Fiscal Sustainability of Health Systems
Bridging Health and Finance Perspectives

Chapter 3

Budgeting practices for health in OECD countries

by
Camila Vammalle, Ankit Kumar, Claudia Hulbert and Gijs van der Vlugt*

This chapter presents the results of an OECD survey of budget officials on budgeting practices for health, which aims at shedding light on the different institutional frameworks, and the instruments available to control health care expenditure in OECD countries. Health represents an important share of public spending, and one that has consistently increased faster than other areas of spending, and faster than GDP. However, controlling public health expenditure growth is particularly difficult for budget officials. A number of factors and institutions are necessary to allow governments to control health expenditure and ensure their fiscal sustainability: long-term forecasts, medium-term projections, timely information on expenditure, adequate revenues, expenditure management tools, monitoring and evaluation procedures, political agreement on targets and co-ordination mechanisms.

* Camila Vammalle and Ankit Kumar are with the OECD, Claudia Hulbert is a consultant and Gijs van der Vlugt is with the Ministry of Finance in the Netherlands.

3.1. Introduction

Health represents an important share of public spending, and one that has consistently increased faster than other areas of spending and faster than GDP. However, as the previous chapter shows, controlling public health expenditure growth is particularly difficult for budget officials. There are two main reasons for this. First, health care is perceived by citizens as a very high priority, with government policies in this area highly scrutinised. Second, there are a great number of stakeholders that intervene between the beneficiary of health care (the citizen/patient) and public resources that finance it. These include: purchasers (such as Ministries of Health, social security institutions, social insurance funds or sub-national governments), a wide range of providers of services (clinicians with different specialities, operating within hospitals and other health facilities), and providers of medicines, tests and equipment (such as pharmaceutical companies and laboratories).

A number of specific factors and institutions are therefore necessary for governments to be able to control health care expenditure growth and ensure its fiscal sustainability (Figure 3.1).

First, governments need accurate information about health care spending and funding sources to "diagnose" its fiscal sustainability. This includes:

- long-term forecasts of the likely evolution of health care spending, given demographic and economic factors, to anticipate trends and drive policy reforms;
- medium-term (three-year to five-year) spending requirements governments can use to draft their budgets;
- timely information about actual spending to enable governments to take early corrective measures if spending targets are likely to be broken;
- evaluation of the evolution of possible revenue sources (taxes and/or contributions) to link spending requirements and projections to available resources.

Second, political and institutional factors that shape the context must be taken into account. While these can be influenced in the medium to long term, they can be taken as given in the short term. Lack of these political and institutional factors could be "risk factors" for the fiscal sustainability of health systems. These factors include:

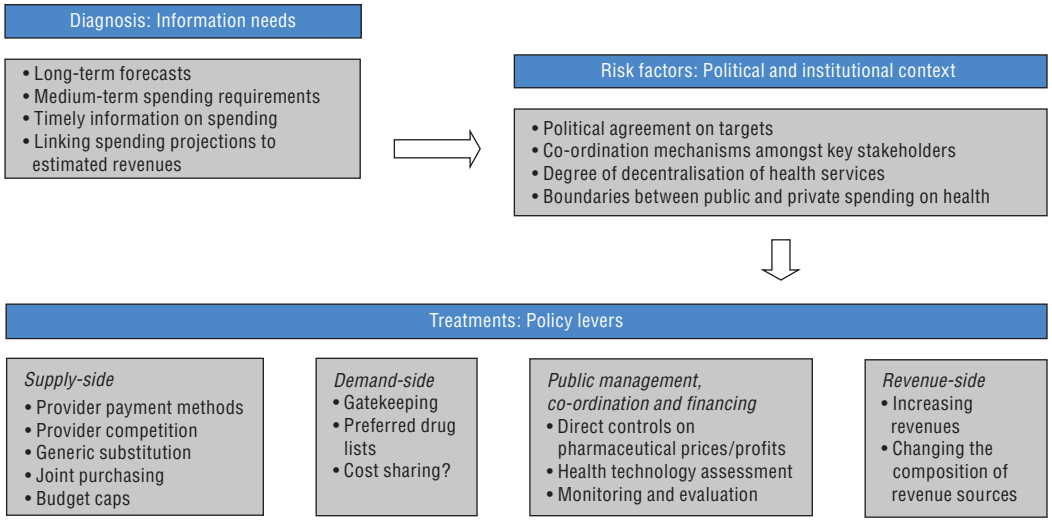
- political agreement on the need to control health expenditure growth and on specific spending targets;
- effective co-ordination mechanisms among all the different stakeholders, which respond to different incentives;
- the degree of decentralisation of health services (in terms of functions and revenues);
- the boundaries between public and private spending on health, i.e. the definition of the health benefits basket.

Finally, there are a number of policy levers and tools ("treatments") that governments can put in place to ensure greater sustainability of health spending without compromising important achievements in access and quality of health care. These will be further discussed

in Chapters 5 and 6. They can be grouped into four categories: supply-side, demand-side, public management and co-ordination, and revenues:

- *Supply-side policy levers include*: developing provider payment methods that ensure the right incentives; provider competition; generic substitution; and joint purchasing.
- *Demand-side tools include*: gatekeeping and preferred drug lists. Cost sharing may help to control costs but risk have negative effects on health.
- *Public management and co-ordination policies include*: direct controls on pharmaceutical prices/profits, health technology assessment and monitoring and evaluation.
- *Financing policies*: increased revenues or changing revenue sources for health care.

Figure 3.1. **Fiscal sustainability framework**



OECD countries have developed different institutional frameworks to address the above requisites. To shed light on these institutional frameworks, and the instruments available to control health care expenditure, the OECD surveyed budget officials on budgeting practices in the health sector. This survey was answered by 27 countries[1] and six sub-national governments (Canadian provinces). The results were discussed at a workshop of budget officials held in January 2014 and at the OECD SBO-Health Joint Network on Fiscal Sustainability of Health Systems in April 2014.

This chapter summarises the key results from the survey. It is organised into four sections which cover respectively: the role of health in the budget process, policies used by budget agencies to influence health spending, decision-making by budget agencies and the challenges of budgeting for health in decentralised contexts.

The majority of results obtained from the survey are descriptive; but a few challenge popular perceptions about the relationship between health and finance. The survey finds that:

- Budget agencies do not perceive co-operation with Ministries of Health to be poor, despite the common view of other commentators that this is a major problem.
- Budget Ministries' main role consists of setting overall fiscal objectives, not exercising detailed control over spending and leaving allocation decisions to Health Ministries.

- While Health Ministries (and academic health policy circles) increasingly emphasise economic assessments of health and labour market impacts of health policies, in many countries, these have little or no influence on budget agencies. This is due to a combination of insufficient capacity in Ministries of Finance to process them and a focus and presentation of these evaluations which may not be optimal to facilitate their use.
- Although long-term projections for health expenditure complement short-term budget policy decisions and help to shape medium-term to long-term policies, the usefulness of such spending projections may be limited by the uncertainty surrounding their estimates, and because budget agencies are principally concerned with the immediate fiscal years.

Box 3.1. **Caveats and challenges of the OECD Survey of Budget Officials on Budgeting Practices for Health**

Implemented for the first time, the survey used to derive these insights is a novel but blunt tool. The survey sought to combine information in the OECD's Budgeting Survey (on budgeting at large) and those from the Health Systems Characteristics Survey. Comments were sought from the WHO, the European Observatory on Health Systems and Policies and selected country officials before this was put to countries. At the workshop of budget officials held in Paris in January 2014, countries noted that there was considerable scope for differing interpretation of budgeting and health vocabularies and efforts have subsequently been made to improve the accuracy of responses provided.

A particular area of difficulty remains decentralised health care systems (particularly, Austria, Canada and Sweden) which found it difficult to answer the questions from the central government point of view or pointed out that their influence extended to only a small portion of health spending. Canada presented the survey to the provinces, and six provinces provided answers. Differences in practices, procedures and challenges faced among these provinces are as large as those seen between countries. The specific challenges of decentralised countries for health care sustainability are further discussed in Chapter 4. Furthermore, a number of questions that sought to gauge performance through self-reporting had potentially inconsistent results, such as budget agencies noting that health has been a difficult area to achieve savings and then reporting positively in terms of their self-perceived success in containing spending.

The survey nonetheless confirmed the popular perception that health is considered by budget officials to be one of the most difficult areas to achieving savings. Some preliminary operational and policy implications include:

- Health Ministries should work with Budget Ministries to make their economic evaluations of health and labour market benefits better understood and more influential in prioritising policies.
- Further efforts to return efficiency gains to budget could help avoid the use of tools that indiscriminately reduce broad categories of health spending.
- Some countries have scope to improve timeliness of spending data to help them track spending, take corrective measures and avoid the need for unplanned savings to meet end-of-year targets.
- Finance Ministries share Health Ministries' concerns about spending in hospital and pharmaceutical sectors, and are concerned about the fiscal sustainability of sub-national governments.

3.2. Approaches in budgeting for health care

There is considerable diversity in how much health spending is included in the government budget; in social insurance countries this can complicate achieving a fiscal position for the public sector

The budgeting process for health tends to be modelled around the key institutions responsible for financing health in a particular country. Three typologies stand out from the results of this survey:

1. Centralised national health systems, where the bulk of health care expenditure is in the central government's budget and determined along with the rest of government spending.
2. Social insurance systems, which have a separate budget for health, with specific revenues assigned to it unlike other government spending. The central government budget often provides subsidies towards the cost of insurance and support for public health programmes.
3. Decentralised health systems, where most health care expenditure is controlled by sub-national governments and is therefore included in a combination of central government and sub-national governments' budgets.

In all OECD countries, some or all health spending is included in the government budget. Most budget-funded countries predictably identified that they include health care in the government budget. Even in the 18 countries (out of 27), with independent social security or insurance funds, or where health is a sub-national responsibility, some expenditures were noted to be part of the central government budget (Table 3.1).

Table 3.1. **Is health care expenditure part of central government budget?**

Partly	Fully
Austria (1)	Hungary
Canada (2)	Iceland
Chile (3)	New Zealand
Czech Rep. (4)	United Kingdom
Denmark (5)	
Estonia (6)	
Finland	
France (7)	
Germany (8)	
Italy (9)	
Japan (10)	
Korea (11)	
Netherlands	
Norway (12)	
Poland (13)	
Portugal	
Slovak Republic (14)	
Slovenia	
South Africa	
Sweden (15)	
Switzerland	
Turkey (16)	

Notes

1. In Austria, a small part (2010: 4.2%) of overall public health expenditure is in the central government´s (Ministry of Health) budget. The public health care system is mainly financed by the Social Security System (65.2%) and via the automatic transfer system to state and local governments (30.7%).

2. In Canada, the federal government provides transfers to sub-national governments for health. The Canada Health Transfer provides funding to all provinces and territories for health care, and supports the principles of the Canada Health Act which are: universality; comprehensiveness; portability; accessibility; and, public administration. Equalisation, for those provinces that receive it, and Territorial Formula Financing provide unconditional funding for receiving provinces and the territories to fund their priorities, including heath care. Outside of federal transfers, the rest of provincial and territorial health care is financed through provincial and territorial revenues. The federal government also provides direct health care spending in areas of federal responsibility, consisting of First Nations' and veterans' health care, health promotion, disease prevention, and health-related research.

3. In Chile, central government budget encompasses 97.7% of public expenditure on health (including the compulsory contribution to health of 7% of wages). Only the expenditure carried out by municipalities, which represent 2.3% of total public health expenditure, are not included in the central government budget.

4. The Czech Republic operates a public health insurance system. Each citizen pays public health insurance contributions as a percentage of their income, and these are not considered as state revenue for budget purposes. The government funds contributions for lower-income citizens. This represents about 23% of total revenues of the public health insurance.

5. In Denmark, government funding of regions (health) and municipalities (partly health) is part of the central government budget.

6. In Estonia, Social tax revenue for health insurance which transferred to Estonian Health Insurance Fund is a component of central government budget.

