fiscal space, improving a government's control over aggregate expenditure, prioritising health expenditure, and managing potential risks.

Overall, collaboration between health and finance ministries is essential to deliver a sustained recovery from COVID-19. Building resilience to face future pandemics and other shocks requires investments in the

health sector, and assurance that the investment is going to the right areas. While COVID-19 has increased the pressure on government resources, it is important to recognise the impact of investing in health systems contributes to the wider economic recovery from COVID-19.

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