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Applying good budgeting practices to health

This report presents a set of high-level good budgeting practices in the health sector. The purpose of these good practices is to support countries in assessing their own budgeting arrangements for health, and in designing budgeting reforms. The report builds on 10 years of work by the OECD Joint Network of Senior Budget and Health Officials.

Delegates to the Committee of Senior Budget Officials are invited to approve this report for publication. Please provide any comments by 27 November 2023. If no objections have been received by that date, the report will be considered approved.

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Table of contents

FIGURES

BOXES

1 Introduction

1. This report on *Applying Good Budgeting Practices to Health* builds on the lessons learnt from more than 10 years of work by the OECD Joint Network of Senior Budget and Health Officials. It presents a set of high-level good budgeting practices in the health sector. The purpose of these good practices is to support countries in assessing their own budgeting arrangements for health and in designing budgeting reforms.

2. The approach acknowledges the significant challenges that countries face in budgeting for health. First, the healthcare sector involves many stakeholders, creating more uncertainty and more asymmetry of information compared to other expenditure areas. Second, in certain countries, health has a budget separate from the general government budget and outside of the standard budgeting procedures. This is often the case for health systems financed through social health insurance schemes or those with decentralised systems. Third, the size of the health budget has increased faster than GDP and government revenues in most OECD countries. It represents one of the largest public expenditure areas, accounting for 16% of government expenditure in 2021 on average across OECD countries – and the financing needs are growing, notably in the aftermath of the COVID-19 pandemic and with ageing being a major trend in most OECD countries. Applying good budgeting practices for health therefore is critical to maximising value-for-money and ensuring the fiscal sustainability of health systems.

1.1. Developing good budgeting practices for the health sector

3. *Applying Good Budgeting Practices to Health* builds on the work of the OECD Joint Network of Senior Budget and Health Officials. More precisely, it draws upon the analytical work presented in the forthcoming OECD Joint Network report *Fiscal Sustainability of Health Systems: Forward-looking and Results-oriented Health Budgeting* to be published in early 2024. The report analyses the major challenges OECD countries face in ensuring the fiscal sustainability of their health systems, and potential solutions to addressing this challenge. The report places a particular focus on the role of good budgeting practices for health, which are built on effective dialogue between health and finance ministries and play a crucial role in facilitating resource allocation decisions and the efficiency of public spending on health. Chapters include:

1. Financing resilient health systems in times of crisis – How can finance and health authorities find agreed policy solutions?
2. Long-term projections – Different paths to fiscal sustainability of health systems
3. Budgeting Practices for Health in OECD Countries
4. Medium-term budgeting for health: Going beyond the annual focus of the budget
5. Programme and Performance Budgeting for health: Linking budgets to results

4. The findings of these chapters serve as the foundation and elaborate on *Applying Good Budgeting Practices to Health*, and they should be consulted in parallel. In addition, the good budgeting practices were developed in collaboration with national delegates of the OECD Joint Network (Box 1).

Box 1. Applying good budgeting practice to health – process

The *Applying Good Budgeting Practices to Health* project was endorsed during the 10th annual meeting of the OECD Joint Network of Senior Budget and Health Officials held in February 2022. Later that year, the OECD Secretariat held a series of workshops with a working group formed of network delegates. During these workshops, participants identified key issues across the budget cycle that the OECD subsequently analysed to formulate a set of high-level good budgeting practices in the context of the health sector.

The members of the working group were delegates from the Ministries of Health and the Ministries of Finance of Austria, Belgium, Canada, Estonia, France, Israel, Japan, Korea, New Zealand, Norway and South Africa. During these workshops, the working group produced a draft set of good budgeting practices for the health sector. This draft was discussed at the 11th annual OECD Joint Network meeting held in February 2023.

These budgeting practices for health will be a living document that will continue to evolve to reflect the latest lessons learned from country experiences.

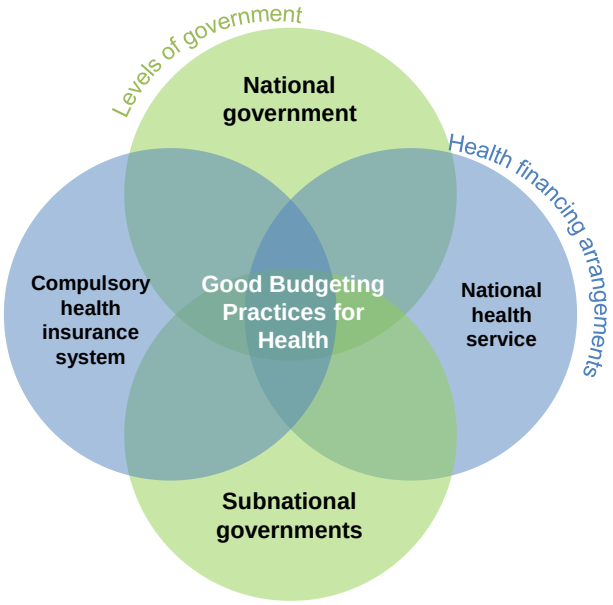
1.2. For whom are the good budgeting practices relevant?

5. *Applying Good Budgeting Practices to Health* was designed to be relevant for all country healthcare settings (Figure 1). This applies to countries with different financing arrangements for healthcare, which are commonly classified into three main types: national health systems, single health insurance funds, or multiple health insurance funds/companies. In national health systems, a large portion of overall spending on healthcare comes from the national government budget. Hence, it is crucial for central government budgets to be aligned with good budgeting practices that are typically applied to all central government expenditure areas.