7. Only a small share of total health spending appears in the central government budget. Most health expenditure are within the Social Security institution, and are included in a separate social security budget law, which is voted annually by the Parliament, together with the "national target for health insurance spending" (*Objectif national des dépenses d'assurance maladie*, ONDAM).

8. In Germany, the federal budget contains a large federal grant to the statutory health insurance (SHI).

9. In Italy, only the share of health expenditure financed by VAT revenue is included in the central government budget.

10. In Japan, almost all health expenditures (such as the National Health Insurance and the elderly medical insurance system) are shared between central and local governments. Therefore, only part of this expenditure appears in the central government budget.

11. In Korea, the National Health Insurance Corporation collects the premiums. However, the central government funds 20% of contributions.

12. In Norway, municipalities are responsible for primary health care and care for the elderly, and the counties are responsible for dental care. These expenditures do not appear in the central government budget.

13. In Poland, most of health care expenditure is carried out by the National Health Fund and financed by health care premiums, and are not included in the central government budget. The role of the budget is limited. It provides funds for health programmes of special importance concerning overall health policy targets (such as development of transplantology, or counteraction of modern civilisation diseases), health insurance premiums for specific groups of the population (the unemployed receiving social security benefits, persons receiving social pensions, farmers, war veterans and others), and investments in public health care institutions, highly specialised services, as well as general expenditures concerning formulation, administration, co-ordination and monitoring of overall health policies, plans, programmes and budgets, preparation and enforcement of legislation, etc. executed by the Ministry of Health.

14. In the Slovak Republic, the budget includes expenditures of the Ministry of Health and of the Office for Health Care Surveillance.

15. In Sweden, most of health expenditure is carried out by sub-national government and thus does not appear in the central government budget. However, the central government budget includes expenditures for OTC pharmaceuticals, general government grants to the county councils, and some earmarked special grants and expenditures on government agencies in the health sector.

16. In Turkey, the majority of health expenditures is in the Social Security Institution budget and does not appear in the central government budget.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 1.

Many social insurance countries provide subsidies on insurance contributions for low-income or specific groups such as veterans (Estonia, France, Germany, Korea, Poland and Switzerland) direct from their budget. In decentralised countries, the central government often provides transfers for health to sub-national governments, which appear as health care spending in the government budget (Austria, Canada, Denmark, Norway and Sweden). The central government also usually finances prevention or special interest programmes, medical research or investments (Canada, France and Poland) and the allocation of funds

to cover general expenditures for formulation, co-ordination and monitoring of overall health policies, plans, programmes and budgets, and for the enforcement of legislation by the Ministry of Health (Austria, Poland, France and the Slovak Republic). These results suggest that the government's budgetary process is an important tool in determining overall spending and achieving policy objectives.

Challenges arise for budget agencies where social security spending is either not subject to legislative review or occurs on a different timeline to the government budget. In most countries (10 out of 18) which have separate health/social security budgets, the latter does not require separate legislative approval, and more than half do not present information about health/social security budgeting in the general budget documentation. These indicators are symptomatic of what is often a broader disconnect between budgets for health spending and for the government at large.

Where social security budgets occur at a different timeline to the rest of the government budget, it can complicate the task of budget officials. The evolution of revenues from or spending in social health insurance results in a need to modify spending in other parts of government to ensure that these both fit within the overall fiscal target for the public sector. In some cases, deficits in social insurance can require additional funding from government budgets and crowd out other budgetary priorities (e.g. spending in another area or fiscal consolidation). This has been an area where certain countries, such as France, have undertaken considerable efforts to align the process for the social security budget with that of the government budget so they are determined simultaneously and the government can decide the extent to which fiscal objectives are met through health or other areas.

Finance Ministries do not tend to prescribe the allocation of funds within health

Budget agencies noted that, more so than in other areas of government spending, they generally leave the allocation of spending and its scrutiny to a combination of Ministries of Health and social insurance agencies. Since the 1990s, the prevailing trend across OECD countries has been a shift towards "top-down" budgeting practices where the executive determines aggregate public finance targets (spending and revenue levels) given medium-term fiscal objectives and prevailing economic conditions. Sectoral ceilings are then set (and approved by the executive), reflecting existing commitments, political priorities and key new policy initiatives. The detailed allocation decisions are then usually delegated to the individual line ministries. Top-down budgeting marks a shift in budgetary roles from a more controlling budget agency and provides line ministries with relatively greater responsibility for resource allocation and for supervising spending.

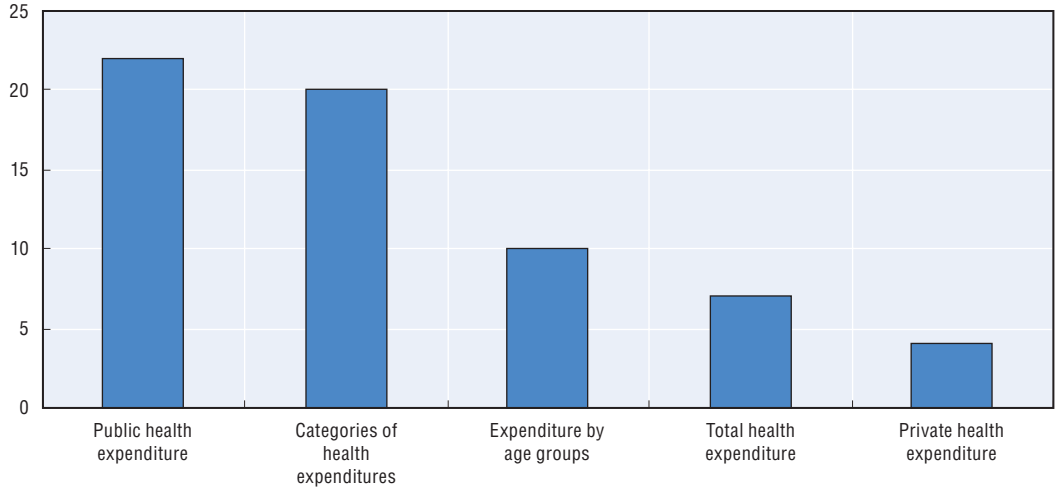
This shift towards a more supervisory role is evident in the extent to which budget agencies do not allocate budgets on the basis of achieving specific health objectives nor towards sub-categories within health spending. About half of the countries (14 out of 27) allocate funds to specific health objectives (preventing cancer, palliative care, Alzheimer, etc.) (Table 3.A1.3). Roughly the same proportion (13 out of 27) specify sub-categories of health care spending (such as hospital in-patient service, primary care, pharmaceuticals), of which five countries only use them for informative (non-binding) purposes (Table 3.A1.3). In countries which specify sub-categories of health care spending in the budget, the number of such categories varies from seven in Australia and France, to above 200 in Iceland, with Hungary and Netherlands being more typical in specifying

18 and 50 respectively. Even in these countries, there is a considerable disparity on the extent to which different sub-categories are actually used to determine the budget at large; they are often focused on funding a supplementary function.

Most countries produce long-term projections, but these are rarely used for decision making

Almost all OECD countries now produce long-term projections of health spending and these are generally publicly available. Among the 26 countries which answered this question, only the Czech Republic, Hungary, Poland and the Slovak Republic do not. In the majority of cases (16 out of 26 countries), these cover 31 to 50 years. Denmark has the longest horizon, as its technical projections run until 2100. These projections are usually publicly available (except in five countries). Long-term projections cover public health expenditure in all the countries surveyed, and most of them (20) provide projections by categories of health spending (e.g. hospitals, primary care, pharmaceuticals) (Figure 3.2 and Table 3.A1.4). Expenditure projections by age group are also quite frequent (ten countries). Fewer countries provide total health expenditure (public, private and by social insurance institutions) and private health expenditure projections (eight and four countries respectively). The responsibility for carrying out long-term projections lies usually in the Ministry of Health (15 of 27 countries); but in almost half of the countries (12 of 27), the Ministry of Finance also carries out these projections, with some countries having both ministries doing so (eight of 27). Independent institutions are also frequent sources of long-term projections (five of 27), as well as other institutions (such as health insurance funds) (seven of 24).

Figure 3.2. **Coverage of long-term health expenditure projections**



Note: For Finland, private health expenditure projections only concern those expenditures covered by health insurance and public-funded compensation.

Source: OECD Survey of budget officials on budgeting practices for health, 2013, Question 11, OECD, Paris.

StatLink http://dx.doi.org/10.1787/888933218666

While considerable effort is invested in long-term projections, these are more often used to influence public debate for difficult reforms than to guide decision making in the current year. The majority of countries responded that the key function of long-term projections is to identify challenges future governments will face and provide

information to and raise the awareness of the public. In Australia these projections were used to justify recent health financing reforms, as they showed that under the existing framework, health care expenditure would soon exceed states' revenue-raising capacity. In the European Union, the ageing working group forecasts long-term sustainability of public spending, including health care. In European Union countries, the results of forecasts feed into the assessment by the Commission and Council of governments' financial sustainability. The relationship between forecasts and policy is probably most explicit in the United States, where legislation on health is evaluated on its supposed effects several decades into the future. Congress has an obligation to ensure the financial solvency of the trust fund from which Medicare's hospital insurance is funded, or payments are reduced to levels such that it can be financed entirely through tax revenues and premiums. However, in practice, law makers have overridden these planned reductions every year since 2003.

The utility of long-term projections is limited by the considerable uncertainty surrounding their estimates, and because budget agencies are ultimately held accountable for the immediate years. Budget agencies noted that the denominator in these forecasts – generally GDP or government spending – is difficult to predict meaningfully, reducing the utility of projections for them. With discussions about health often involving arguments that new policies require considerable lags to take effect (e.g. electronic health, prevention policies), it was noted that longer-term fiscal evaluations may justify some policies which would not seem interesting if only the short-term was considered, but there was scepticism about whether these would lead to actual savings.

3.3. Expenditure control tools

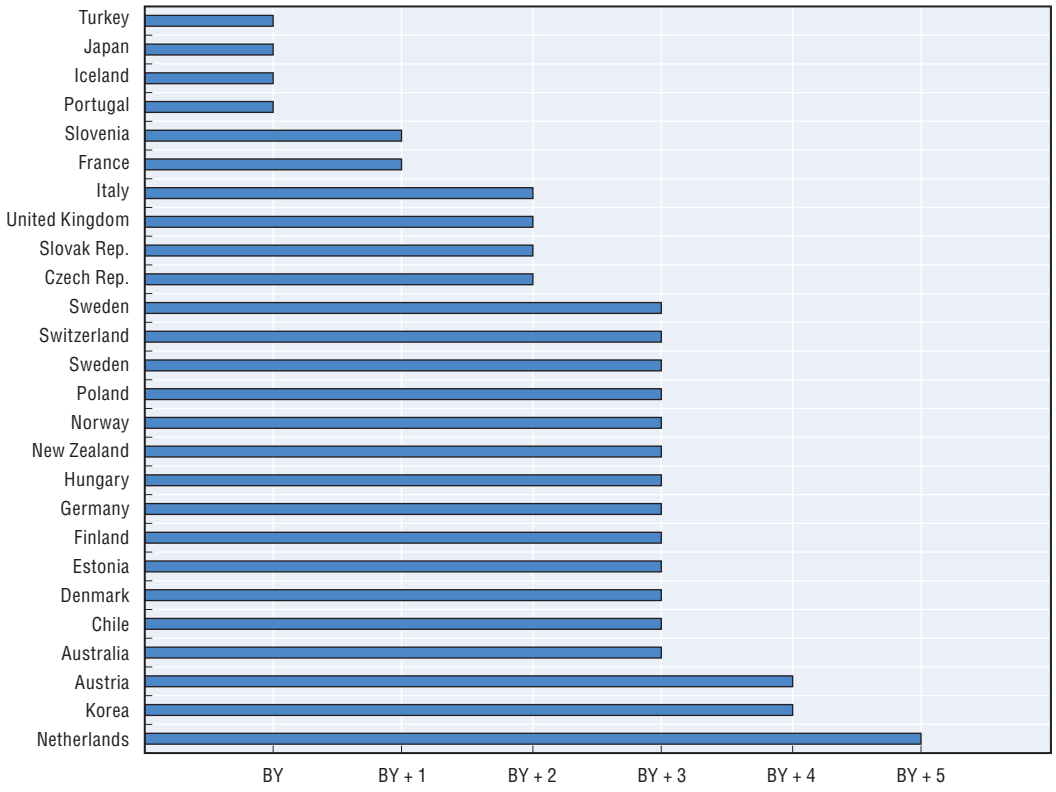
With most countries seeking to target a budget trajectory as well a fiscal position in a certain year, it has become important for budget agencies to have a multi-year vision of health spending.

