5TH MEETING OF THE JOINT NETWORK ON FISCAL SUSTAINABILITY OF HEALTH SYSTEMS

4-5 February 2016, Paris

SYNTHESIS NOTE

The fifth meeting of the OECD Joint Network on Fiscal Sustainability of Health Systems highlighted the value of the network as a space for health and finance officials to improve dialogue and mutual understanding. The quality of the interventions and the high level debate held in each of the sessions showed that this young network is consolidating as one of the main international arenas for inter-ministerial dialogue on health financing issues. With the publication of the Fiscal Sustainability of Health Systems Bridging Health and Finance Perspective report, the recognition of the network has increased, creating a remarkable momentum to carry on new initiatives for policy research.

This year, the OECD Joint Network’s meeting gathered 103 participants: 85 country delegates, from 34 different countries, including representation from the Ministry of Finance, Ministry of Health, Social Security Funds, and health and public finance research institutes; and 6 high-level experts and representatives from International Institutions (WHO, RAND Europe and Case Western Reserve University). Evaluations from participants highlighted the quality of the country cases presented, the relevance of the topics selected, and the presentations of experts and international institutions. In particular, participants considered that the meeting provided a perfect balance between academic analysis and practical lessons from policymakers.

Session 1: Setting the scene: determinants of health and health spending

Overview

Health spending contributes to improved health outcomes, but broader social determinants also matter. Assessing the relative contributions of these factors to health is useful for priority-setting, as is a closer understanding of the underlying mechanisms by which income and other social factors affect health. For example, a number of studies have shown the importance of income, education, lifestyle choices and the environment on life expectancy, alongside health spending.

At the same time, most OECD countries face substantial cost pressures to their health systems. Exploring the impact of policy and institutional factors on spending growth, alongside broader drivers of income, technology and demography, can help guide cost containment policies. For example, different provider payment mechanisms and regulatory policies have been shown to help contain costs.

Main panellists and topics

- Determinants of Health Spending, Joaquim Oliveira Martins, Head of Division Regional Development and Policy Division OECD.
• **Inclusive growth and health**, Marion Devaux, Economist/Policy Analyst Health Division OECD

**Key messages**

- Health, health care and the wider economy are closely interlinked. To improve population health and reduce health inequalities, governments need to focus not only on health care policies, but also on suitable inclusive growth policies.

- At the macro-level, both health system and wider determinants affect health, with relative contributions depending on country’s level of economic development. Health spending, income, employment, job quality, level of education, lifestyle and environment are all important variables associated with life expectancy.

- Policies aiming to improve health require investment across multiple sectors and close collaboration with a variety of stakeholders (i.e. a whole-of-government approach with private sector involvement).

- Demographic and non-demographic factors (e.g. income) explain only a share of health care expenditure; there are other expenditure drivers that must be taken into account. In particular, institutions and policies can play a major role in explaining variations on health spending.

- Policies and institutional factors matter for differences in health care spending: Supply (e.g., competition, tighter regulation of service prices) and demand (e.g., more explicit definition of the publicly funded benefit package) policies are relevant for cost-containment strategies.

- The analysis presented only shows correlation not causality. Higher expenditure levels could have an impact on policies and institutions. Further analysis is needed to control for reverse causality. Furthermore, additional analysis could be performed to study complementarities between different policies and institutional designs.

**Session 2a: Purchasing arrangements - governance**

**Overview**

Health provision involves a multiplicity of actors that intervene between the beneficiary and the public resources that finance health services. The complexity of the system, the limited number of providers, and information asymmetries can create higher transaction costs and inefficiencies, distorting prices in the health market. Purchasing systems and payment incentive systems can play a major role in correcting such failures.

Many OECD countries have enacted or are discussing reforms to promote a more active, strategic purchasing of health services, moving beyond the more traditional passive approach. Key objectives of these reforms are: to make health systems more responsive to changes in health needs over time; to address health inequalities; and to incentivise more efficient practices. Strategic purchasing can offer a more active and transparent approach, but needs to be carefully designed to ensure funding flows to stated priority areas. Despite the efforts to improve efficiency through the purchasing system, countries still face challenges in the structuring and implementation of such arrangements.
Main panellists and topics

- **Commissioning for sustainable healthcare**, Tom Ling, Rand Institute Europe
- **Governance of purchasing arrangements in Estonia**, Triin Habicht, Head of Department of Health System Development, Estonian Ministry of Social Affairs
- **Purchasing of health care services in Polish health insurance system**, Rafal Bulanowski, Department of Health Insurance, Ministry of Health

Key messages

- UK commissioning architecture still faces weaknesses: funding cycles and logics often fit poorly with delivery and prioritisation; information asymmetries, time lags, status/trust issues, search frictions and implementation challenges; weak demand-led innovation.