6. Meanwhile, for countries with health systems primarily organised around health insurance (either single or multiple funds), good budgeting practices should extend to health insurance funds, who may have large responsibilities for planning, formulating, executing, and reviewing health expenditure. Moreover, in such systems, the central government may retain ownership of health expenditure – i.e., through a role in the budget process or direct transfers to the health insurance systems – and therefore should apply good budgeting practices for health.

7. Additionally, in many OECD countries, subnational governments play a significant role in the health system. The consequence is that health spending is distributed across central and subnational budgets. Budget procedures at the subnational level operate with a varying degree of autonomy from national budgeting procedures, and thus should follow recognised good practices.

Figure 1. Applying good budgeting practices to health framework



Source: Authors

1.3. What are the objectives?

8. *Applying Good Budgeting Practices to Health* should help achieve four key objectives for the health sector (Figure 2.): ensuring fiscal sustainability of health systems; optimising resource efficiency; delivering high quality health services and guaranteeing access and equity for all. The contribution of the good budgeting practices in achieving these objectives are highlighted throughout.

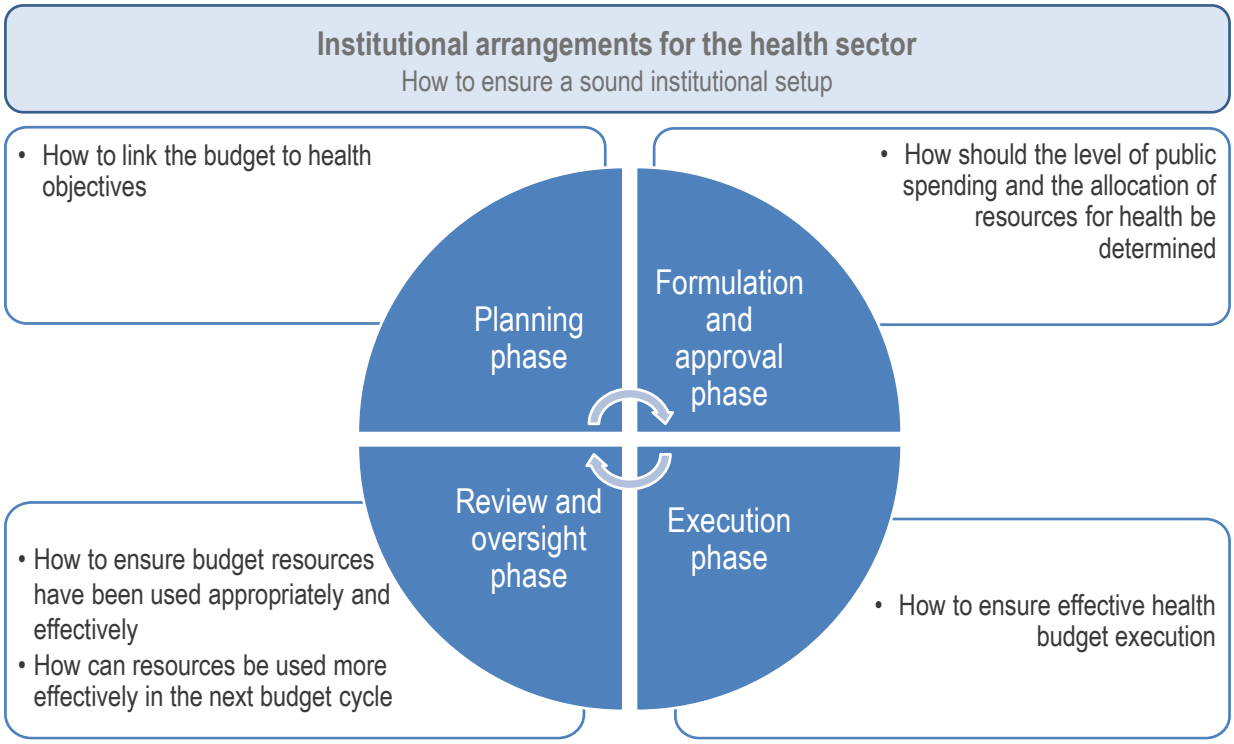
Figure 2. Objectives of good budgeting practices for health

Source: Authors

1.4. The Applying Good Budgeting Practices to Health framework

9. The good budget practices outlined in *Applying Good Budgeting Practices to Health* follow a framework that aligns with the traditional budget cycle. However, this framework distinguishes between institutional arrangements for the health sector (which are not discussed annually), and the annual budget cycle (planning, formulation and approval, execution, and review) (Figure 3).

Figure 3. Applying Good Budgeting Practices to Health framework



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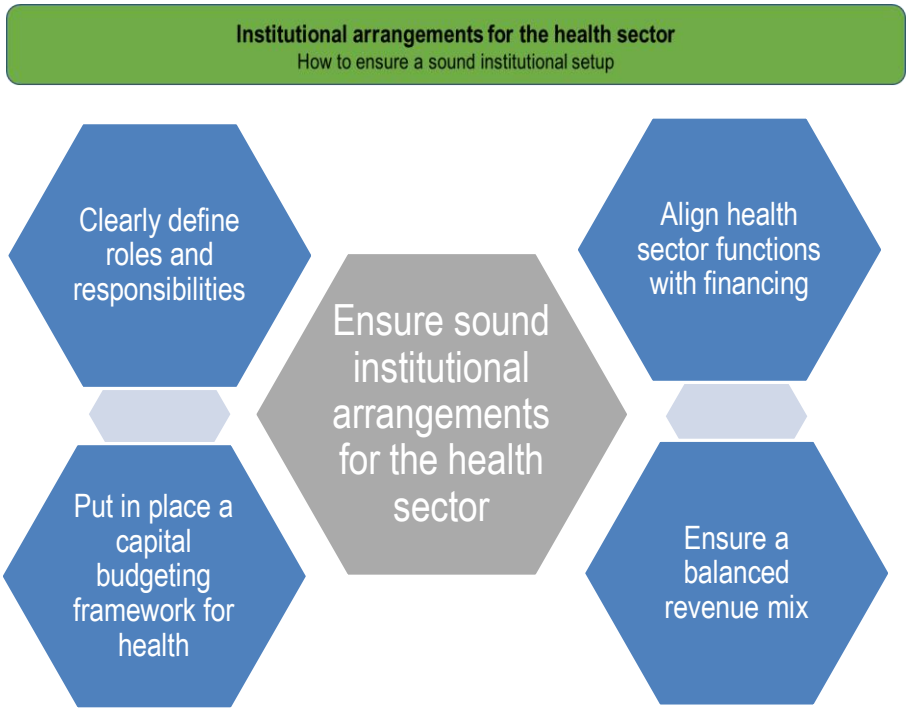
2 Applying good budgeting practices to health