Most countries have targets or ceilings for spending over several years, though ultimately it is economic and not health-specific factors that determine their level

As they are obliged to publish estimates for public spending for several years, most OECD countries publish health expenditure estimates for the coming three to five years. While the majority of countries provide three-year estimates, it ranges from zero (in Portugal) to five (in Netherlands and Korea) (Figure 3.3).

Most OECD countries use some kind of budget ceiling over several years for central government's expenditure on health. In 80% of surveyed countries, budget agencies developed a desired level of spending for health, and this target was reached in about two-thirds of cases. Even in countries that specify targets and not ceilings, these have become more and more binding over time. This survey only enquired about ceilings that apply to central government expenditure which is included in the budget, not those that may apply to expenditure by social security institutions, private insurers or sub-national governments (Box 3.2). Ceilings may be overall ceilings on expenditure by the Ministry of Health (36%), constrain specific categories of health services (e.g. hospitals, primary care) (35%) or be set for particular programmes (16%) (Table 3.A1.5). The popularity of ceilings reflects the perception by Budget Ministries that Health Ministries are best placed to determine where potential efficiency gains lie in their portfolio.

Figure 3.3. **Years of estimates for health spending in the budget**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 7.

StatLink http://dx.doi.org/10.1787/888933218675

Box 3.2. **Ceilings on health expenditure by sub-national governments or social security institutions**

Austria: There are ceilings on health expenditure by the social security system and states, but these are approved by other laws (agreement between the states and the federal level and a law on health reform).

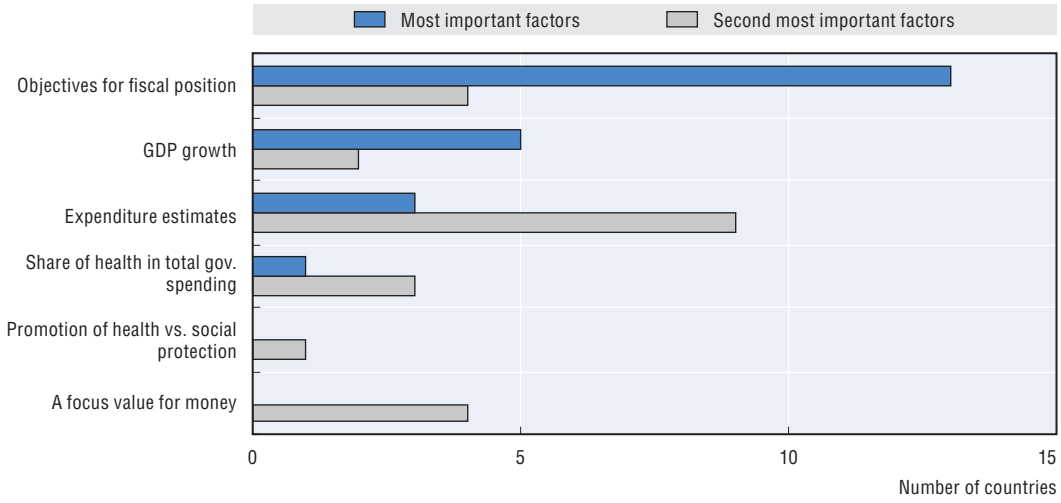
Denmark: Since 2014, all government spending is subject to real expenditure ceilings. This implies a separate four-year budget ceiling for regional governments' expenditure on health (which represent more than 75% of total public health spending), as well as a specific expenditure ceiling for municipalities, which includes health. This system sets a flat spending level for four budget years, which is the basis for subsequent annual negotiations between the central government and local authorities on the spending level for the forthcoming year. Any upward change in the ceilings for sub-national governments must be compensated by the same reduction in the budget ceiling for central government expenditure. A violation of these fixed expenditure ceilings would entail economic sanctions.

Poland: The expenditure ceiling for the National Health Fund is set for the budget year and consists of an overall ceiling and ceilings by categories of health services. Procedures for amending these ceilings are stipulated in law. Financial plans of the National Health Fund cover three subsequent years (BY+3), but they are only estimates and not ceilings.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 45.

Ceilings for health expenditure tend to reflect executive priorities about the budget and not factors specific to health. These are most frequently set by the central budget authority (43% of countries), by the Parliament (24%), by executive branches of government and their agencies (e.g. the Prime Minister, President and their offices), and by independent bodies (5%) (Table 3.A1.6). The objectives for the fiscal position and the outlook for GDP growth were identified as the key priorities for setting ceilings in most countries (Figure 3.4). The results show that economic factors dominate over considerations of health policy in the perspective of Finance Ministries and governments, as is to be expected.

Figure 3.4. **Factors influencing ceilings for health**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 47.

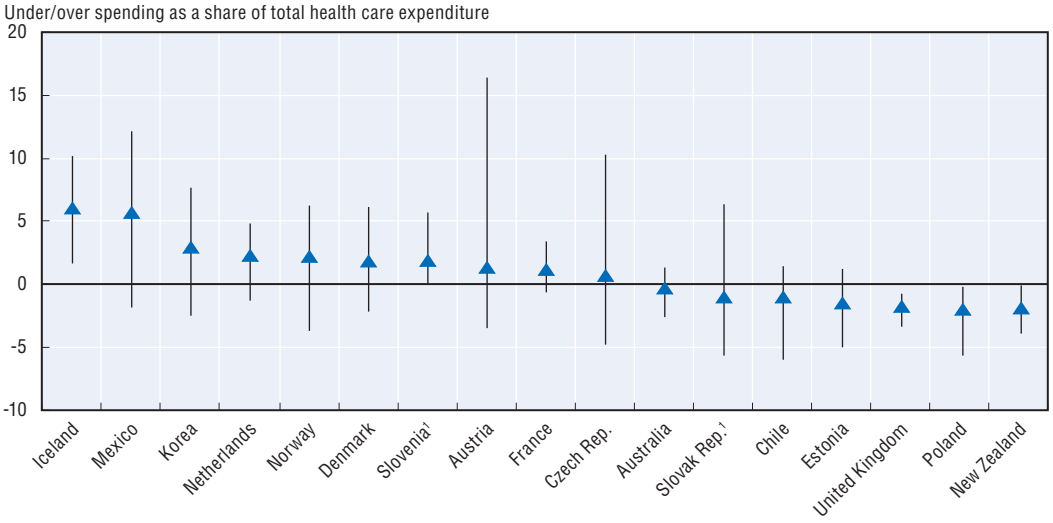
StatLink http://dx.doi.org/10.1787/888933218689

Despite ceilings, budget overruns in health remains common and often leads to unplanned savings demands at the end of the year

A crude measure of the success of both ceilings and the accuracy of central government budget estimates is the extent of budget overruns and underspending. Many countries have frequent budget overruns (i.e. actual health care expenditure exceeding budgeted expenditure) though the average varies greatly between countries. More importantly, the dispersion around the average was very large and there was no systematic correlation with countries that identified themselves as having ceilings or targets. In the last seven years, most countries have experienced both budget overruns and underspending (Figure 3.5). The few countries with consistently low average variations were predominately budget-funded (Australia, New Zealand and the United Kingdom), which may reflect that their control over health system management provides them with greater budgetary control. France was an exception to this rule, perhaps reflecting recent policy efforts to impose spending targets on social security spending.

In response to persistent budget overruns, a majority of countries have developed early warning mechanisms to follow the path of health expenditure through the year and identify when targets may be broken (Figure 3.6, Table 3.A1.8 and Box 3.1).

Figure 3.5. **Size of budget overruns and underspending in percentage of budgeted spending, 2006-12**

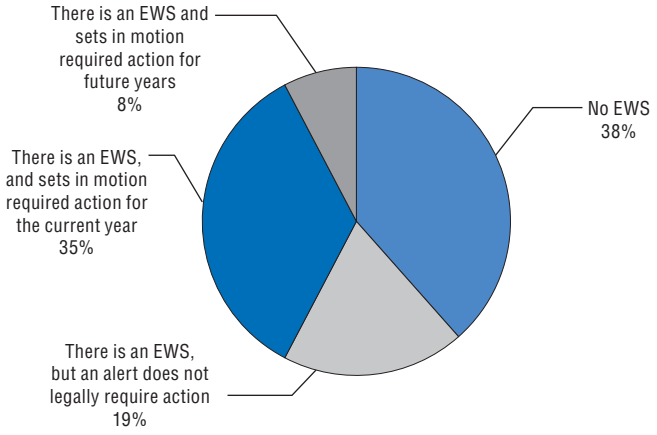


1. Slovenia and the Slovak Republic data are for the past five years.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 48.

StatLink http://dx.doi.org/10.1787/888933218691

Figure 3.6. **Early-warning systems (EWS)**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 49.

StatLink http://dx.doi.org/10.1787/888933218701

A prerequisite for an early warning mechanism – and to monitor and control budgets in general – is to have timely information. This is a challenge for many countries, particularly those with a social-health-insurance-based system. In most countries, the central budget authority receives information from one to six months after the spending occurs (Figure 3.8). In others, it may take up to two years for some spending information to reach budget authorities (such as spending by hospitals and psychiatric institutions in Netherlands). In most cases, the delay is explained by data-collection issues or reporting from health care institutions/insurers (Netherlands) or sub-national

governments (Switzerland). Budget agencies noted that delays in information made it harder for them to work with Health Ministries to take corrective measures through the year and in some cases prompt additional savings within a short time frame to meet end-of-year fiscal objectives.

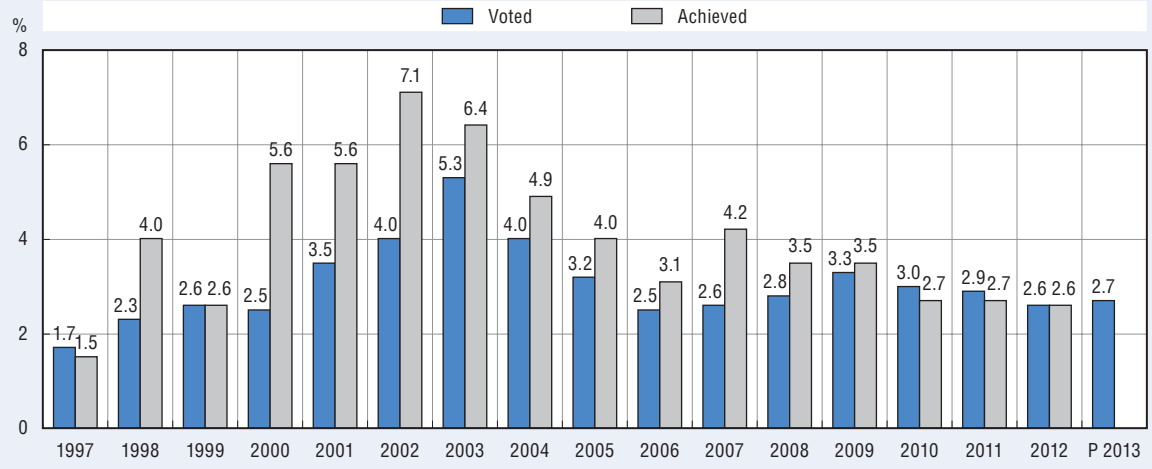
Box 3.3. **Early warning mechanism in France**

The national objective for health care expenditure (ONDAM) was introduced in France in 1996. During the first decades, the ONDAM targets were consistently overrun, leading to large social security deficits (see Figure 3.7). In 2004, the administration decided to introduce stricter monitoring of health care spending through the creation of an Alert Committee. The committee's responsibilities, progressively enlarged over time, are to alert the Parliament, the government and the National Health Insurance Fund about increases in health care expenditure that could exceed the ONDAM targets.

