Fiscal Sustainability of Health Systems

Bridging Health and Finance Perspectives

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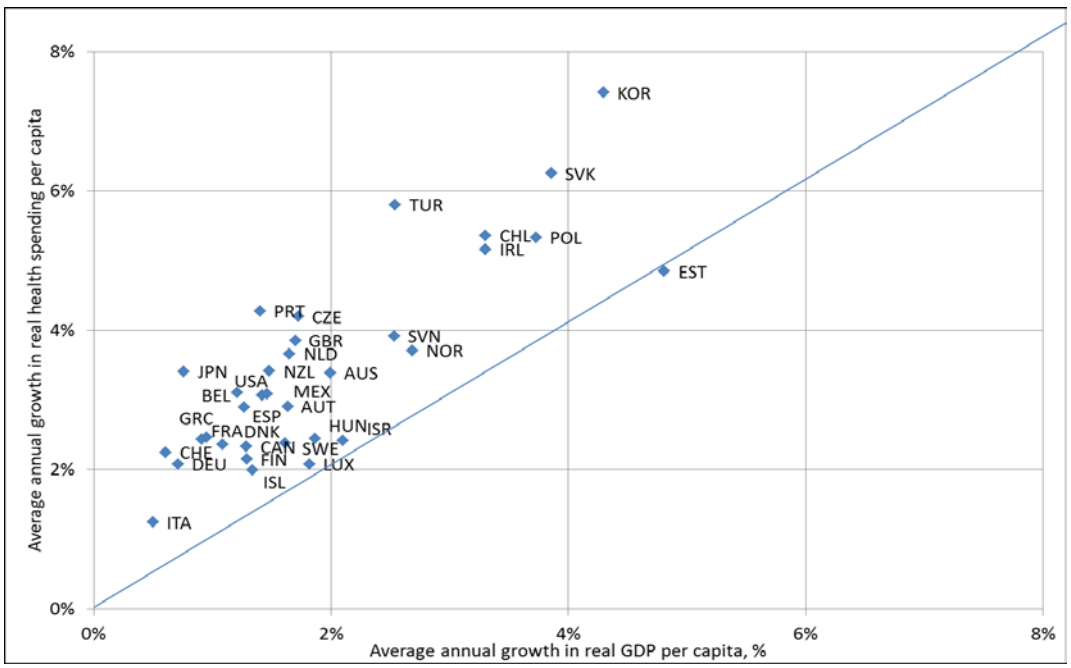
Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives provides a detailed overview of institutional frameworks for financing health care in OECD countries. It offers a comprehensive mapping of budgeting practices and governance structures in health across OECD countries.

Health care poses an important budgetary challenge

Spending on health has typically outpaced economic growth in most OECD countries (Figure 1). This is of particular concern from a fiscal sustainability perspective, as public funds account for around three-quarters of total spending on health across the OECD. However, 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, a great number of stakeholders (such as purchasers, service providers and other bureaucratic and administrative intermediaries) intervene between the beneficiary of health care and public resources that finance it, which may soften health expenditure control.

Figure 1. Average annual growth rate of real health spending and GDP per capita, 1990-2012 (or nearest years)



Source: OECD Health Statistics 2015

Health spending growth has been markedly slower since the global financial crisis

After an average annual growth rate of just over 4% throughout the OECD for the period 2000-08 (Figure 2), health spending (including private) grew at an average of 2.6% in 2009, -0.4% in 2010, 0.3% in 2011 and 1% in 2012. This reflects both a general slowdown across most OECD countries and substantial reductions due to austerity policies on public spending in some countries (notably in Greece, Ireland, Italy, Portugal and Spain). Whilst the slowdown in health spending was to a large extent mirrored by reduced GDP growth rates or recession, health systems were often particularly affected by the economic downturn. Across the OECD as a whole, total health spending (including capital spending) accounted for 9.2% of GDP on average in 2012, slightly lower than 9.3% in 2011 and 9.4% in 2010. Growth in health spending has been slower than GDP growth in a majority of OECD countries in recent years, which is in contrast to the situation pre-crisis.