2.1. Ensure sound institutional arrangements for the health sector

10. Health system institutional arrangements are unique to each country, with distinct implications for the health budgeting process. While there is no one-size-fits-all set of good budgeting practices, certain elements contribute to establishing a sound institutional setup.

Figure 1. Ensure sound institutional arrangements for the health sector



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2.1.1. Clearly define roles and responsibilities

- Define **common objectives** among key agencies to accomplish national health objectives.
- Ensure strong **co-ordination mechanisms** between government agencies and different levels of government (e.g., joint planning, formal co-operation agreements, information, and monitoring requirements, and harmonised digital platforms).
- Clearly **identify the responsibilities** in the Ministry of Finance to discuss and oversee the health budget.
- Clearly **identify the responsibilities** in the Ministry of Health and/or Social Health Insurance agency for discussing health budget issues with the Ministry of Finance.
- Where relevant, clearly **identify the responsibilities** in the Ministry of Health and/or Ministry of Finance for discussing health budget issues with subnational governments.

Box 1. Country example – Norway

In Norway, the Ministry of Health and Welfare is composed of subordinate agencies, covering areas such as e-health, public health, budget and financial affairs, hospital ownership, specialist healthcare services and municipal healthcare services.

In 2015, the Ministry of Health and Welfare re-clarified the roles and mandates of all the subordinate agencies governed by the Ministry. The aim was to create a collective understanding among all the agencies and to clarify the roles and responsibilities assigned to each of them. This reform contributed to more efficient use of public funding. It also reduced the numbers of agencies from 15 to 11.

In the aftermath of the COVID-19 pandemic, the Government has signalled a similar reform involving the subordinate agencies. The aim is to use lessons learned from how Norway tackled the pandemic, and new opportunities brought by innovation and digitalisation, to redraw the organisational chart within an unchanged budget frame. The regional health trusts with hospitals are not included in this new exercise.

2.1.2. Align health sector functions with financing

- Avoid unfunded mandates by ensuring resources are in place for each agency or subnational government to carry out their responsibilities.
- Avoid duplicate financing of multiple agencies or levels of government to provide the same service.

Box 2. Country example – United States

In 1995, the United States enacted the Unfunded Mandates Reform Act (UMRA). The purpose of the UMRA was to help reveal, and ultimately limit, the high (and often hidden) costs of federal mandates on state and local governments to undertake regulatory activity without sufficient federal compensation for this activity.

The UMRA establishes a framework for the Congressional Budget Office (CBO) to estimate the direct costs of mandates to state and local governments and to the private sector. Aside from these informational requirements, the UMRA allows Congress to decline unfunded mandates if they are estimated to cost more than a specified threshold.

In the health sector, the UMRA has raised concerns regarding various healthcare reform bills. This includes, for example, a federal act requiring public entities to comply with new reporting regulations on health insurance plans. This would have imposed substantial costs on state and local governments that would greatly exceed UMRA's thresholds.

2.1.3. Ensure a balanced revenue mix

- **Diversify** revenues used to finance health expenditure.
  - Avoid an over-reliance on wage-based contributions or other taxes with a narrow base.
- Avoid an over-reliance on **earmarked** taxes for health as a substitute for a budget process that adequately prioritises the health sector.
  - Earmarking taxes for health can be justified in some circumstances (e.g., to increase acceptability for needed tax increases).
  - Consider the use of health taxes to influence negative consumption behaviours that affect population health.

Box 3. Country example – France

The revenues to finance the health sector in France have evolved and diversified over time. After beginning as a system funded almost entirely from wage-based contributions, these contributions accounted for less than half of revenues for healthcare in 2020.

The government sought to diversify revenue sources away from purely wage-based contributions by introducing the Contribution Sociale Généralisée (CSG) tax in 1991. The CSG is one single tax but with different rates for different types of revenues. The CSG levies taxes on wage income but also extends to income from financial assets and investments, pensions, unemployment benefits, disability benefits and gambling. In 2020, the CSG financed 24% of healthcare.

2.1.4. Put in place a capital budgeting framework for health

- **Align capital budget frameworks** with population needs, national development needs, and environmental objectives.
- Develop **medium-term capital plans** for the health sector that go beyond the annual budget.
- Include information on the **expected impact on operating costs** when presenting capital investment proposals, to assess their potential future fiscal implications.
- **Collaborate on health capital plans** between central and subnational levels of government, as well as across agencies, to establish coherence in capital policies and priorities.

Box 4. Country example – Austria

The National Plan for Large Medical Equipment contains the principles and objectives of equipment planning in Austria. Notably, it contains guidelines on the number of major equipment units nationwide and for each federal state.