The government annually sets the level of accepted deficits for national objectives (0.5% since 1 January 2013). The Alert Committee must follow a defined schedule throughout the year. First, it must assess health care spending in the previous year to re-evaluate the basis for the national objective and assess whether planned policies are in line with them. Secondly, it must state whether objectives for the current year are likely to be met or to remain within authorised overruns. If this is not the case, the committee must notify the three institutions, which have to propose correcting measures within a month. The committee must then provide an evaluation of the possible impact of these recovery measures. Finally, the committee must publish an evaluation of the current year's prospects for meeting the national objectives, and the determinants for the following year's target. It can raise concerns if it estimates that growth-rate projections and proposed savings are not realistic.

Figure 3.7. **Voted ONDAM vs. achieved health expenditures**

Percentage growth



Source: Projet de Loi de Financement de la Sécurité Sociale, Social Security Accounts, Social Security Directorate, Paris.

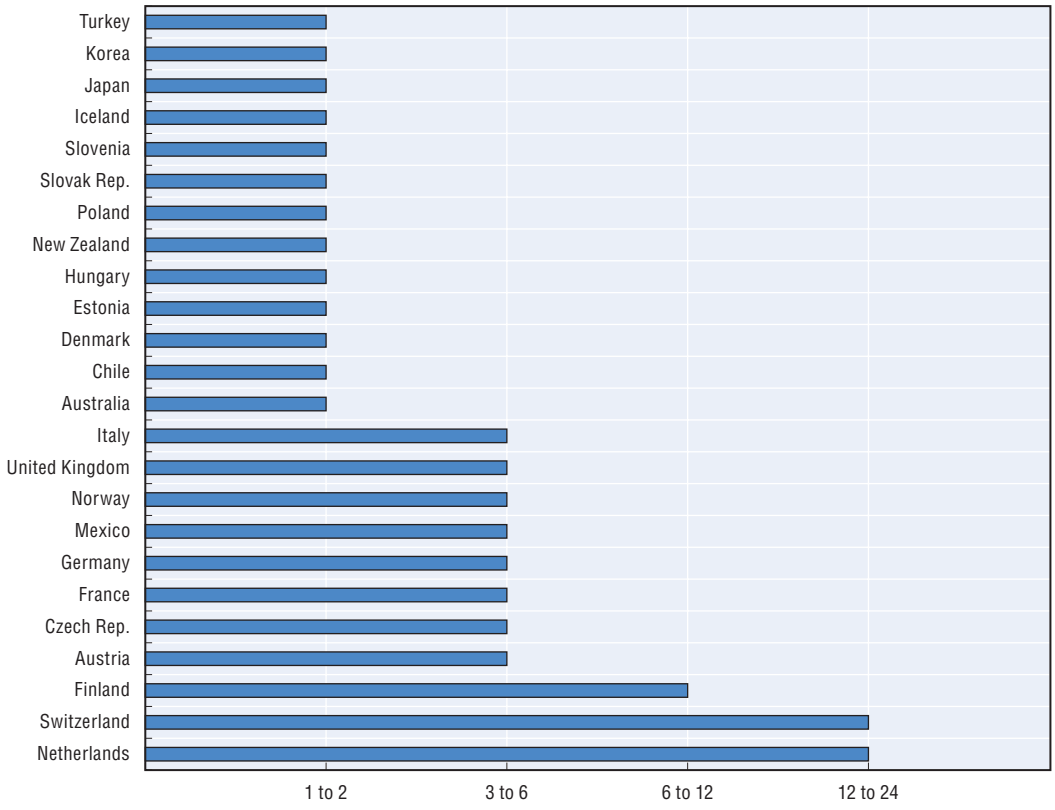
StatLink http://dx.doi.org/10.1787/888933218716

The introduction of the Alert Committee led to a significant decrease in the growth rate of health care expenditure in France over the last decade (from 7% in 2002 to 3% in 2010). National objectives have been met since 2010. However, future target forecasts should allow for a 2.5% growth in health care spending (instead of 3%), hence introducing further savings to be made in the health care sector.

Source: see Chapter 8 on French case study.

Figure 3.8. **Delay in reporting health expenditure to central budget authority (CBA)**

In months, maximum value



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 22.

StatLink http://dx.doi.org/10.1787/888933218726

Budget agencies are seeking to bring efficiency gains back to budget, but feel they have blunt tools by which to try to do this

Budgetary officials remarked that harvesting efficiency gains is notoriously difficult in health. It was noted that the devolution of control over spending to the Health Ministry has left budgetary agencies with mainly broad-based tools to control spending. A novel alternative to ceilings was that around one-third of countries have established automatic mechanisms which reduce the baseline allocation by the amount of expected or assumed productivity gains. It was acknowledged that the estimation of health sector productivity is a fraught task, but that it was equally unreasonable to argue that few productivity gains exist in the health sector. Where such policies exist, they affect some part of expenditure only (e.g. hospital budgets) (Table 3.A1.9). In some countries, the growth rate of health care expenditure is capped (Austria). In Canada, the growth of the federal block transfer for health (the Canada Health Transfer) provided to provinces and territories is fixed. However, there are not targets for the total health care expenditures of the country: most expenditure decisions are made at the provincial/territorial level, and their governments have the option, but not the obligation, to set caps on their expenditures. In other countries, objectives or budgets are set in terms of productivity gains to be reached (Denmark and the United Kingdom); New Zealand and Israel do not compensate fully for health price inflation. The main category of spending affected by automatic cuts is pharmaceuticals.

Spending reviews have been used in about half of surveyed countries to pinpoint savings in particular areas. In Australia, Denmark and Netherlands, these often do not target overall health care expenditure, but some sub-category of spending. Reviews are implemented yearly in only a few countries (Chile, Netherlands and Turkey). A few countries have conducted yearly reviews only since the beginning of the global financial crisis (France). In the United Kingdom, reviews are systematic but cover a three-year period. Canada conducted Strategic Reviews over the 2007-11 period, targeting different ministries each year. In this context, the Department of Health was reviewed in 2011. Most countries conduct regular reviews, according to governments' priorities (Australia, Hungary, Italy and Poland). Mexico and New Zealand conducted a single evaluation review in 2009.

Some countries also use incentive-based mechanisms to reach efficiency gains. In Denmark, for example, 2% of hospital budgets is provided in the form of a crude "pay for performance" arrangement that is only granted if the hospital provides 2% more activity with the same budget. In Israel, the formula by which the central government transfers funds to the health funds has a component to compensate for price inflation. But in practice, price inflation is not fully compensated, which is a way of pushing health funds to seek productivity gains. Finally, about half of the countries surveyed have performance agreements for the Ministry of Health, with the executive usually in charge of setting performance indicators.

3.4. Decision making and assessment

Perhaps the area that causes the most consternation for Health Ministries is the gatekeeping role of budget agencies in assessing new policy proposals. Budget agencies noted that their assessment predominately focused on fiscal considerations and the robustness of the policy's design.

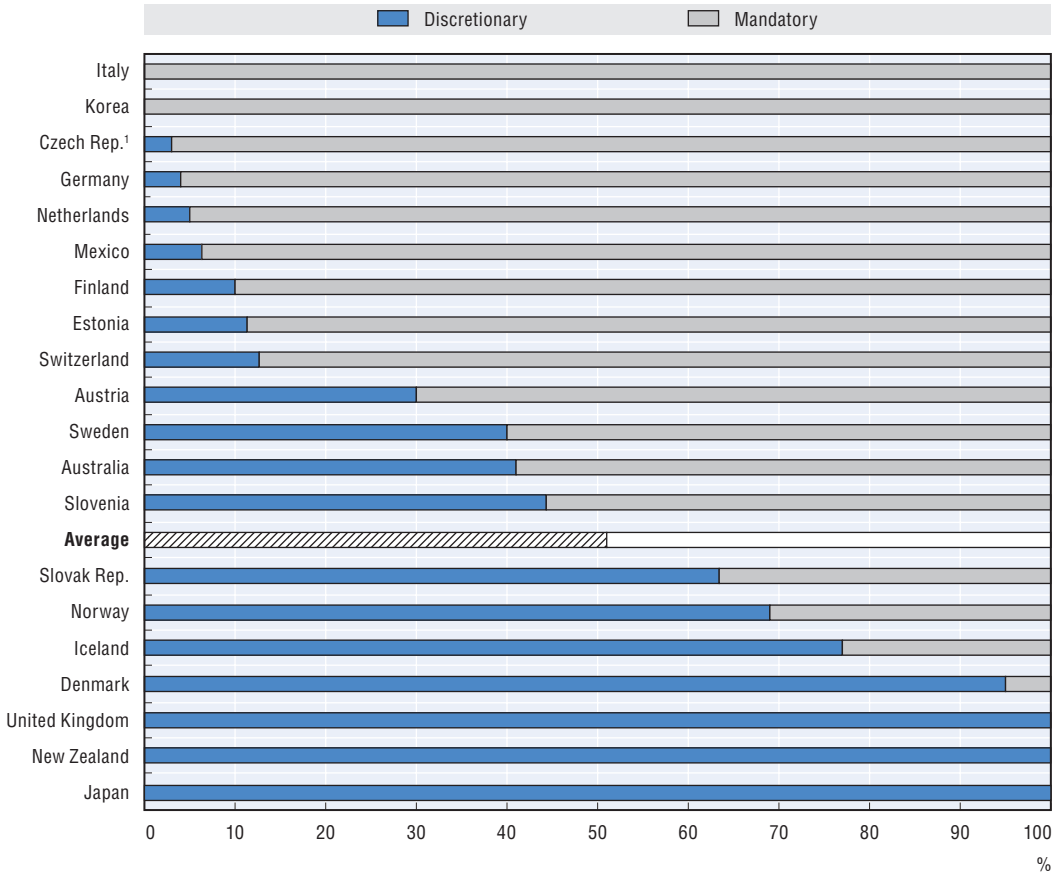
Health care is usually an open-ended entitlement, possibly making spending control more difficult

There is enormous variation in the extent to which health care spending is considered as an entitlement or a discretionary programme. Mandatory health spending was defined as an open-ended entitlement (i.e. demand driven) which requires the Legislature to modify a law in order to change the level of spending. While on average, about half of health spending is mandatory, there are wide variations (Figure 3.9). While it is possible that countries with higher mandatory spending may simply engage Parliaments more frequently, in practice budget agencies noted this made changes more difficult to achieve.

Central budget authorities mainly focus on macro-fiscal aspects of health care spending

The survey found that central budget authorities see themselves as being mainly occupied with macrofiscal supervision of health care and are less involved in designing or implementing policy in health. The most commonly identified responsibilities for budget agencies were assessing health policy proposals, estimating future health spending, proposing desirable amounts of health care expenditure and/or advising on spending priorities (Figure 3.10). In most countries, central budget authorities are not involved in the development or implementation of health policies (Table 3.A1.10).

Figure 3.9. **Share of discretionary vs. mandatory health spending, average 2006-12**



1. In the Czech Republic, the 3% of health expenditure included in the government budget are discretionary. The remaining 97% can be considered as mandatory.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 5.

StatLink http://dx.doi.org/10.1787/888933218731

Central budget authorities tend to perceive that they have little influence on health policy issues such as listing new drugs or medical services, while they perceive themselves to have considerable influence on spending on health programmes and payments to doctors or pharmaceutical prices (Figure 3.11). In most countries, the central budget authority also plays a crucial role along with the Ministry of Health in estimating financial changes from a modification to existing health programmes (Table 3.A1.11).