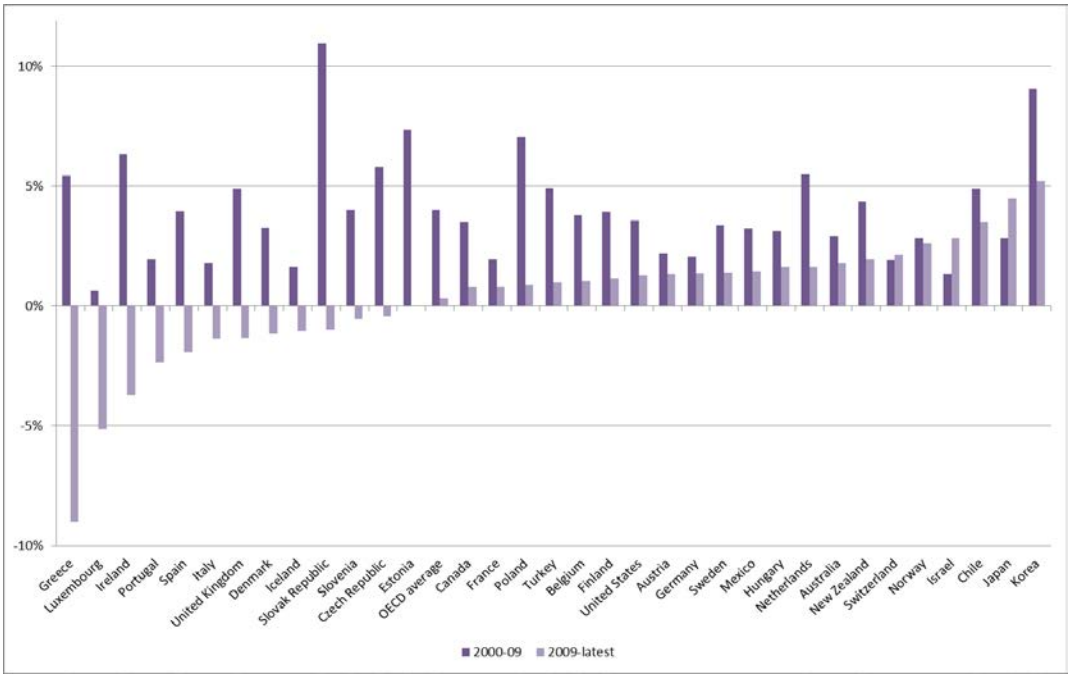
Despite the recent slowdown in health spending, concerns about the fiscal sustainability of health system remain large

Although health spending growth has been markedly slower since the global financial crisis, government health spending is expected to rise in the medium to long-term. This poses fiscal sustainability challenges.

In the absence of effective cost containment policies, OECD projections show that public spending on health and long-term care is on course to reach almost 9% of GDP in 2030 and as much as 14% of GDP by 2060.[1]

Pressures on health expenditure are mainly due to new technologies, which extend the scope, range and quality of medical services; rising incomes, which engender higher expectations on the quality and scope of care; and, to a lesser extent, population ageing.

Figure 2. Average annual growth rates in real health spending per capita, from 2000 to the latest year



Source: OECD Health Statistics, http://dx.doi.org/10.1787/health-data-en.

As the global financial crisis of 2008 continues to have after-effects in most countries, questions of sustainability and efficiency of public finances have moved more strongly to the forefront. The share of health spending has represented an increasing share of total public expenditure and now accounts for around 15% of government spending. It is unlikely that health care can continue to crowd out other areas of government budgets as it has in the past. The fiscal sustainability challenge is therefore particularly acute in the health sector and it urgently requires governments to manage public finances credibly. Reforms and good institutions are therefore necessary for governments to be able to control health care expenditure growth and ensure its fiscal sustainability.