The planning of large medical-technical equipment (CT, MRI, ECT, STR, COR and PET) is carried out according to quantitative and qualitative planning criteria. Population benchmarks (number of inhabitants per large-scale equipment unit or number of units per million inhabitants), as well accessibility benchmarks are used to calculate demand for each large-scale equipment.

Other factors can be considered for planning decisions. These include the range of services in hospitals, equipment utilisation, including the need to keep equipment on hand for emergency situations, as well as organisational or operational/overall economic reasons, including corresponding cost assessments.

2.2. Link the budget to health objectives (planning phase)

11. The planning phase fosters discussions on medium and long-term health objectives and priorities, and ensuring their incorporation into the annual health sector budgeting process. A budget based on programmes and integrating performance information helps align budgets to health objectives.

Figure 2. Link the budget to health objectives

Source: Authors

2.2.1. Project health revenues and expenditures over the medium-term

- Develop **medium-term health expenditure projections** (3-5 years).
  - Base methodology on robust projections of GDP and other economic indicators.
  - Reflect baseline needs assessment and the impact of policy decisions (including new policy proposals and/or cost of inaction) in projections.
  - Formalise the use of projections by embedding the results into the budget process.
- Develop **medium-term health revenue projections** (3-5 years) (where relevant).
  - Disaggregate revenue projections by type of revenue.
- Compare expenditure and revenue projections to **assess the extent of funding shortfalls.**
- **Identify data requirements** for projection models, including gaps in data availability.
- Clearly identify **responsibilities** for conducting medium-term projections.
  - Designate a single agency to consolidate and formalise projections.

Box 5. Country example – Medium-term health expenditure projections in the Netherlands

The Bureau for Economic Policy Analysis in the Netherlands conducts medium-term health expenditure projections for a three-year period. These projections include expenditures related to the three insurance schemes providing health coverage: the Health Insurance Act (Zvw), the Long-Term Care Act (Wlz), and the Social Support Act (Wmo). Additionally, publicly funded youth care expenditure is included in these projections.

The projection model estimates health expenditure under the assumption of unchanged policy. For each scheme, the model increases health expenditure recorded in the previous year by a growth rate and then adjusts for existing policies that have a cost-implication in future periods.

The growth rate consists of five components:

- General inflation
- The relative increase in health sector wages and prices of other health inputs
- Demographics (size and composition of the population)
- Income growth (per capita)
- Other growth (e.g., new technology, new pharmaceuticals).

2.2.2. Align the budget for health with medium-term priorities

- Specify the **medium-term priorities** for the health sector and estimate their budgetary impact.
- Use **medium-term expenditure frameworks** for health as a tool to link the budget with medium-term health priorities.
  - If possible, integrate health expenditure in the national medium-term expenditure framework.
  - At a minimum, align medium-term frameworks for health with national medium-term expenditure frameworks (where relevant).
- If multi-annual budget allocations for health are set, **follow a transparent framework** to adjust allocations in response to shocks.

Box 6. Country example – United Kingdom (England)

The United Kingdom has a long history of using medium-term expenditure frameworks for health. These frameworks are designed to provide a predictable funding outlook for healthcare service purchasers, fostering more effective and efficient management of healthcare expenditure.

In 2018, the government announced its latest multi-year funding settlement in the form of the five-year deal for NHS England. Under this deal, funding for the next five years was protected by legislation. The five-year funding deal and the long-term objectives of the health sector are linked through the NHS Long Term Plan.

2.2.3. Align the budget structure with health objectives

- Create **linkages and cross-references** across the health budgets of different agencies.
- Avoid **overly detailed** resource allocations that restrict the decision-making authority of health agencies and their ability to redistribute funds within their budgets throughout the year.
- Consider the use of budget **programmes** that align with strategic priorities of the health sector and move away from a budget structure based on inputs.
  - Embed programmes within a single institution (as a general rule).
  - Consider linkages across programmes that collectively contribute to broader health objectives, while ensuring that responsibilities for cross-cutting programs involving multiple agencies are clearly defined and that agencies are held responsible for achieving results.

Box 7. Country example – Canada

Canada has a long-established programme and performance budget framework in place for the federal budget for health. The federal budget includes expenditures of the "Health Portfolio", compromised of five federal governments agencies responsible for health promotion and protection in Canada. The budget of each agency in the Health Portfolio is organised around programmes, such as "health security", "infectious disease prevention and control", and "health protection and promotion".

Most healthcare services are delivered through the 13 provincial and territorial systems, with each provincial or territorial government operating with a Ministry of Health or equivalent and subsequent budget for health. Provincial governments have autonomy over the adoption and implementation of budget practices and processes as long as they are in line with accepted principles of good budgetary governance. Therefore, several provincial and territorial governments – such as Alberta and Ontario – have also moved towards a programme-based budget for health. These programmes are primarily organised around the type of health service provided, such as "continuing care," "community care," and "acute care."

2.2.4. Incorporate performance information within or alongside the budget for health

- Include **key performance indicators** which facilitate ex-post evaluation of allocations in the budget for health.
- Utilise existing **health system performance assessment** frameworks and indicators.
- Ensure the data needed to conduct evaluations can be and is **readily collected.**

Box 8. Country example – Ireland

Performance budgeting was first introduced in Ireland in 2012 as part of a broader set of reforms to the public expenditure framework. Each year, the Department of Health (along with each Government Department) defines performance and equality targets for the upcoming budget year. These targets encompass output metrics specifically linked to the activities funded by particular programmes or policies. For example, output metrics for the primary care programme include indicators such as "number of contacts with GP out-of-hours," "number of GP Trainees," and "number of patients seen by nurses."