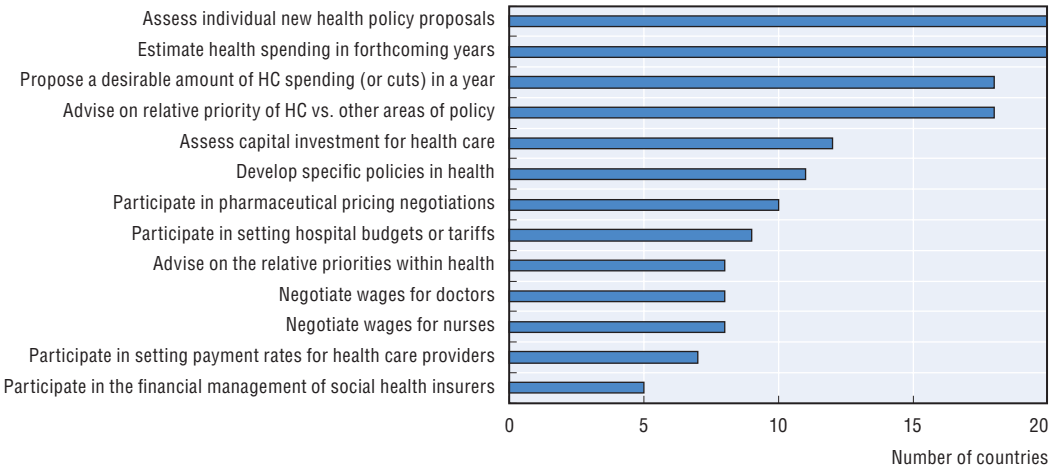
The survey shows that the two highest priority areas for cost control for budget agencies are hospital expenditure and pharmaceutical costs (Figure 3.12 and Table 3.A1.12). This suggests a degree of consensus with the policy ambitions of their colleagues in health.

Economic evaluations provided by Health Ministries are often not influential for budget agencies, which acknowledge they struggle with having capacity to assess such issues

While in most countries budget authorities receive economic evaluations of the expected health benefits from new policy proposals suggested by the Ministry of Health, these are not reported to be a major factor in the prioritisation of policies. Around 70% of budget agencies noted that they received economic evaluations from Health Ministries

for all or some policies (Table 3.A1.14). However, they also noted that these assessments count "to a lesser extent" in their assessment of policy proposals (Table 3.A1.15). This suggests a lack of connection between the economic evaluations being conducted within Health Ministries (and academic health policy circles) and their perceived utility to budget agencies. Similarly, 68% of budget agencies responded that equity considerations are either the responsibility of the Health Ministry or something they are not actively engaged with (Table 3.A1.16).

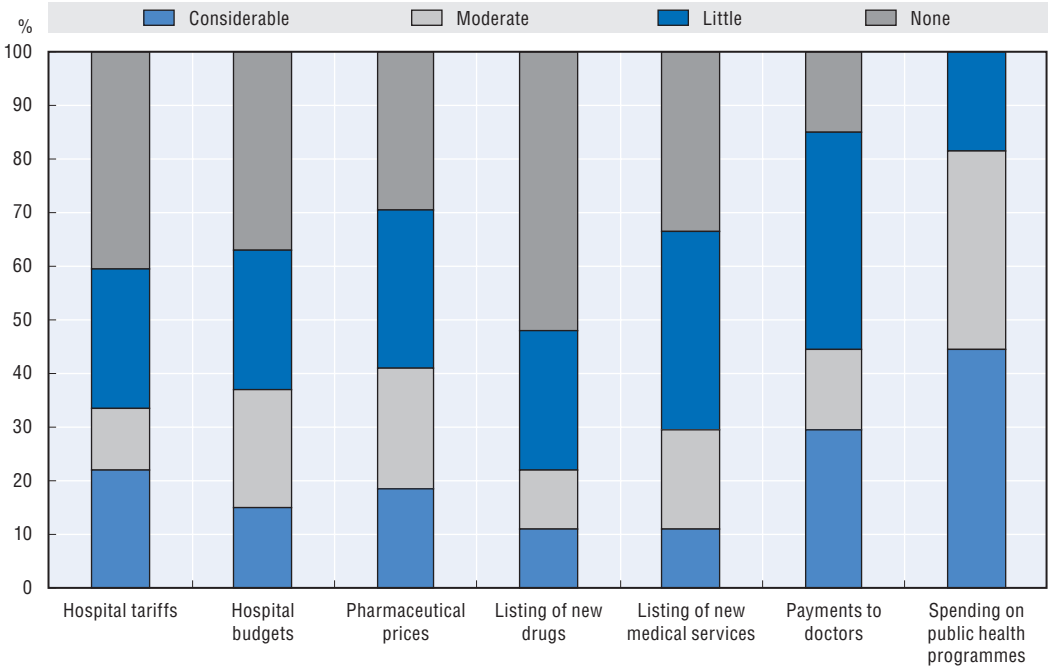
Figure 3.10. **Main healthcare-related functions undertaken by the central budget authority**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 24.

StatLink http://dx.doi.org/10.1787/888933218743

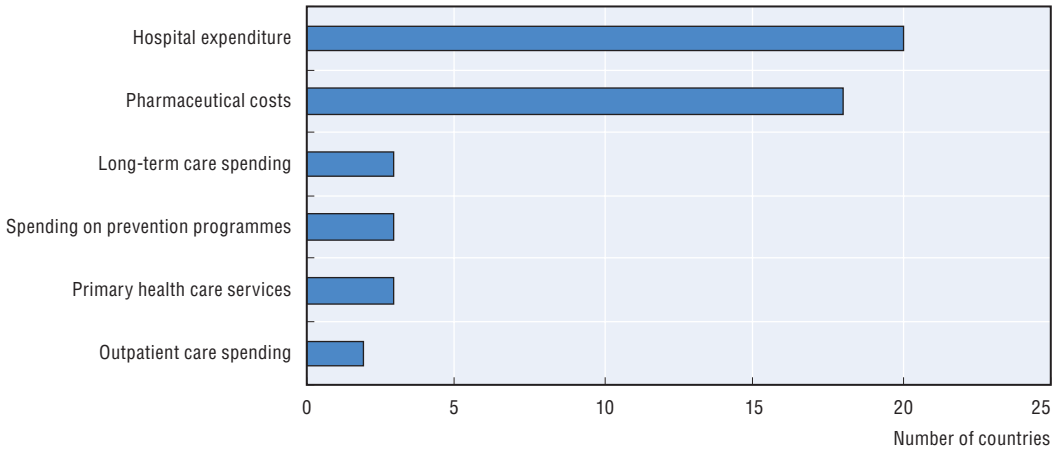
Figure 3.11. **Influence of the central budget authority (CBA) over healthcare-related policies**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 34.

StatLink http://dx.doi.org/10.1787/888933218758

Figure 3.12. **Top priority areas for health expenditure control for budget officials**

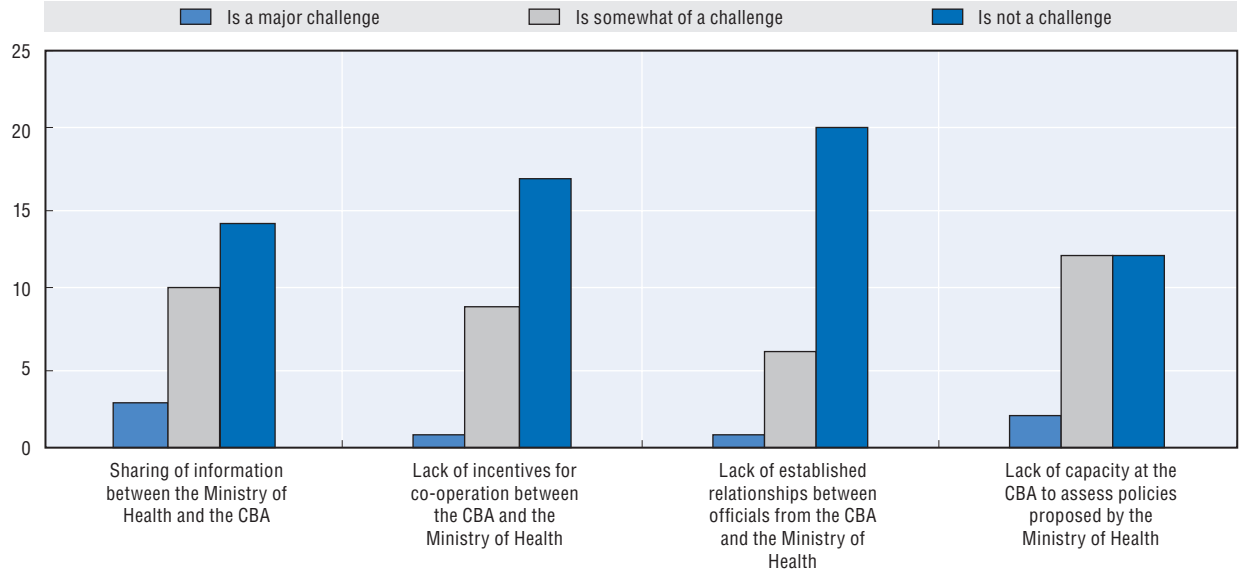


Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 37.

StatLink http://dx.doi.org/10.1787/888933218768

While there is considerable discussion about challenges in co-operation between central budgetary authorities and Ministries of Health, most budget authorities did not consider these challenges to be major (Figure 3.13 and Table 3.A1.17). Many countries in fact have many formal and informal institutions through which these two bodies can co-operate, with the survey revealing several successful examples of co-operation: the taskforce "towards sustainable health care spending" between the Dutch Ministries of Health and Finance; France highlighted that its social spending team is jointly supervised by Ministries of Budget and Health; and Australia established *ad hoc* committees with officials from both in developing specific reforms. Only the Czech Republic, Portugal and Poland reported that they do not have any formal or informal co-ordination mechanism between both ministries (Table 3.A1.18).

Figure 3.13. **Perceived co-ordination challenges between the Ministry of Health and the central budget authority**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health h, 2013, Question 26.

StatLink http://dx.doi.org/10.1787/888933218777

However, just over half of budget agencies noted that they have a lack of capacity for assessing policies. The number of central budget authority staff working on health varies widely across countries, from 35 in Mexico to less than one fulltime in Austria and Slovenia. This number reflects a range of factors specific to the structure of the health system and the institutional culture of the country. France, Mexico and the Netherlands have high results, which reflect the fact that those working on health also have responsibilities covering other social policy areas. The loss of sector-specific knowledge in central budget authorities that is a consequence of a "top-down" budgeting approach may have come at the cost of limiting resources to assess proposals emerging from Health Ministries.

3.5. Decentralisation of health financing and expenditure

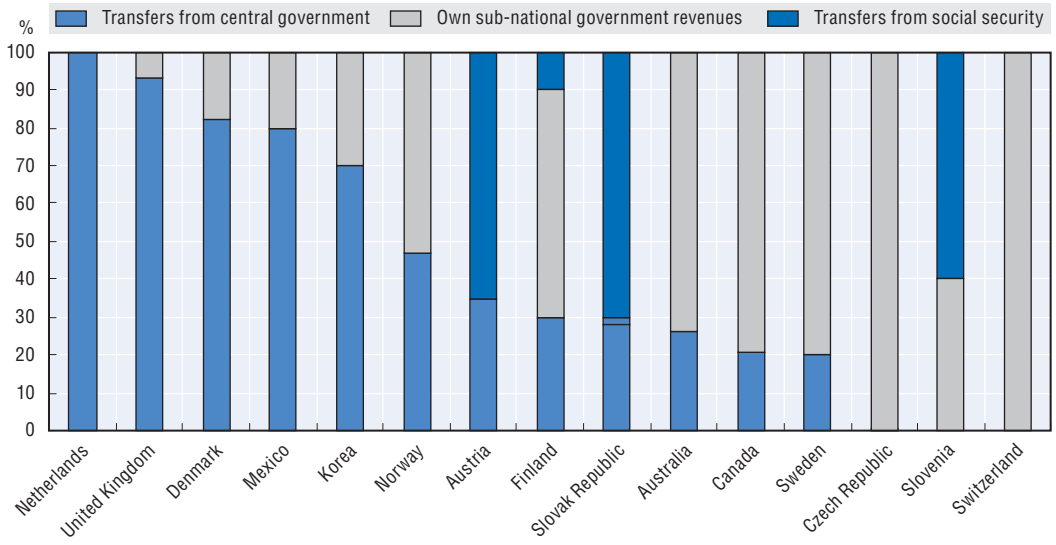
Decentralised governments (or entities) are often dependent on transfers from central governments and social security bodies to meet their obligations to the population on health care. In many OECD countries, the share of sub-national government budgets allocated to health care has increased from 2000 to 2011. Rising health care costs are reported to be generating pressure on sub-national government budgets. This is complicated by their (generally) lesser revenue-raising capabilities and the effect of internal migration, particularly of retiring populations. These trends were sometimes noted to potentially threaten sub-national governments' finances in the medium to long term. This section gives a summary of the main issues related to fiscal decentralisation of health. More detailed analysis is presented in Chapter 4.