- UK commissioning is searching for solutions to overcome these challenges (e.g. new models of care, integrated care organisations, NICE guidelines, evidence based medicine, Academic Health Science Networks, reformed tariff to reward innovation), but there is still weakly developed commissioning for innovation and improvement.

- Approaches to improve commissioning systems need to take into consideration the way commissioning sits within the wider architecture of sustainable healthcare. Commissioning should provide signals and incentives for long-term innovation and improvement, including investing for future benefit and to achieve savings for others. In addition, it requires clear and consistent messages, fairness in competition, and relationship-building with provider.

- Estonia has a stable health insurance system and a strong institutional design, with the majority of public funds being pooled in the Estonian Health Insurance Found (EHIF). Health insurance revenue base is explicitly determined, which gives incentives to optimize within the budget and to set explicit limits on health insurance obligations. However, existing fragmentation may lead to inefficiencies in health funding and provision (e.g. there are differences in rules and power of purchasing, there are incentives in place to focus on “your own piece” rather than in patients’ needs, and there is not a clear definition of responsibilities among stakeholders).

- There have been recent reforms to the governance of purchasing arrangements in Poland. In 2015, the government established a new department in the Agency for Health Technology Assessment, aiming to introduce a national tariffs framework for health care services. This agency works on developing methods for calculating national tariffs and mechanisms for collecting cost data from healthcare providers. The Agency for Health Technology Assessment and Tariffs is also working on developing new reimbursement methods that should enhance coordination of care and reward better clinical outcomes.

Session 2b: Purchasing arrangements - improving procurement, curbing fraud and abuse

Overview

Public procurement is a key element for the fiscal sustainability of health systems. On average, medical goods represent 20% of current health expenditures in OECD countries. More strategic, efficient and transparent procurement processes can be a powerful tool to reduce costs in the health sector. In
addition it can improve health services by improving the availability of medicines and products required by health providers.

Public procurement is one of the government activities most vulnerable to waste, fraud and corruption, due to its complexity, the size of the financial flows it generates, and the close interaction between the public and private sectors. Vulnerability to fraud and corruption is an endemic feature of health purchasing systems in particular. The complexity of the organisational arrangements in place creates space for regulators, financiers, providers, patients and suppliers to engage in sub-optimal and undesirable behaviours, potentially leading to significant losses for the system.

**Main panellists and topics**

- **The Belgian Experience**, Jo De Cock, CEO of the NIHDI
- **Procurement strategies and processes for health**, Janos Bertok, Head of Division, Public Sector Integrity OECD
- **Public Purchases and fraud prevention in Mexico**, Jose Genaro Montiel, General Director of Programming, Organisation and Budget, Ministry of Health

**Key messages**

- Fraud and abuse in the health care sector should be understood better. The definition is not unique: it depends on the nature and context. A broad portfolio of activities needs to be taken into account when designing public policy strategies (i.e. errors, abuses, frauds and corruption).

- Belgian experience highlighted that the critical success factors for combating fraud and abuse are: prevention (awareness, information, and clear and fraud tested legislation); sufficient investigation and prosecuting capacity (quantity and quality); structured approach based on risk analysis; tailored and fast interventions and appropriate sanctions and claw back procedures; and cooperation with different stakeholders (justice, providers, patients, and data availability).

- International cooperation can play an important role in combating fraud and abuse. The European Health Fraud and Corruption Network HFCN, established in 2005, works as a network of governmental authorities, health insurers, and counter fraud investigation units. The OECD could be a key actor to stimulate good practices, and support and align data standardisation.

- The OECD has a strong commitment to support the transformation of public procurement from an administrative task to a core strategic instrument. Concrete action plans and recommendations, which form a comprehensive view, have already given some positive results (for example the recent reform of procurement strategies of IMSS and ISSSTE in Mexico).

- The main challenges and constraints when purchasing for the health sector are: lack of clear and comprehensive strategies, lack of appropriate collection of data, knowledge and capability deficiencies that hinder the development of an efficient procurement function, lack of market intelligence and engagement with suppliers, need for strengthened use of competitive tendering, and coordination issues with sub-national governments.

- The Mexican experience provides some important lessons on procurement. In 2012, the Mexican federal government revised the scheme for transferring resources to states, considering the possibility of sending inputs rather than financial resources. In order to ensure good quality and
timely supply, the government implemented a scheme where inputs are purchased centrally and on a consolidated basis, and then distributed to the states. The first major consolidated purchase was held in 2013, and generated significant savings for the health sector (639MDD).