Additionally, the Department of Health must establish outcome metrics designed to measure any changes in the objectives or goals intended to result from these activities. For instance, the primary care programme's outcome is “to deliver significantly strengthened primary care services in a cost-effective manner. The core objective is to achieve a more balanced health service by ensuring the vast majority of patients and clients who require urgent or planned care are managed within primary and community based settings”.

Reporting on outputs and outcomes is through the annual publication of the Public Service Performance Report (PSPR). This provides a comprehensive overview of the Department of Health’s performance in relation to the performance targets established in the previous year. The Performance Report is also a key tool to support Parliamentary committees in scrutinising spending and engaging in a performance dialogue with the Department of Health.

2.2.5. Develop a long-term outlook for health linked to funding

- Outline the **long-term priorities** for the health sector, including the consequences of policy inaction.
- Develop **long-term health expenditure and revenue projections** (10+ years).
  - Methodology for long-term projections should reflect the major drivers of expenditure (e.g., demography, rising incomes, new technologies, input costs) and revenue trends (e.g., macroeconomic outlook, demography).

Box 9. Country example – Australia

Every 5 years, Australia produces “The Intergenerational Report”, projecting an outlook of the government budget, including health expenditure, for the next 40 years. It examines the long-term sustainability of current policies and the key drivers of future health spending.

The Treasury is responsible for long-term projections, based on a macro-level model used to project total central government health spending. The model is based on an alignment of spending to demographic factors, supplemented by assumptions around growth in unit cost such as technological change.

2.3. Have clear criteria for determining the level of public spending on health and allocating resources within health (formulation and approval phase)

12. During the budget formulation and approval phase, the government proposes the overall level of public spending for health in the upcoming budget year, and the allocation of resources within the healthcare sector across policy areas and priorities. Following this, the budget proposal undergoes scrutiny and debate in the legislature before final approval.

13. Good practices at this stage are crucial to ensure that resource allocation decisions align with current priorities. They help prevent decisions being based solely on historical incremental patterns, which are less responsive to evolving healthcare needs.

Figure 3. Have clear criteria for determining the level of public spending on health and allocating resources within health

Source: Authors

2.3.1. Evaluate fiscal constraints

- Ensure consistency with **national fiscal constraints** when developing estimations of annual and multi-annual budget request/s for health.
- Use **price indexes** that accurately represent the real growth in input costs to account for inflation when assessing fiscal constraints.
- Consider the use of **hard budget ceilings or expenditure targets** for health expenditure.
  - Incorporate emergency clauses to allow for adaptation to major shocks (e.g., contingency funds, emergency procurement procedures, reporting mechanisms).

Box 10. Country example – United Kingdom

In the United Kingdom, the Contingencies Fund Account is used to finance urgent spending before receiving approval from Parliament. The Fund is under control of the Treasury, and wherever possible, Parliament is made aware of the intention to use the Fund. Since 1974, the size of the fund is set as 2% of the amount of the government budget in the preceding year.

The Contingencies Fund was used to finance emergency response measures to the COVID-19 crisis in the health sector and other public sectors. A new government act in 2020 made provision to temporarily increase the Fund. Under this Act, the available contingencies not requiring parliamentary approval increased from 2% to 50% of the government budget from the preceding year. This adjustment allowed for the advancement of up to GBP 266 billion to government departments. However, this change was time-limited and expired on 31 March 2021.

2.3.2. Evaluate health expenditure needs

- Distinguish between **baseline spending and new policies**:
  - Accurately estimate the costs of maintaining existing health services (i.e., maintaining current coverage and quality of services).
  - Separately estimate the costs (operating and capital) of new health policy proposals and the consequences for the budgets of different agencies.
  - Establish a transparent and systematic process for prioritising policy proposals to distinguish between higher and lower priority initiatives.
- Ensure the assumptions behind health expenditure needs assessment are **transparent and not frequently** changed.
- Use sound **Health Technology Assessment** in a systematic manner to provide evidence-base information.
- Carry out **rapid needs assessment** of new health expenditure needs during health crises.

Box 11. Country example – Sweden

Government expenditure in Sweden is classified into 27 Expenditure Areas, including one for "Healthcare, medical care, and social services" under the responsibility of the Ministry of Social Affairs. Each year, the government proposes an expenditure ceiling for central government spending for the third year ahead. This is the upper limit that expenditure must not exceed.

Sweden's fixed expenditure ceilings provide a solid framework for realistic discussion about policy priorities and trade-offs. The top-down principle requires that an increases in an area must usually be matched with offsetting savings elsewhere within that expenditure area unless there is some scope for unfinanced reforms and the reform is considered to be of high political importance. This forces the Ministry of Social Affairs to prioritise spending within the health area to make place for new demands in the annual budget process.

2.3.3. Use explicit criteria as a tool to facilitate budget negotiation

- Consider using **explicit criteria** to facilitate negotiation on the level of health expenditure, whether as the starting point for budget development or as automatic drivers.
  - Criteria should reflect the cost of maintaining existing health policies.
  - The criteria and underlying assumptions must be transparent and not frequently changed.

    Consider the use of automatic drivers (e.g., inflation, demography) to absorb changes in cost pressures.

Box 12. Country example – Israel

Health financing in Israel is organised predominantly around a compulsory health insurance system, with individuals free to choose among four competing Health Maintenance Organisations (HMOs). Each year, a total budget is set for the compulsory health insurance system. This budget includes automatic adjustment mechanisms, according to three drivers: demographic growth, technological developments, and a price index.