Sub-national government budget decisions can have a substantial influence on health spending

The survey sought to collect new data on how sub-national governments financed health care spending, as current sources only provide data on financing of sub-national government at large. As expected, this showed that sub-national governments (and entities, in the case of the United Kingdom) rely both on transfers from central authorities and on their own sources of revenues to finance health care expenditure (Figure 3.14). At both ends of the spectrum, sub-national governments in Netherlands rely exclusively on transfers, while in Switzerland, more than 90% of spending is funded by own revenues. The survey also helped identify the extent to which sub-national governments (SNG) receive transfers from social security bodies to finance health care (in Austria, Finland, the Slovak Republic and Slovenia).

Most transfers from central authorities are general purpose (not earmarked to health), suggesting that the budgetary decisions by sub-national governments have a significant influence in determining how much is spent on health in many countries. These represent the largest share of transfers in Australia, Austria and Norway (Figure 3.15). Block grants earmarked for health are mainly used in Denmark, Finland and Canada. Grants may also be attached to specific health objectives (Mexico, the Netherlands and the Slovak Republic). The highest degree of control from central governments over spending decisions is financing through grants earmarked for specific health programmes (Korea, Mexico) or reimbursement on the basis of services delivered (Denmark, Mexico and Norway).

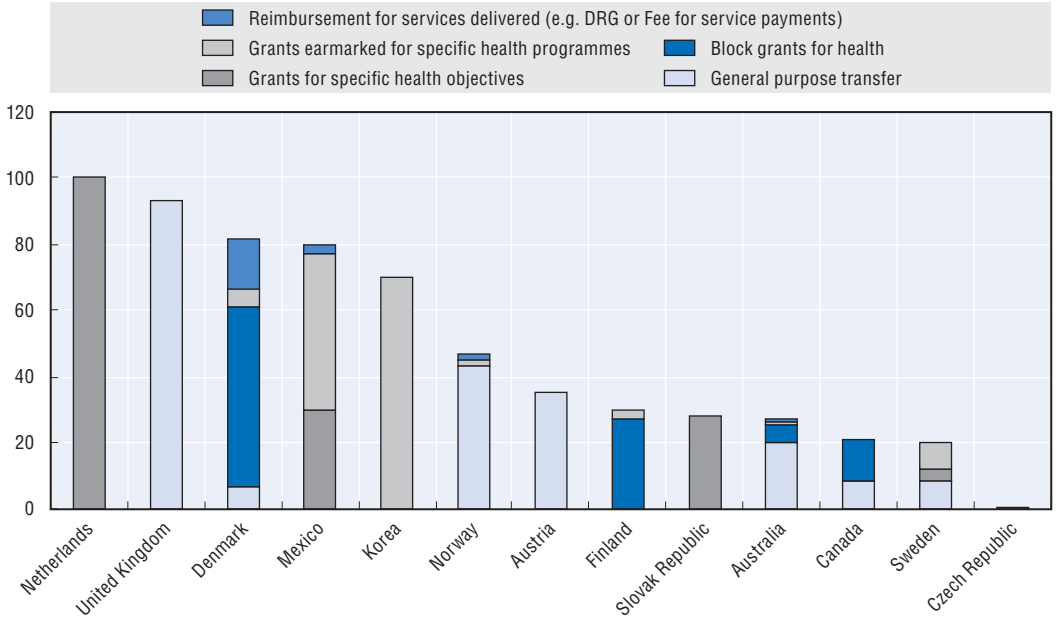
Figure 3.14. **Sources of revenues financing SNG health expenditure**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 14.

StatLink http://dx.doi.org/10.1787/888933218784

Figure 3.15. **Composition of transfers from central authorities as a share of total SNG health care spending**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 15.

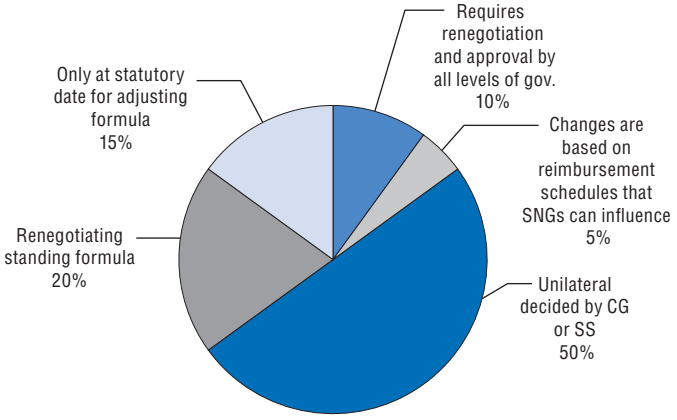
StatLink http://dx.doi.org/10.1787/888933218798

Sub-national governments have relative stability in their funding and are often responsible for ensuring spending targets are adhered to

Few countries reported that there are major variations in funds provided to sub-national governments from year to year (Table 3.A1.19). Generally, central authorities may only modify resources on a multiyear basis, or have a limited capacity to vary resources from year to year (Denmark, Finland, Italy, Switzerland, etc.). In Austria, funds collected by

the central government are automatically transferred to the state governments according to multiannual regulations. In contrast, central governments may significantly modify resources allocated to sub-national government spending from one year to another in the Czech Republic, France and Norway. When the parameters under which funds are allocated (e.g. a formula or share of revenues) change, half of the countries surveyed reported that this occurred unilaterally by central government or social security agencies (Figure 3.16). In Australia, Chile, Denmark and Slovenia, negotiations to change the formula are necessary (Table 3.A1.20).

Figure 3.16. **What is the procedure for central government (CG) or social security (SS) to vary total resources transferred?**



Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 17.

StatLink http://dx.doi.org/10.1787/888933218801

A majority of countries reported that central governments are not the lender of last resort should sub-national governments fail to meet their obligations for financing health care. Central governments are ultimately responsible for funding health care expenditures in Chile, Denmark, France, Hungary, Italy, Japan, Korea and Netherlands. Central governments are not ultimately responsible for financing in countries where sub-national governments play the largest role in financing health care (Australia, Austria, Canada,[2] Finland, Mexico, Sweden and Switzerland) (Table 3.A1.21). The credibility of institutional arrangements to stop the central government from stepping in if a sub-national government cannot finance health services is questionable. Budget agencies pointed out that the lack of a legal obligation to step in may reduce moral hazard by lower levels of government, particularly where they hold responsibility for hospital capital planning. Nonetheless, most countries have mechanisms in place to provide financing of last resort for sub-national governments at large (if not specifically for their financial obligations related to health).

Central governments commonly set spending targets for health to be met by sub-national governments. Twelve out of 20 countries reported spending targets that were either a subset of a more general framework of expenditure ceilings for sub-national governments (e.g. Denmark), or temporary ceilings within the framework of recent consolidation plans, such as Austria where the federal and sub-national governments agreed to limit health care spending to nominal GDP growth and, from 2016 onwards, to not exceed 3.6% growth (OECD, 2013). In some cases, sub-national governments themselves introduce targets to limit health expenditures, such as in Canada's province

of Ontario, which has capped growth in health care spending to 2.1% a year over 2013-16. In half of the countries that responded, the Ministry of Health was responsible for controlling sub-national health care expenditure (Finland, France, Hungary, Japan, Korea, Netherlands and Slovak Republic). The central budget authority is responsible for supervising sub-national government health expenditure in 36% of cases (the Czech Republic, Denmark, France, Italy and Sweden). The Social Security Agency is responsible for such control only in Slovenia (Table 3.A1.22).

While spending targets for sub-national government are common, specific performance targets and measures of outputs and outcomes are less so. When central governments monitor the performance of sub-national governments this more often tends to be through specific performance targets rather than measures of outputs and outcomes or analyses. Half of the countries surveyed reported using performance targets. In comparison, 35% of countries required sub-national governments to have output or outcome measures and only 10% required value-for-money analyses. In a large majority of countries surveyed, the Ministry of Health is primarily responsible for establishing this policy framework for sub-national governments. Other policy-setting bodies include the central budget authority (Italy), the executive (Australia) or the Parliament (the Czech Republic, Germany, Hungary and Switzerland). Only in Canada and the United Kingdom are sub-national governments responsible for setting their own policy objectives.

Taking responsibility for the governance of health systems is a challenge in decentralised contexts

There was a divergence of views on whether controlling public health expenditure was different in centralised or decentralised systems, suggesting that institutional factors broader than just health mattered more. Sweden reported that they found it easier to control costs when health is financed and provided by sub-national governments. Others noted that this complicates affairs: citizens tend to complain directly to the Ministry of Health of the central government when there is a problem and local governments do not bear the full political cost of unpopular decisions. Similarly, an increase in the number of stakeholders (particularly elected stakeholders), can soften budget constraints. The occurrence of a "blame game" between levels of government for the provision of health care services is a frequent feature of countries where sub-national governments play an important role in health provision.

A number of countries noted that determining the appropriate size of sub-national government to effectively manage health care services has been a challenge in recent years. In Sweden, for example, there are 21 county councils, but studies show that six would be more efficient (Blomqvist and Bergman, 2007). Reducing the number of sub-national governments is politically difficult – and sometimes constitutionally or historically impossible, in particular in federal countries where states pre-existed the federation (Austria, for instance). Denmark conducted a successful reform of municipal mergers in 2007, reducing the total number of municipalities from 300 to 100 and the number of regions from 14 to 5. One of the main drivers of this reform was precisely to reach a more adequate size for health care service provision (OECD, 2012). Finland has also been implementing a gradual reform of its health care system since 2007. In March 2014, it reached a political agreement to transfer health and welfare services from municipalities to five regions.

3.6. Conclusion

This chapter shows the variety of budgeting practices and procedures for health expenditure across OECD countries. These practices and procedures depend on institutional factors such as the origin of public health systems, the role of autonomous social security institutions or the degree of decentralisation. These institutional considerations, in particular relative to budgeting, shed some light on the capacity of governments to control health care expenditure growth.

Since the 1990s, there has been a gradual shift towards top-down budgeting in OECD countries, leading to a reallocation of responsibilities between the central budget authority and the Ministry of Health. Central budget authorities are mainly responsible for macro-fiscal tasks in the health sector and are content to leave policy development and implementation to Health Ministries.

There are challenges in reconciling these two perspectives, most notably whether efficiency gains in health are being returned to taxpayers. To aid the certainty of their fiscal estimates, most OECD countries use some kind of budget ceiling to limit the growth of health care expenditure, and a large majority of countries use a medium-term expenditure framework. These are often complemented by specific mechanisms to control the evolution of health care spending. Early warning systems have been introduced in most countries and usually help to reduce the growth in health care spending. Other mechanisms used to enhance spending efficiency include automatic cuts or spending reviews. Most of these tools remain quite blunt – and are often the source of disagreements between ministries on whether savings sought are appropriate. Co-ordination between the central budget authority and the Ministry of Health in better harvesting efficiency gains might help this difficult process become a more rational one.