- Mexico has well developed tools to support public procurement in the health sector, such as: Compranet (online public procurement platform), global contracts (contratos marcos), contact protocols, and direct adjudication (possibility to adhere to current public biddings). However, the country still faces challenges to achieve universal health care, improve medicines supply, increase efficiency in health spending, improve conditions of service delivery and price, improve quality, and strengthen values in the health sector administration.

Session 3: Spending reviews in health

Overview

Budgeting tends to be incremental and public expenditure often reflects historical choices or set funding formula rather than represent government/citizen priorities. Spending reviews can be a useful tool to improve the efficiency and effectiveness of public expenditure on health, as they allow reassessing baseline spending in light of government’s priorities and governance structure. International experience has shown that it can be a powerful tool to help governments improve control over aggregate expenditure, and create fiscal space for new spending priorities. Even though there is no single methodology for spending reviews, international experiences highlight the need for appropriate linkages with the budgetary process, clear definitions of the objectives and scope, participation and buy-in from line ministries, and having a system of outcome evaluation and efficiency analysis already in place.

After the global financial crisis, spending reviews have become more common among OECD countries. According to the OECD 2012 survey on Budgeting Practices and Procedures, half of the member countries have a spending review process in place. In the majority of countries, health has been identified as a key priority for achieving fiscal consolidation. However, the use of spending reviews in the health sector is still very limited.

Main panellists and topics

- **Spending Reviews: OECD practices and applications for Health**, Ronnie Downes, Deputy Head Budgeting and Public Expenditures Division, OECD

- **Health System Expenditure Review: Slovenia**, Vlasta Kovcic Mezek, Directorate of Health Economics, Ministry of Health

- **Spending reviews and health care in the Netherlands**, Theo Van Uum, Financial and Economic Affairs Department, Ministry of Health, Welfare and Sports

Key messages

- After the global economic crisis, spending reviews have become a standard tool of fiscal consolidation and resource re-prioritisation. Fiscal rules, fiscal framework, demands of “fiscal space” for national development goals, and integration into the multi-annual budgetary framework are key elements for maintaining the impetus of spending reviews in the future.

- In a similar way, spending reviews need to be integrated and be supported by the national evaluation framework, in order to maintain and develop their role as policy prioritisation tool.
• The implementation of spending reviews in the health sector requires a proper analysis of the following questions: are national health priorities clear and up-to-date? Are processes, structures, and resources aligned with these goals? What are the main horizontal cost drivers of health? How does evaluation of specific programmes fit in this overall context?

• The Dutch experience showed that politicians and civil servants have different responsibilities in the spending review process. In a similar way, the timing of implementation is also a critical factor. In contrast, having an independent chair and having the participations of the Prime Minister’s Office were not identified as critical factors.

• Slovenia carried out an in-depth Health Expenditure Review process through working groups, data gathering, working meetings, workshops, and policy dialogues. The main lessons of this report are: there is a need to diversify revenues and develop countercyclical approaches to financing health care, comprehensive health insurance plays a key role in maintaining fiscal balance, delayed payments lead to provider debt that is ultimately the responsibility of the Ministry of Finance, and general revenues should cover non-health service items.

Session 4: Improving transparency and accountability in the health sector: linking performance information to budgets

Overview

In recent decades OECD member countries have made a great effort in linking performance information to budgets in the health sector. However, many challenges still remain in defining how performance information could be used to reduce costs and improve health care provision. To a greater or lesser extent, performance information is used in health budgeting in most OECD countries. However, very few countries have a direct linkage between results and resources. Rather, performance information is usually used to inform the debate on budget allocations. Increasingly, it is seen as a managerial tool, within line ministries or agencies, for improving the efficiency, effectiveness and accountability of sectoral spending. The health sector is one of the few areas where some countries have introduced direct performance related payments, creating a straight link between measurable results and resource allocation. For example, whilst DRGs are mainly understood as a provider payment method, they have also been considered as a performance budgeting tool. That is, by linking payments to a standard cost per intervention, it provides incentives to providers to increase efficiency.