Tools and policy levers to meet the fiscal sustainability challenge

Budget and health officials face the shared challenge of ensuring that any increase in health spending respects fiscal sustainability constraints, while delivering the best value for money. The OECD SBO-Health Officials Joint Network (see Box 1) identified a number of policy tools that can help countries control health care expenditure growth and ensure its fiscal sustainability (Figure 3).

Governments need to (i) diagnose and monitor the fiscal sustainability of their health systems, (ii) assess political and institutional factors, and (iii) implement policy levers and tools to ensure greater sustainability of health spending. Experiences from France, the United Kingdom and the Netherlands show how reform initiatives can take time to be successful, requiring buy-in from key stakeholders within and beyond the health system (see Box 2).

1. "Diagnose" fiscal sustainability challenges

Governments need information about health spending and funding sources in order to be able to control health care expenditure growth and ensure its fiscal sustainability. Tools that can help governments in this diagnosis include long-term forecasts, which take into account demographic and economic factors; short-term spending requirements that governments can use to set or shape their budgets; timely information on actual spending; and an evaluation of the evolution of possible revenue sources (taxes and/or contributions).

Box 1. OECD SBO-Health Officials Joint Network

Over the past four years, the OECD Senior Budget Officials – Health Officials Joint Network on the Fiscal Sustainability of Health Systems (OECD SBO-Health Joint Network) has enabled countries to share experiences and lessons learned on health and budget policies. Drivers of health expenditure growth, the challenges of health in public budgets, and policies implemented by countries to control spending both before and in response to the financial crisis were some of the topics debated. To shed light on the different institutional frameworks and instruments used to control health spending, the OECD SBO-Health Joint Network also surveyed budget officials on country budgeting practices in the health sector. The OECD publication "Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives" provides a synthesis of discussions and findings from the survey, along with insights from national policy documents and the literature.

Most OECD countries produce ***long-term projections***. Only four out of 26 OECD countries do not have them (Czech Republic, Hungary, Poland and the Slovak Republic). Most of these projections cover a horizon of 31 to 50 years. However, these forecasts are rarely used for decision making.

A number of countries have imposed ***short-term spending requirements***. Nearly half of OECD countries (such as Australia, Canada, Chile, Denmark, France, Italy, Netherlands, or the United Kingdom) have also used spending reviews to identify potential savings in health expenditure.

"Early warning systems" have proven effective in several countries to allow corrective measures. However, such systems need timely information, and, in some countries (such as Finland, Switzerland and the Netherlands), information on actual spending can take up to two years to be reported to the Ministry of Finance.

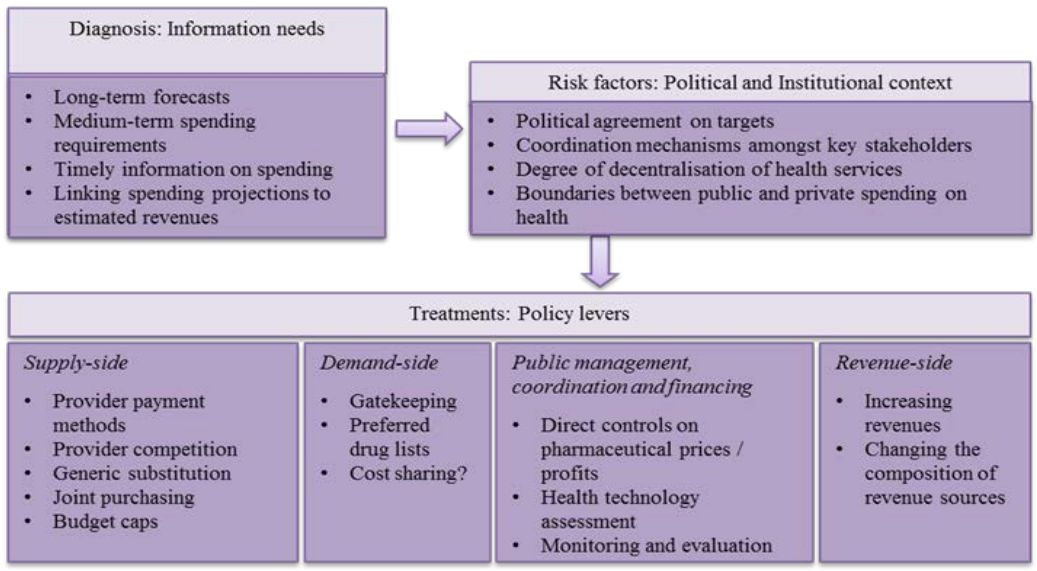
The ***evaluation of the evolution of revenue*** sources is particularly important given ageing populations, which will lead to shortfalls in certain revenue-raising mechanisms such as payroll taxes. Yet many OECD countries have a high reliance on payroll taxes. In Austria, the Czech Republic, Germany, Korea, Poland, the Slovak Republic and Slovenia for example, more than 70% of revenues for funding government health expenditures came from payroll contributions (Figure 4).