The demographic index accounts for population growth. The price index reflects the changing price of inputs in the health sector, mainly in the wages of health professionals. Technological adjustments allow for the absorption of new medical technologies into the health basket. Decisions on the inclusion of new technologies are determined by a specialised committee, linking the results of health technology assessment to the budget impact.

The process of having a set formula increase for the health budget has simplified the annual budget process, by reducing the scope of annual negotiations between health and finance ministries. In addition, building in explicit criteria into the budget process guarantees a minimum increase to the health budget each year, and provides some visibility over future funding levels.

2.3.4. Equitably distribute resources for health across budget programmes

- Allocate funding across programmes based on **an assessment of costs, health needs, and relative priorities.**
- Use **performance information** from previous budget year/s to inform the budget distribution.
- Signal the distribution of resources over a **multi-annual period** to allow for effective forward planning.

Box 13. Country example – Latvia

In 2006, Latvia's Cabinet of Ministers approved a new programme-based budget format with a three-year perspective for all public expenditure including health. The budget for the Ministry of Health focuses on four policy targets, with most expenditure (approximately 80% of the health budget) allocated to the healthcare target. Public Health, Pharmacy and Sector Management and Policy Planning make up the remaining three policy targets. Appropriations are based on programmes and sub-programme.

Performance metrics are included in the budget document in the form of a 'Policy and Resource Management Scorecard'. These scorecards are the core framework for linking expenditure and other inputs with policy goals and results for Parliamentary scrutiny and budgetary analysis. Each year, the results of the performance scorecard are analysed, and can be used as a justification for increasing or decreasing funding during the subsequent budget formulation stage.

2.3.5. Equitably distribute resources for health across localities

- Use a **needs-based funding formula** to equitably distribute resources across localities (whether the health system is organised around a single purchaser or multiple purchasers).
- Embed **accountability** mechanisms overseeing the distribution of resources across localities to preserve financial discipline and ensure funds are spent as intended.
- Establish mechanisms to allow for the **redistribution of resources** across multiple purchasers, such as risk equalisation mechanisms (in systems with multiple purchasers).
- Signal the distribution of resources over a **multi-annual period** to allow for effective forward planning.

Box 14. Country example – United Kingdom (Scotland)

Since 2004, the Scottish Resource Allocation formula distributes approximately 70% of the total NHS Budget between the 14 territorial NHS Boards in Scotland. These Boards are tasked with providing hospital and community health services as well as physician prescribing.

The primary aim of this formula is to ensure equitable access to health services by evaluating the population's varying needs and compensating providers for differences in workload and unavoidable variations in unit cost. This is achieved by employing a weighted capitation approach to calculate the percentage allocation of the budget for each NHS Board. The four components of the formula are:

- Population
- Age/sex adjustment
- Additional needs based on morbidity and life circumstances (accounts for additional needs of the population over and above those due to age and sex)
- Excess costs of providing services in different geographical areas (accounts for unavoidable additional costs of delivering services due to remoteness and rurality).

The Technical Advisory Group for Resource Allocation was established in 2005 to continually assess and develop the formula and ensure that it remains fit for purpose into the future.

2.3.6. Ensure an open process for the discussion and approval of the budget for health

- Encourage **public participation** and consultation with citizens and civil society organisations during budget discussions for health, in accordance with national legal frameworks.
  - Publish a user-friendly and accessible version of the health budget.
- Support the **analytical capacity of parliament** to understand health budget proposals and the assumptions behind them.
- Formalise the process for **discussion and approval** of the health budget.
  - Ensure a process for the discussion and approval of the budget for Social Health Insurance agencies (where relevant).

Box 15. Country example – Estonia

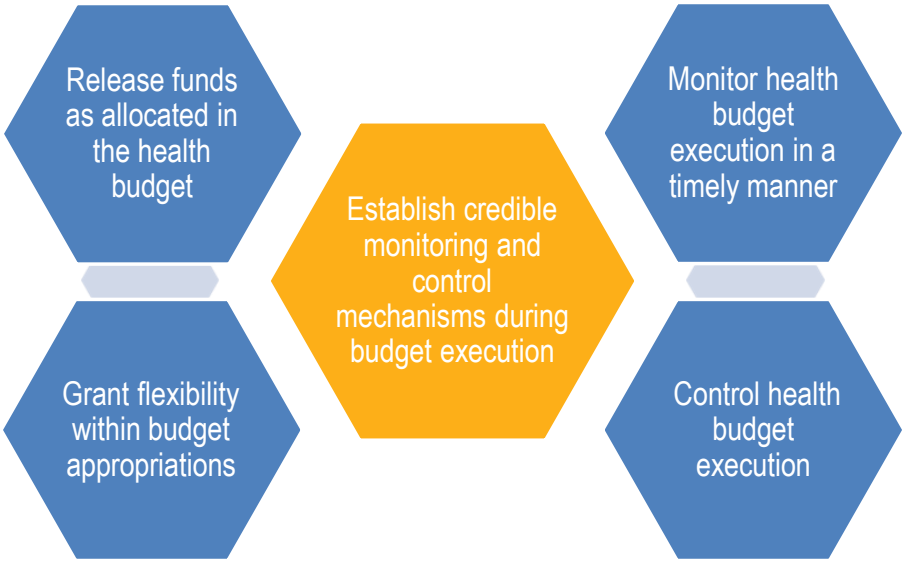
Most health expenditure in Estonia is financed through the budget of the Estonia Health Insurance Fund (EHIF), which is part of the state budget. Parliament approves the budget position (deficit or surplus) of the EHIF. However, a detailed budget is approved by the Supervisory Board of the EHIF.