Main panellists and topics

• Performance information, transparency, and accountability in the health sector: experience in the United States (and a bit beyond), Joseph White, Case Western Reserve University

• Performance information and health system efficiency in France, Ayden Tajahmady, Deputy director of the Division of Statistics and Strategic research, National Health Insurance Fund for Salaried Workers (CNAMTS)

• Using performance information in national health insurance, Korea, Kyohyun Kim, Health Insurance Review & Assessment Service, HIRA Research Institute
Key messages

- Accountability based on measures requires conditions that may be hard to meet. It requires that the message is clear and targeted properly, that measures are perceived as accurate, fair and legitimate, officials subject to incentives are able to respond effectively do not have political capacity to change the rules. There are also common measurement problems (e.g. statistical validity, non-observable aspects of performance, aggregate ratings of the “same thing” may be very different, documentation may not equal performance) and common implementation issues (e.g. cost in time, money, diverted attention from other activities, and inverted incentives if linked) that make it difficult to use measurement and results to inform policy making in the health sector. According to one of the panellists, “Improvement through performance management would be a beautiful thing, but, like unicorns, it does not exist in real life”.

- Despite the difficulties behind using performance information, Korea and France provide good experiences in designing robust and effective performance frameworks in the health sector. One of the main challenges with linking performance information to budgeting is how to make sense of the huge amount of data collected to improve efficiency.

- France described its state of the art system to use performance information to change stakeholders’ behaviours to improve efficiency. France collects information on health provision for more than 60 million individuals, and creates different types of indicators (such as burden of disease and their cost, or causes and costs of sick leaves). Indicators are used for political decision, health care professionals’ management tools, and patients’ empowerment. Even though it is difficult to evaluate the impact of these tools, past implementation has shown that they may have an impact on patients’ and professionals’ behaviors in the mid and long term.

- In Korea, performance information is used to provide feedback to individual providers, to report to the public, and to inform the pay for performance system. After more than 15 years of implementation, the outcomes of the program have been positive, improving performance in the health sector (e.g. acute stroke care, use of prophylactic antibiotics and use of antibiotics for common cold), reducing variation of quality within providers, and building positive governance for accountability. Some challenges still remain in terms of priority setting and leadership, technical design of the program for predictability and fairness, and complementing the base payment and health systems.

Session 5: Future challenges in health financing, working towards Universal Health Coverage and the Sustainable Development Goals

Ensuring healthy lives and promoting well-being for all is one of the key targets of the Sustainable Development Goals (SDGs), with Universal Health Coverage a critical part of the SDGs and a central goal for many non-OECD countries. Universal health care systems can be understood to have four main objectives: reducing unmet health needs, reducing inequalities in access to health goods and services, improving service quality and improving financial protection. Until now, the Joint Network has mainly focused on achieving greater efficiency and reducing costs in the provision of health services, but little has been said regarding financial protection and its impact on fiscal sustainability of health systems. Still, this is an important aspect of health system performance, which is particularly relevant to poverty reduction and labour market dynamics.

The approach of the OECD Joint Network for promoting dialogue between health and finance officials, and the tools developed by the Joint Network, is now being applied to non-OECD countries. The
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OECD Joint Network’s Secretariat has been active in sharing these approaches, in particular in Africa and the LAC region.

Main panellists and topics

- **Contribution of the Joint Network to Universal Health Coverage and the Sustainable Development Goals: the Regional Joint Networks**, Camila Vammalle, Economist/Policy Analyst, Budgeting and Public Expenditures Division OECD

- **Monitoring financial protection**, Tamás Evetovits, WHO Barcelona Office for Health Systems Strengthening

Key messages

- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all is a critical factor for achieving the third Social Development Goal: “Ensure healthy lives and promote well-being for all at all ages”.

- The vision of the WHO/Europe is a Europe free of impoverishing health expenditures. In order to remove financial barriers in the health sector, public spending should increase, by broadening the revenue base, diversifying revenue sources for health, reducing reliance on social tax and using general budget transfers for non-active population groups; out of pocket payments should be reduced, especially for the poorest households that are consistently at greatest risk of catastrophic spending; and waste levels should decrease.

- In many countries there is a need to increase health coverage and improve health outcomes. Public health expenditure is therefore expected to grow in these countries, both as a share of GDP and as a share of total public spending. Given the scarcity of resources, it is important that any new money spent on health care is as effective as possible. Budgetary and financial management systems are therefore crucial. Under these circumstances, the OECD Joint Network could have an important role by promoting dialogue between health and finance officials.

Network future programme of work

In light of the discussions held during the meeting, country representatives proposed the following subjects to be included in the future programme of work:

1. Use of performance information in the health sector
2. Long-term care
3. Decentralization and sub-national governance of health care financing
4. Cost sharing and the concern of protection for the poor
5. Impact of complementary health insurances (voluntary or not) on public finances, and measures taken to compensate poorer population for their costs.