Notes

1. Australia, Austria, Canada, Chile, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Iceland, Italy, Japan, Korea, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Sweden, Switzerland, Turkey, the United Kingdom.
2. Except for certain population groups, such as veterans and First Nations, for which the federal government is responsible for the funding of health care.

References

ASISP – Analytical Support on the Socio-Economic Impact of Social Protection Reforms (Europe) (2012), *Annual Report 2012, Pensions, Health Care and Long-Time Care, Norway*, European Commission.

ASISP (2011), *Annual Report 2011, Pensions, Health Care and Long-Time Care, Greece*, European Commission.

Blomqvist, P. and P. Bergman (2007), "Does Regionalisation of Nordic Health Care Systems Make Them Less Democratic? An Empirical Test of the Swedish Case", Uppsala University Working Paper No. 4, Sweden.

Dexia (2012), *Les finances publiques territoriales dans l'Union européenne*, Paris.

OECD (2013a), *OECD Economic Surveys: Austria 2013*, OECD, Paris, *http://dx.doi.org/10.1787/eco_surveys-aut-2013-en*.

OECD (2013b), *Budgeting Practices and Procedures in OECD Countries*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264059696-en*.

OECD (2012), *Reforming Fiscal Federalism and Local Government: Beyond the Zero-Sum Game*, OECD Fiscal Federalism Studies, OECD, Paris, *http://dx.doi.org/10.1787/9789264119970-en*.

ANNEX 3.A1

Survey answers by country

Table 3.A1.1. **Perception of difficulty in reducing health care expenditure**

	Yes – Health is one of the top two policy areas from which it is hardest to achieve savings	Yes – in general, it is harder to achieve savings in health than in most areas	Same – Health is as hard as any other area of government spending	No – It is easier to achieve savings in health than in other areas of government spending	No – Health is one of the easiest policy areas from which to achieve savings
Australia			X		
Austria		X			
Canada			X		
Chile	X				
Czech Republic		X			
Denmark			X		
Estonia		X			
Finland		X			
France			X		
Germany		X			
Hungary		X			
Iceland	X				
Italy			X		
Japan		X			
Korea	X				
Mexico	X				
Netherlands		X			
New Zealand			X		
Norway		X			
Poland		X			
Slovak Republic			X		
Slovenia	X				
Sweden			X		
Switzerland		X			
Turkey		X			
United Kingdom		X			
Total	**5**	**13**	**8**	**0**	**0**

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 42.

Table 3.A1.2. **Success of the central budget authority (CBA) in keeping health care spending within desired parameters in the last four years**

More successful than in other areas of policy	As successful as in other areas of policy	Less successful than in other areas of policy
Italy	Australia	Iceland
Mexico	Austria	Chile
Poland	Czech Republic	Finland
Turkey	Denmark	Korea
United Kingdom	Estonia	Netherlands
	France	Slovenia
	Germany	
	Japan	
	Hungary	
	New Zealand	
	Norway	
	Slovak Republic	
	Sweden	
	Switzerland	

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 29.

Table 3.A1.3. **Types of budget allocation**[1]

	Budget allocated to specific health objective?		Budget allocated by sub-categories of health care services?			
					If Yes	
	NO	YES	NO	YES	These categories are used for informative (non-binding) purposes	These categories form the basis of appropriation
Australia		X		X	X	
Austria	X		X			
Canada	X		X			
Chile			X			
Czech Republic		X	X			
Denmark		X	X			
Estonia		X	X			
Finland		X	X			
France		X		X		X
Germany	X		X			
Hungary		X		X		X
Iceland	X			X		X
Italy		X		X	X	
Japan		X		X		X
Korea		X		X	X	
Mexico		X		X		X
Netherlands		X		X		X
New Zealand		X		X		X
Norway	X			X		X
Poland	X		X			
Portugal		X		X	X	
Slovak Republic	X		X			
Slovenia	X		X			
Sweden	X		X			
Switzerland	X		X			
Turkey	X			X	X	
United Kingdom	X		X			
Total (27 answers)	**12**	**14**	**14**	**13**	**5**	**8**

1. These answers only refer to the health expenditure which is included in the (central/federal) government budget.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 6.

Table 3.A1.4. **Categories included in projections**

	Total health expenditure	Public health expenditure	Private health expenditure	Expenditure by age groups	Categories of health expenditures (e.g. primary care, hospital, long-term care)
Australia		X			X
Austria		X		X	X
Canada	X	X	X	X	X
Chile		X			X
Denmark		X		X	X
Estonia	X	X	X	X	X
Finland	X	X	X	X	X
France		X			X
Germany		X			
Hungary		X			X
Iceland					X
Italy	X	X		X	X
Japan		X			X
Korea	X	X		X	X
Mexico		X			X
Netherlands	X	X	X	X	X
New Zealand		X			X
Norway					X
Poland		X			X
Slovenia		X			X
Switzerland	X	X		X	X
Sweden	X	X		X	
Turkey		X			
United Kingdom		X			
Total	**8**	**23**	**4**	**10**	**20**

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 11.

Table 3.A1.5. **Existence of specific ceilings for health expenditures**[1]

No	Yes, it sets expenditure ceilings for overall expenditure by the Ministry of Health (or Social Affairs)	Yes, it sets expenditure ceilings by programme	Yes, it sets expenditure ceilings by category of health services (e.g. hospitals, primary care, etc.)
Australia[2]	Chile	Korea	Austria
Finland	Czech Rep.	Norway	Denmark
Japan	Estonia	Poland	France
Sweden	Germany[3]	Portugal	Hungary
Switzerland	Hungary		Italy
	Iceland		Mexico
	Mexico		Netherlands
	Netherlands		New Zealand
	Slovak Rep.		Poland
	Slovenia		Slovak Rep.
	Turkey		United Kingdom

1. These answers only refer to the health expenditure which is included in the (central/federal) government budget.

2. The majority of Australian government health expenditure is based on entitlement (e.g. Medicare benefits), and does not have an expenditure ceiling. However, non-entitlement expenditure (e.g. prevention activities) is capped.

3. In Germany, ceilings do not include expenditure of Statutory Health Insurance.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 45.

Table 3.A1.6. **Entity primarily responsible for setting the health expenditure ceiling(s)**[1]

	Ministry of Health	Central budget authority (e.g. Ministry of Finance)	Executive Branch: Prime ministers or president's office or cabinet	Executive agency	Legislative Branch; Parliament	Independent Body	Not applicable
Australia							X[2]
Austria	X						
Canada							X
Chile		X					
Czech Republic		X	X		X		
Denmark		X			X		
Estonia		X			X		
Germany					X		
Korea		X					
Netherlands		X				X	
New Zealand					X		
Poland	X	X		X			
Portugal			X				
Slovak Republic		X					
Slovenia				X			
United Kingdom		X					
Total	**2**	**9**	**2**	**2**	**5**	**1**	**2**

1. These answers only refer to the health expenditure which is included in the (central/federal) government budget.

2. The majority of Australian government health expenditure is not subject to ceilings. However, for the specific items which are subject to ceilings, the Ministry of Health is primarily responsible for setting these.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 47a.

Table 3.A1.7. **Most important factors when establishing ceilings or targets for health**[1]

	Estimated GDP growth			General government objectives for the fiscal position			Share of health spending in total public spending			Expenditure estimates and projections			Value for money analysis of specific health policies			The balance of public versus private spending on health by households			The balance of health promotion versus social protection in health spending		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Australia				X								X		X							
Austria		X		X								X									
Chile				X					X		X										
Czech Republic	X				X							X									
Denmark			X	X				X			X			X				X			X
Estonia		X				X				X											
Finland		X		X														X			
France				X							X				X						
Germany				X					X		X										
Hungary	X			X			X				X			X				X		X	
Iceland		X		X								X									
Italy				X					X		X										
Japan	X									X						X					
Korea	X				X							X									
Mexico	X			X				X		X					X			X			X
Netherlands					X				X	X											
New Zealand				X					X		X										

Table 3.A1.7. **Most important factors when establishing ceilings or targets for health**[1] *(cont.)*

	Estimated GDP growth			General government objectives for the fiscal position			Share of health spending in total public spending			Expenditure estimates and projections			Value for money analysis of specific health policies			The balance of public versus private spending on health by households			The balance of health promotion versus social protection in health spending		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Norway					X					X											X
Poland			X		X					X											
Slovak Republic				X					X		X										
Slovenia	X			X				X			X			X				X			X
Switzerland		X		X																	
Turkey			X	X							X										
United Kingdom				X							X				X						
Total	**6**	**5**	**3**	**17**	**5**	**1**	**1**	**3**	**6**	**6**	**11**	**5**	**0**	**4**	**3**	**1**	**0**	**5**	**0**	**1**	**4**

Note: 1 for the most important factor, 2 for the second most important and 3 for the third.

1. These answers only refer to the health expenditure which is included in the (central/federal) government budget.

Source: OECD Survey of budget officials on budgeting practices for health, 2013, Question 47.

Table 3.A1.8. **Existence of an early warning system to alert that health expenditures may exceed targets or legally binding levels**

No, there is not such a system	Yes, there is a system that detects overruns, but an alert *does not legally require* action	Yes, there is a system that detects overruns and sets in motion *required action for the current year*	Yes, there is a system that detects overruns and sets in motion *required action for future years*
Czech Republic	Chile	Iceland	Austria
Estonia	Norway	Australia	Denmark
Finland	Slovak Republic	Denmark	
Germany	Turkey	France	
Japan	United Kingdom	Hungary	
Korea		Italy	
Netherlands		Mexico	
Poland		New Zealand	
Sweden		Slovenia	
Switzerland			

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 49.

Table 3.A1.9. **Use of automatic reductions in health expenditure**

No	Only a part of health spending is subject to automatic reductions	Yes, all health spending is subject to an automatic reduction every year
Australia	Denmark	
Canada	France	
Chile	Italy	
Czech Republic	New Zealand	
Estonia	Slovenia	
Finland	Switzerland	
Germany	Turkey	
Hungary		
Iceland		
Japan		
Korea		

Table 3.A1.9. **Use of automatic reductions in health expenditure** *(cont.)*

No	Only a part of health spending is subject to automatic reductions	Yes, all health spending is subject to an automatic reduction every year
Mexico		
Netherlands		
Norway		
Poland		
Slovak Republic		
Sweden		
United Kingdom		

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 38.

Table 3.A1.10. **Functions undertaken by the CBA**

	Advise on the relative priorities across sectors	Estimate future health spending	Propose a desirable amount of health care spending	Advise on the relative priorities within health	Assess individual new health policy proposals	Develop specific policies in health	Participate in pharmaceutical pricing negotiations	Participate in setting hospital budgets or tariffs	Participate in setting payment rates for health care providers	Negotiate wages for doctors	Negotiate wages for nurses	Assess capital investment for health care	Participate in the financial management of health insurers
Australia	X	X			X	X		X					
Austria	X		X		X		X						
Canada	X				X								
Chile	X	X	X		X			X		X	X	X	
Czech Republic		X	X		X							X	X
Denmark	X	X	X	X	X	X				X	X	X	
Estonia		X											
Finland		X			X		X		X				
France	X	X	X	X	X	X	X	X	X			X	X
Germany		X			X								
Hungary		X	X				X	X					
Iceland	X	X			X		X	X	X	X	X	X	
Italy		X	X			X	X	X		X	X	X	
Japan	X	X		X									
Korea	X	X	X		X								
Mexico	X		X		X			X		X	X	X	X
Netherlands	X	X	X	X	X	X							
New Zealand	X	X	X	X	X							X	
Norway	X		X	X	X	X		X	X			X	
Poland		X	X		X				X				
Portugal			X										
Slovak Republic	X	X	X	X	X	X							
Slovenia									X	X	X	X	X
Switzerland	X	X			X	X	X						
Sweden	X		X		X	X	X						
Turkey	X	X	X			X	X	X	X	X	X	X	X
United Kingdom	X	X	X	X	X	X	X			X	X	X	
Total	**18**	**20**	**18**	**8**	**20**	**11**	**10**	**9**	**7**	**8**	**8**	**12**	**5**

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 24.