The Supervisory Board is composed of six members, including representatives of the Ministry of Health and the Ministry of Finance. Public participation in the budget is facilitated through the inclusion of insured persons on the board, representing the Estonian Trade Union Association, the Estonian Chamber of Disabled People, and the Estonian Employees' Unions' Association.

2.4. Establish credible monitoring and control mechanisms during budget execution (execution phase)

14. After the budget has been approved, funds are disbursed during the budget execution phase according to appropriations made in the budget. Monitoring and control mechanisms are essential during this phase to ensure compliance with the budget. Effective monitoring helps identify any substantial deviations from planned expenditure, enabling timely corrective actions to keep the budget on track.

Figure 4. Establish credible monitoring and control mechanisms during budget execution



Source: Authors

2.4.1. Release funds as allocated in the budget for health

- Create a clear **disbursement schedule** to ensure health agencies and/or programmes receive funds in a timely manner to prevent over or under execution.

Box 16. Country example – Norway

In Norway, the four regional health authorities have the responsibility for implementing national health policy through organising, managing, and co-ordinating activities with the hospital and pharmacy trusts, which provide most hospital care. Regional health authorities are reimbursed on a monthly basis according to an activity-based financing payment method. These reimbursements are calculated and adjusted throughout the year. Hospital trusts, regional health authorities, and the Ministry of Health closely monitor spending and outcomes on a monthly basis. If short-term cash injections are needed, hospital trusts can draw on an overdraft mechanism.

2.4.2. Monitor health budget execution in a timely manner

- Encourage **monthly health expenditure reporting,** reflecting the structure of the budget.
- Conduct a **mid-year budget** review of health expenditure covering the first few months of the current budget year.
- Prepare a detailed audited **year-end budget** execution report of health expenditure within six months of the end of the budget year.
  - Utilise and discuss reports to assess compliance to the budget by comparing performance against the approved budget and provide explanations of significant variances.
- Design monitoring and reporting mechanisms with a clear understanding of their **purpose, intended users, and the accountability chains** involved to ensure that monitoring aligns effectively with specific needs for the sector.
- **Digitalise budget reporting** for health by embracing digital tools and platforms that can streamline reporting procedures and improve data accuracy.

Box 17. Country example – Belgium

Belgium employs a process known as permanent audit to monitor and control health expenditure within its social health insurance system. This approach consists of monthly monitoring of all health insurance reimbursements. Reports detailing the evolution of expenditure and volumes of healthcare usage are published on a monthly, quarterly, and semi-annual basis.

In response to these monitoring reports, both the Minister of Social Affairs and the National Institute for Health and Disability Insurance have the authority to suggest corrective actions at any point to mitigate the risk of exceeding budgetary targets. This proactive approach helps maintain fiscal discipline and ensure that health expenditure remains within the allocated budget.

2.4.3. Control health budget execution

- Put in place **in-year corrective mechanisms** as a pre-emptive tool to control budget execution.
  - Consider use of 'alert committees' to implement corrective mechanisms to avoid over or under execution of the health budget.
  - Use price and volume controls as an instrument to control costs.

Box 18. Country example – France

France sets an annual target for health expenditure, known as the 'Objectif national de dépenses d'assurance maladie', or ONDAM. To ensure compliance with the ONDAM target, France introduced several monitoring and corrective mechanisms.

An 'Alert Committee' signals to key stakeholders if health expenditure risks exceeding the ONDAM by more than 0.5%. In addition, tools to correct the price of healthcare have been gradually put in place to limit the risks of exceeding the ONDAM.

Since the introduction of these measures, France has been better able to control health expenditure growth and prevent annual health expenditure exceeding the target.

2.4.4. Grant flexibility within budget appropriations for health

- Provide **flexibility in the use of funds** to accommodate changing priorities, economic conditions, or unforeseen events.
  - Allow health agencies to re-allocate funds within their own budget envelope during budget execution (i.e., through transfers of resources across line items).
  - Permit limited carryovers of unspent appropriations to the next fiscal year.
  - Allow for the use of supplementary budgets in exceptional circumstances.

Box 19. Country example – Australia

In Australia, appropriations are structured as outcomes, which are the intended outcomes of government spending. For example, the budget for the Department for Health outlines six outcomes, one of which is focused on "improved wellbeing for senior Australians through targeted support, access to appropriate, high-quality care, and related information services." Each outcome is further broken down into one or more programmes, which are specific activities undertaken by government entities to achieve those outcomes.

Funds cannot be shifted between different outcomes without the approval of parliament through an appropriation law. However, funding can be reallocated across programme throughout the budget year as required, giving agencies a significant degree of flexibility.

2.5. Conduct regular and independent reviews of health expenditure (review and oversight phase)

15. The budget review and oversight phase encompass processes to ensure resources for health have been used appropriately, effectively, and efficiently during the previous budget cycle. It also involves examining how resources can be used more effectively in the next budget cycle.

Figure 5. Conduct regular and independent reviews of health expenditure

Source: Authors

2.5.1. Strengthen the role of independent institutions

- Conduct **internal financial audits** to examine the consistency of health spending with budget law and the quality of financial reporting.
- Conduct **internal performance audits** to examine the effectiveness of health spending and the extent to which it contributes to achieving health system objectives.
- Encourage the participation of **independent institutions and civil society** in the review of the health budget.
  - Promote the oversight of independent fiscal institutions to carry out analytical studies of the health sector.
  - Ensure external audit of the health budget through audit institutions.
  - Engage civil society during the budget review to foster a more transparent and inclusive approach.

Box 20. Country example – Lithuania

In Lithuania, the National Audit Office serves as the supreme public audit institution responsible for overseeing the management and use of publics funds and the execution of the state budget.