2. Assess the "risk factors" to the fiscal sustainability of health systems

A number of political and institutional factors work together and interact in complex ways, affecting the fiscal sustainability of health systems.

Most countries have for example ***targets or ceilings for health spending*** over several years. These are typically determined by economic rather than health-specific factors. However, over-spending in health (i.e. spending more than the budgeted amount) remains endemic in many OECD countries, which may reflect poor control over health system management.

Figure 3. Fiscal sustainability framework

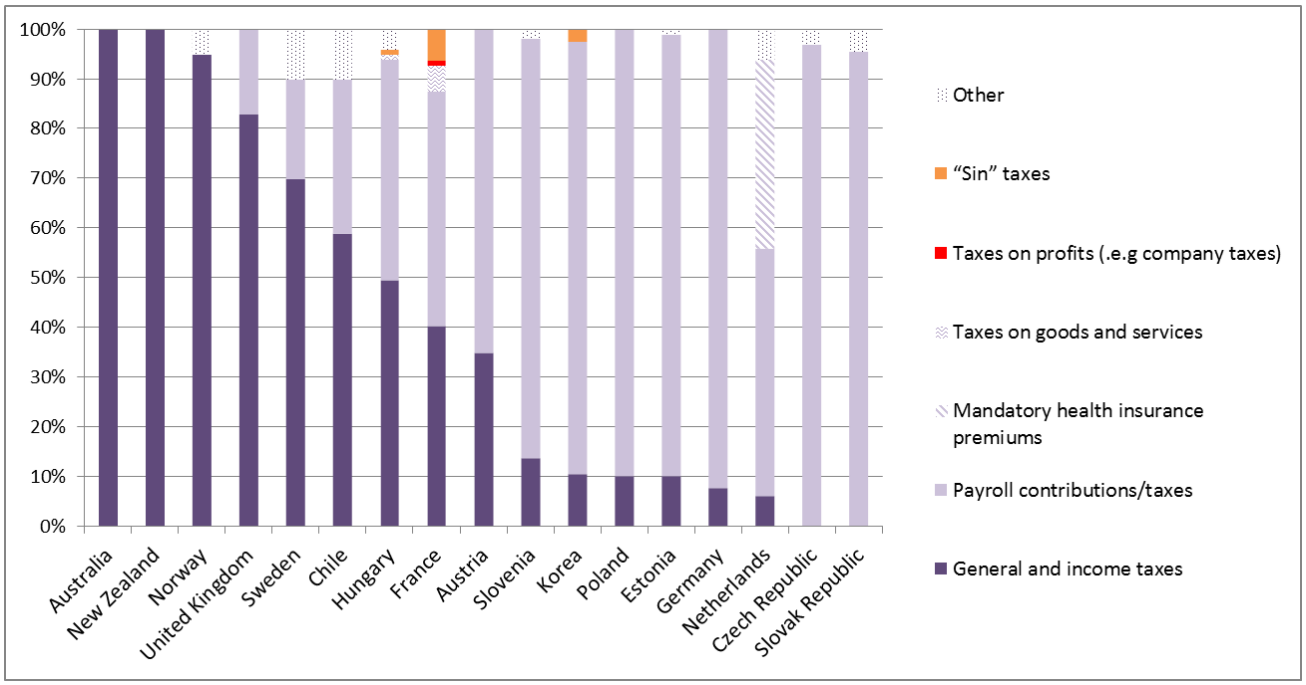


Many OECD countries also have formal and informal institutions through which ***central budgetary authorities and Ministries of Health can co-operate***. Only the Czech Republic, Portugal and Poland reported that they do not have any formal or informal co-ordination mechanism between both ministries. However, this co-ordination has not always proved effective, perhaps because of a lack of health-specific knowledge by central budget authorities.

The ***decentralised nature of health systems*** in several OECD countries is another risk factor for fiscal sustainability. In most OECD countries, sub-national governments play a role in health spending. On average, they are responsible for 30% of public health expenditure, but this share exceeds 90% in federal, quasi-federal and northern European countries. Such systems may find controlling cost difficult as it increases the number of stakeholders and softens budget constraints (with central government implicitly responsible for bailouts).

The ***boundaries between public and private spending*** on health are another important factor affecting the fiscal sustainability of health systems. The best way to consider the role of private financing, whilst maintaining universality of population coverage, is to be more specific and selective in defining the basket of services covered by public prepayment systems. Governments should define what services need to be accessible to all without any financial barrier (such as all essential and cost-effective care) but a more systematic assessment of the cost-effectiveness of existing therapeutic strategies should also be considered. However, Health Technology Assessments are typically limited to assessing new (rather than existing) health interventions. Active strategies to adjust the benefit basket with disinvestment in cost-ineffective interventions have been rare.

Figure 4. Revenue sources for funding government health expenditures, 2010 or latest year



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

3. Develop policy levers to ensure greater sustainability of health spending