Table 3.A1.11. **Extent to which the CBA can influence health care policies**

	Policies																							
	Hospital tariffs				Hospital budgets				Pharmaceut-ical prices				Listing of new drugs				Listing of new medical services				Payments to doctors				Spending on public health programmes			
	C	M	L	N	C	M	L	N	C	M	L	N	C	M	L	N	C	M	L	N	C	M	L	N	C	M	L	N
Australia					X						X				X				X				X			X		
Austria				X				X			X					X			X				X			X		
Canada				X				X				X				X				X				X				X
Chile	X					X						X				X		X			X				X			
Czech Republic			X				X				X				X				X				X					X
Denmark			X		X					X					X				X		X				X			
Estonia			X				X				X				X				X				X					X
Finland				X			X			X			X					X					X		X			
France	X				X						X					X		X					X		X			
Germany			X				X				X				X				X				X			X		
Hungary	X					X			X				X				X					X			X			
Iceland		X				X					X				X				X			X				X		
Italy	X							X		X						X	X				X				X			
Japan	X							X	X							X				X	X				X			
Korea				X				X				X				X				X				X		X		
Mexico		X				X						X				X				X	X					X		
Netherlands				X			X					X			X				X				X					X
New Zealand				X			X					X				X				X			X			X		
Norway		X				X				X				X					X			X				X		
Poland				X				X			X					X			X				X			X		
Portugal			X		X					X				X				X				X			X			
Slovak Republic				X				X				X				X				X				X		X		
Slovenia				X			X					X				X				X	X							X
Switzerland				X				X	X				X				X						X		X			
Sweden	X							X	X							X				X				X	X			
Turkey			X			X			X					X				X			X				X			
United Kingdom			X					X		X						X				X	X				X			

C: considerable; L: little; M: moderate; N: none.

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 34.

Table 3.A1.12. **Areas which have been key priorities for expenditure control in health in recent years**

	Hospital expenditure	Outpatient care spending	Primary health care services	Long-term care spending	Spending on prevention programmes	Pharmaceutical costs	Other
Australia			X			X	X
Austria	X			X			
Chile	X						X
Czech Republic	X					X	
Denmark	X					X	
Estonia							X
Finland			X	X			
France	X					X	
Germany	X					X	
Hungary	X					X	
Iceland	X					X	

Table 3.A1.12. **Areas which have been key priorities for expenditure control in health in recent years** *(cont.)*

	Hospital expenditure	Outpatient care spending	Primary health care services	Long-term care spending	Spending on prevention programmes	Pharmaceutical costs	Other
Italy	X					X	
Japan	X	X	X	X	X	X	X
Korea	X	X				X	
Mexico		X			X		
Netherlands	X			X			
New Zealand	X					X	
Norway	X					X	
Poland	X					X	
Portugal	X					X	
Slovak Republic					X		
Slovenia	X					X	
Sweden			X			X	
Switzerland	X					X	
Turkey	X				X	X	
United Kingdom	X						X
Total	**20**	**3**	**4**	**4**	**4**	**18**	**5**

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 37.

Table 3.A1.13. **Existence of a "desirable" level of spending for health care set by the CBA**

No	Yes, and the "desired" level of spending has been reached	Yes, but the "desired" level of spending was not reached
Japan	Austria	Chile
Australia	Czech Republic	Korea
Germany	Denmark	Netherlands
Korea	Estonia	Slovenia
Slovenia	Finland	Switzerland
	France	
	Hungary	
	Italy	
	Mexico	
	New Zealand	
	Norway	
	Poland	
	Sweden	
	Slovak Republic	
	Turkey	
	United Kingdom	

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Questions 30 and 31.

Table 3.A1.14. **Countries in which the CBA receives economic evaluations of expected health benefits from new policy proposals suggested by the Health Ministry**

Yes, accompanying all new health policy proposals	For some health policies	Rarely	Other	Only for pharmaceuticals or listing new medical services
Austria	Australia	Chile	Korea	
Hungary	Canada	Czech Republic		
Japan	Denmark	Estonia		
Poland	Finland	Germany		
Slovak Republic	France	Iceland		
Slovenia	Italy	Mexico		
	Netherlands	Sweden		
	New Zealand			
	Norway			
	Switzerland			
	Turkey			
	United Kingdom			

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 32.

Table 3.A1.15. **Assessment of health policy proposals (on the basis of economic assessments of their expected benefits) by the CBA**

To a large extent: Policy proposals are prioritised or supported on the basis of their expected life-years saved ahead of all other factors	*To some extent:* Policy proposals are prioritised or supported on the basis of expected life-years saved along with other factors	*To a lesser extent:* It is the job of the Health Ministry to indicate priorities and the CBA is principally concerned with their fiscal implications	Other
Australia	Finland	Austria	Japan
	Mexico	Canada	Switzerland
	New Zealand	Chile	
	Norway	Czech Republic	
	United Kingdom	Denmark	
		Estonia	
		France	
		Germany	
		Hungary	
		Iceland	
		Italy	
		Korea	
		Netherlands	
		Poland	
		Slovak Republic	
		Slovenia	
		Sweden	
		Turkey	

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 33.

Table 3.A1.16. **Assessment of the impact of health policies on equity by the CBA**

To a large extent, health policies are often assessed for their impact on equity	To some extent, equity is an important consideration but not a primary concern	Assessing the impact on equity of health policies is usually the responsibility of the Health Ministry	Budget policy makers are not actively engaged with equity issues in health
New Zealand	Australia	Austria	Chile
	Finland	Canada	Czech Republic
	Germany	Denmark	Estonia
	Iceland	France	Netherlands
	Italy	Hungary	Slovak Republic
	Korea	Japan	Slovenia
	Mexico	Poland	Switzerland
	Norway	Portugal	
		Sweden	

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 35.

Table 3.A1.17. **Major challenges encountered in the co-operation between the CBA and the Ministry of Health**

	Is a major challenge	Is somewhat of a challenge	Is not a challenge
Sharing of information between the Ministry of Health and the CBA	Chile, Korea, New Zealand	Australia, Estonia, France, Germany, Iceland, Mexico, Netherlands, Portugal, Slovenia, Switzerland	Austria, Canada, Czech Republic, Denmark, Finland, Hungary, Italy, Japan, Norway, Poland, Slovak Republic, Sweden, Turkey, United Kingdom
Lack of incentives for co-operation between the CBA and the Ministry of Health	Korea	Chile, Denmark, Estonia, France, Germany, Iceland, New Zealand, Norway, Slovenia	Australia, Austria, Canada, Czech Republic, Finland, Hungary, Italy, Japan, Mexico, Netherlands, Poland, Portugal, Slovak Republic, Sweden, Switzerland, Turkey, United Kingdom
Lack of established relationships between officials from the CBA and the Ministry of Health	Korea	Chile, Estonia, Germany, Iceland, New Zealand, Slovak Republic	Australia, Austria, Canada, Czech Republic, Denmark, Finland, France, Hungary, Italy, Japan, Korea, Mexico, Netherlands, Norway, Poland, Portugal, Slovak Republic, Sweden, Switzerland, Turkey, United Kingdom
Lack of capacity at the CBA to assess policies proposed by the Ministry of Health	Korea, Portugal	Austria, Denmark, Estonia, Finland, Germany, Mexico, New Zealand, Norway, Poland, Slovenia, Sweden, United Kingdom	Australia, Canada, Chile, Czech Rep., France, Hungary, Iceland, Italy, Japan, Netherlands, Slovak Rep., Switzerland, Turkey

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 26.

Table 3.A1.18. **Existence of a formal co-ordination body between the CBA and Ministry of Health, and other institutions for co-ordination**

Yes	Regular informal consultation and meetings	Ad hoc bodies created for specific needs (discussing a reform, etc.)	Consultation for budget preparation only	None
Italy	Australia	Austria	Germany	Czech Republic
Finland	Canada		Hungary	Portugal
Mexico	Chile		Iceland	Poland
Norway	Denmark		Japan	Slovenia
Turkey	Estonia		Korea	
	France		New Zealand	

Table 3.A1.18. **Existence of a formal co-ordination body between the CBA and Ministry of Health, and other institutions for co-ordination** *(cont.)*

Yes	Regular informal consultation and meetings	Ad hoc bodies created for specific needs (discussing a reform, etc.)	Consultation for budget preparation only	None
	Netherlands		Slovak Republic	
	Sweden		Switzerland	
			United Kingdom	

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 25.

Table 3.A1.19. **Ability of the central government (or social security) to vary total resources transferred to sub-national governments for health from one year to the next**

To a large extent – central government can significantly vary total resources from one year to the next	To a moderate extent – central government can make changes within a specified margins	To a small extent – central government has little capacity to vary total resources from year to year	Resources are varied on a multi-year basis (every 3-5 years) and not generally year to year
Czech Republic	Australia	Denmark	Austria
France	Chile	Finland	Canada
Norway	Korea	Mexico	Italy
	Slovak Republic	Netherlands	United Kingdom
	Sweden	Slovenia	
		Switzerland	

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 16.

Table 3.A1.20. **Procedure for central government (or social security) to vary total resources transferred to sub-national governments from one year to the next**

	Unilateral changes can be decided at the central (or social security) level	Changes require re-negotiating a formula for the distribution of funds	Changes cannot be made until the next statutory date for the revision of the formula	Changes require negotiation and approval by all levels of government concerned but are not based on a formula	Changes are based on reimbursement schedules that sub-national governments can influence	Other
Australia	X	X		X		
Austria			X			
Canada			X			
Chile	X	X				
Czech Republic	X					
Denmark	X	X				X
Finland					X	
France	X					
Hungary	X					
Korea	X					
Mexico			X			
Netherlands				X		
Norway	X					
Slovak Republic	X					
Slovenia		X				
Switzerland						X
Sweden	X					
Turkey	X					
United Kingdom	X					
Total	**12**	**4**	**3**	**2**	**1**	**2**

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 17.

Table 3.A1.21. **Influence of the central government (CG) on overall health spending by sub-national governments**

	CG has ultimate responsibility for health care financing		CG sets targets for health spending by sub-national governments		CG establishes performance targets for sub-national governments		CG prescribes outputs or outcome measures for sub-national governments on health		CG requires sub-national governments to carry out value-for-money analysis	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Australia		X	X		X		X			X
Austria		X	X		X			X		X
Canada		X		X		X		X		X
Chile	X			X	X		X			X
Czech Republic		X		X		X		X		X
Denmark	X		X		X		X			X
Finland		X	X			X		X		X
France	X		X		X		X		X	
Hungary	X			X		X	X			X
Italy	X		X		X		X			X
Japan	X		X			X		X		X
Korea	X		X		X		X		X	
Mexico		X	X		X			X		X
Netherlands	X		X		X			X		X
Norway		X		X	X			X		X
Slovak Republic		X	X			X		X		X
Slovenia		X	X			X		X		X
Switzerland		X		X		X		X		X
Sweden		X		X		X		X		X
United Kingdom		X		X		X		X		X
Total	**8**	**12**	**12**	**8**	**10**	**10**	**7**	**13**	**2**	**18**

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 19.

Table 3.A1.22. **Institution primarily responsible for controlling health spending by sub-national governments**

	Ministry of Health	Central budget authority (CBA)	Ministry of Interior or of Local Administrations	Social Security Agency	Other
Australia					X
Austria					X
Canada					X
Chile					X
Czech Republic		X			X
Denmark		X			
Finland	X				
France	X	X			
Hungary	X				X
Italy		X			
Japan	X				
Korea	X				
Mexico					X
Netherlands	X				
Norway					X
Slovak Republic	X				
Slovenia				X	
Switzerland					X
Sweden		X			
Turkey			X		
United Kingdom					X
Total	**7**	**5**	**1**	**1**	**10**

Source: OECD Survey of Budget Officials on Budgeting Practices for Health, 2013, Question 20.