The National Audit Office conducts three types of public audit:

- Financial audit – assessment of entities annual financial statements and reports on budget execution
- Performance audit – assessment of entities activities in terms of economy, efficiency and effectiveness.
- Compliance audit – assessment of entities activities in terms of compliance with legal acts and/or other requirements is assessed.

The National Audit Office routinely conducts public audits within the healthcare sector. For instance, a 2023 audit focused on examining the risks associated with the planned healthcare network restructuring scheduled for 2030.

2.5.2. Produce and use Health Accounts as part of the core set of financial data

- Use health accounts to inform **policy decisions** e.g., to analyse health expenditure growth, inform resource allocation decisions, for international benchmarking.

Box 21. Understanding Health Accounts

Health accounts provide a systematic description of the financial flows related to the consumption of healthcare goods and services. Their intent is to describe a health system from an expenditure perspective. Health accounts can address such questions as:

- Who pays for healthcare?
- What health goods and services are consumed?
- Who provides the services?

First developed by the OECD in 2000, the *System of Health Accounts (SHA)* is an internationally accepted methodology for classifying health expenditures according to the three axes of financing, consumption, and provision. Collaborative effort between the OECD, WHO and the European Commission led to a revised edition in 2011. More specifically, the purposes of the System of Health Accounts are:

- to provide a framework of the main aggregates relevant to international comparisons of health expenditures and health systems analysis
- to provide a tool, expandable by individual countries, which can produce useful data in the monitoring and analysis of the health system
- define internationally harmonised boundaries of healthcare for tracking expenditure on consumption.

2.5.3. Carry out spending reviews and other types of evaluations

- Conduct regular ***ex ante* appraisal** of health budget initiatives (current and capital) to assess coherency with national health objectives and establish key performance indicators.
- Conduct regular ***ex post* evaluation** of health budget initiatives (current and capital).
- Undertake assessments of **health system performance** with connections to financial sustainability issues.
- Consider **integrating spending reviews of health expenditure** as part of the budget process, on a regular rather than ad hoc basis.
  - Encourage active engagement of health agencies during the spending review process.
- Incorporate the results of spending reviews and other types of evaluations into the formulation of the next health budget.

Box 22. Country example – Slovak Republic

The Value for Money Department within the Ministry of Finance was established to increase the effectiveness of government spending, improve public services, and consolidate public finances in the Slovak Republic. To meet this objective, the Department carries out regular spending reviews conducted in rounds, with approximately three sectors reviewed per year.

Joint analytical teams of the Ministry of Finance and Health are responsible for reviews of the health sector. This includes the preparation of final reports containing measures for improvement and an action plan for their implementation.

As a result of the spending reviews, the Slovak Republic has been able to identify significant potential cost-saving measures in the health sector. For example, the 2019 spending review identified cost-saving measures of EUR 542 million per year. The measures cannot be fulfilled immediately, but require gradual implementation, some of them as long as 10 years.

Next steps

16. The *Applying Good Budgeting Practices to Health* will play a pivotal role in the future work of the OECD Joint Network of Senior Budget and Health Officials. Already, the good budgeting practices serve as the foundation of the OECD Joint Assessment Tool, developed in collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria. The primary aim of this tool is to assess health financing systems in both OECD and non-OECD countries, particularly in the alignment of their health budgeting systems with these best practices.

17. Likewise, a future development for the *Applying Good Budgeting Practices to Health* might involve including maturity categories in the good budgeting practices. This could help gauge the extent to which these practices are effectively implemented across OECD countries. Such an approach could also shed light on the primary obstacles and challenges faced by OECD countries in the adoption and execution of these good budgeting practices.

18. Finally, it is important to emphasise that the *Applying Good Budgeting Practices to Health* is a living document. The OECD Joint Network expects to develop future iterations of this work, informed by the most up-to-date advancements in budgeting practices. This could include deep dives on specific sub-topics such as budgeting for digital transformation.

Glossary

Budget Programme: A type of budget classification that groups expenditures with related policy objectives.

Fiscal Sustainability: The ability of a government to maintain public finances at a credible and serviceable position over the long term, also referred to as the sustainability of public finance. Fiscal sustainability implies governments can maintain policies and expenditures into the future, without major adjustments and excessive debt burdens for future generations.

Health Technology Assessment: The systematic and multidisciplinary evaluation of health technologies and interventions, covering both their direct and indirect consequences.

Medium-Term Expenditure Framework: A structured approach to integrating fiscal policy and budgeting over a multi-year horizon.

Ministry of Health: Line ministry/department responsible for health.

Ministry of Finance: Line ministry/department responsible for the overall government budget, also referred to as the Central Budget Authority.

Performance Budgeting: The use of performance information to (i) inform budget decisions (whether as a direct input to budget allocation decisions or as contextual information and/or inputs to budget planning), as well as (ii) instill greater transparency and accountability throughout the budget process (by providing information to the public on performance objectives and results).

Health Providers: Organisations and actors that deliver healthcare goods and services, such as hospitals, residential long-term care providers, and ambulatory healthcare providers.

Health Purchasers: The main financing agents involved in the management of one or more financing schemes. Purchasers can take many forms, such as a Ministry of Health, subnational authorities, a national health service, a mandatory or voluntary health insurance or an autonomous agency. Purchasers either pay the health provider directly or reimburse the patient after they receive care.

Social Health Insurance Agencies: Agencies that handle the administration of social health insurance scheme/s or compulsory private health insurance scheme/s.

Spending Reviews: A collaborative process of developing and adopting policy options by analysing the government's existing expenditure within defined areas and linking these options to the budget process.

System of Health Accounts: A statistical reference manual providing a systematic description of the financial flows related to the consumption of healthcare goods and services.