Many health systems in the OECD are at risk of not being fiscally sustainable unless substantive policy change occurs. Policy makers have four broad ways to promote greater sustainability of health spending without compromising important achievements in access and quality of health care.

First, on the ***supply side***, provider payments that reward quality of outcomes, provider competition, pharmaceutical generic substitution, and reforms in purchasing policies have helped contain costs across a range of countries. Workforce legislation (including reforms restricting the supply of health professionals and wage controls) have had more mixed results. Automatic cuts in health budgets have helped reduce growth in health spending, but are a rather blunt policy tool because they cut both necessary and unnecessary care. Unfortunately, many countries (Czech Republic, Denmark, Estonia, Ireland, Italy, and the Netherlands) reduced spending on prevention following the crisis. While this leads to short-term savings, it has harmful effects both on costs and on health outcomes in the longer term.

Second, on the ***demand side***, expanded cost-sharing has helped contain costs but with adverse impacts on access to care. There is some evidence that physician gatekeeping (as seen in the United Kingdom) and preferred drug lists (as seen in the United States and Canada) have had an impact on consumer behaviours in positive ways, helping to contain costs without adverse effects on patients. Encouraging private health insurance has not been effective in relieving public budgeting pressures because the public health system continues to cover the cost of the most expensive services and patients (Australia, Spain and the United Kingdom).

Public management and co-ordination reforms, a further approach to achieve financial sustainability, have had varying degrees of success. Direct control of pharmaceutical prices and profits has proved effective in containing costs (as seen in Canada, France, Germany and Japan), but the long-term effects on incentives for innovation remain controversial. Health Technology Assessments that include cost-effectiveness analysis can promote more informed, realistic decisions on public health care provision, but rarely have they been used to support decisions to delist less cost-effective products.

Last, on the ***revenue side***, care needs to be exercised in advocating ever-increasing revenues as a response to rising expenditure pressures – not least given the distortionary economic effects of high marginal tax rates. Where additional revenues are required, a move towards broader-based models would appear appropriate, especially in countries with health insurance systems that are more reliant on payroll taxes. Denmark, France, Germany, Hungary, Slovak Republic, Croatia and Slovenia have broadened the revenue base through new or extended taxes. “Sin taxes” have important public health effects but play only a modest role in financing health services.

Box 2. Country experiences

In **France**, broad macro-level controls of health care spending took time to be effective. Particularly notable was the introduction of the National Objective for Healthcare Spending (ONDAM) targets in 1996. The ONDAM targets became an effective cost-containment tool when an early warning system was introduced that allowed payments to be withheld from health providers, and Parliament officially validated the targets. On the revenue side, France has made considerable efforts to diversify the sources of health financing over the last two decades. The introduction of the Contribution Sociale Généralisée (CSG) has successfully reduced reliance on wage-based contributions for health insurance. Twenty years after its founding, the CSG now accounts for some 35.3% of social health insurance revenues.

The **United Kingdom** government introduced stringent caps on overall government health spending in recent years. There were two key components to meet these caps: pay freezes or limits to pay growth; and reductions in administrative costs, principally by abolishing a tier of National Health Service (NHS) management (the nine Regional Strategic Health Authorities). These components were complemented by more specific strategies by local health commissioning bodies. Each local commissioning body has a plan to deliver savings, including better medicines management and demand-management measures to reduce growth in the use of hospital care. A significant component of the savings comes from reducing the price commissioners pay NHS and other providers for care. The national tariff (DRG prices) has, for example, been reduced by an average of 1.5% in cash terms between 2011-12 and 2014-15.

In the **Netherlands**, regulated competition for health insurance was introduced in 2006. Early evidence suggests it has led to better quality of care, with positive and negative effects on costs. It has also reduced government's ability to contain costs. Certain preconditions which have to be met for attaining cost-containment under regulated competition were imperfectly implemented, at least initially. First, fee-for-service elements in combination with ex-post budget corrections decreased cost-containment incentives for both insurers and care providers. Second, enrolees were generally not channelled towards the best performing hospitals as insurers typically signed contracts with almost all providers as insights into quality of care were lacking. Third, the degree of competition amongst both care providers and health insurers were insufficient. On the budgeting side, two other principles were lacking to attain cost-containment: budgeting policies were not designed to dampen unnecessary increases in public demand; and government was not able to prevent or redress overruns as quickly as possible. The government has recently refined some key budgeting policies in response to these concerns. One policy is particularly notable: the reduction of ex-post budget correction mechanisms, so that health insurers are encouraged to contain costs individually.

Did you know? Key points about fiscal sustainability of health systems

- Health spending has risen faster than economic growth in all OECD countries over the past 20 years. Public funds still account for around three-quarters of health spending.
- Public spending on health and long-term care in OECD countries is set to increase from around 6% of GDP today to almost 9% of GDP in 2030, and as much as 14% by 2060 unless governments can contain cost growth.
- Most countries allocate close to the OECD average of 15% of government spending to health. From 2000 to 2012, health's share of government expenditure rose by 1.4 percentage points.
- Early warning systems that have been introduced in many OECD countries have proven effective to allow corrective measures when health spending exceeded budgeted amounts. Spending reviews is another mechanism used to enhance health spending efficiency.
- Policies to promote financial sustainability of health systems should not compromise the universality of health care coverage. Countries should be more specific and selective when defining the benefit basket. More active strategies to dynamically adjust the benefit basket should be considered, with disinvestment in cost-ineffective interventions.
- Pharmaceutical policies, such as encouraging generic substitution and pricing policies, provider payment reforms that reward good outcomes, and more explicit priority-setting measures are some key ways to contain costs with limited adverse effects on patients.

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Read the report at www.oecd.org/health/health-systems/fiscal-sustainability-of-health-systems-9789264233386-en.htm

1. De La Maisonneuve, C. and J. Oliveira Martins (2013), "A Projection Method for Public Health and Long-term Care Expenditures", *OECD Economics Department Working Papers No. 1048*, OECD Publishing, Paris, http://dx.doi.org/10.1787/5k44v53w5w47-en.

2. The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.