1 Financing resilient health systems in times of crisis: How finance and health authorities can find common policy solutions

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This chapter analyses both the short-term challenges to increase health budgets in an uncertain economic climate, as well as medium to longer-term solutions to financing more resilient health systems. The chapter discusses the policy options and good practices open to governments to meet both health and finance objectives.

Key messages

- Following the unprecedented funds spent on combatting COVID-19, many OECD countries continue to face acute health spending pressures. This reflects ongoing pandemic-induced backlogs for certain health services, and higher than expected inflation. However, many countries' health systems are now also operating under more stringent budgetary constraints, linked to sluggish economic growth and competing pressures for public resources.
- Unless there is a major policy shift, this dual challenge of health spending pressures and resource constraints is only going to intensify. This reflects rising incomes and ageing populations increasing the demand for healthcare, potential constraints to productivity growth given the labour-intensive nature of the health sector, and new technologies that expand the boundaries of what illnesses can be treated.
    - Projections show that over the next two decades, growth in health spending from public sources is likely to outstrip both the growth in the economy and in government revenues, across OECD countries.
    - Without significant policy change, an increase of 2.4 percentage points to the health-to-GDP ratio is projected, as compared to pre-pandemic levels. That is, total health expenditure is projected to reach 11.2% in 2040, on average across OECD countries (up from 8.8% of GDP in 2018).
- At the same time, the pandemic highlighted the need for smart spending to strengthen health system resilience, notably to protect underlying population health, fortify the foundations of health systems through a digital transformation and investment in core medical equipment, and bolster health professionals working on the frontline.
    - Previous analysis estimated that on average OECD countries need to spend an additional 1.4% of GDP relative to pre-pandemic levels to be better prepared for future shocks (ranging from 0.6% to 2.5% across countries), though such spending is expected to produce some cost-savings in future years.
    - Combining this additional spend on strengthening resilience with the projections of health spending described above, health expenditure is, without other major policy changes, projected to result in a 3.0 percentage point increase by 2040 compared to pre-pandemic levels, to stand at 11.8% of GDP in 2040, on average across OECD countries.
- Urgent action is therefore needed to finance more resilient health systems whilst ensuring the fiscal sustainability of health systems. Historically, OECD countries have relied on **four broad policy options.** These options are non-exclusive but constrained to differing extents by the economic climate, especially in the more immediate term.
- **Option 1: increase overall government spending and allocate part of these additional funds to health.** This requires an increase in government revenues or additional debt financing. OECD surveys on citizen social programme preferences consistently show that health is the area where citizens are most willing to increase government spending, with the latest of these OECD surveys showing that 74% of respondents supported greater spending when primed with a general reminder on the costs. However, despite this support, large increases in overall government spending will be hard for many countries, due to high levels of government debt and associated higher costs of borrowing, as well as the challenge of trying to raise taxes during a cost-of-living crisis.

- **Option 2: increase the allocation to health within existing government budgets.** Even though citizens rate health as a high priority, the relative priority given to health in government budgets has only seen a modest increase over time: health spending accounted for 15% of total government expenditure on average in 2021, an increase of 1 percentage point compared to 2011, despite higher spending during the pandemic. Today, health is increasingly competing with other government spending priorities, notably to tackle the cost-of-living crisis, fund a green transformation, and, for some countries, increased defence spending. Still, in countries with comparatively low budget allocations to health, health authorities could use this as political leverage to push for an increased budget share.
- **Option 3: reassess the boundaries between public and private spending.** Without additional public resources available for health, more healthcare spending will by default shift to the private sector. In 2022, the share of spending by governments or compulsory health insurance across OECD countries was already at 76%. However, cuts to benefit packages or increases in user charges risk exacerbating health inequities. The ratio of private to public spending has remained relatively constant over the last two decades, on average across OECD countries. Nevertheless, a debate on longer-term directions on the public-private boundary needs to be had, in terms of what are the best buys for limited public budgets, and whether changes could be made to user charges without impeding access.
- **Option 4: find efficiency gains.** Given the limits of the three options above, increasing value-for-money of health services must be even more strongly emphasised. Achieving bold efficiency gains by cutting ineffective and wasteful spending, while also reaping the benefits of technology and the digital transformation of health systems, including Artificial Intelligence (AI), is imperative. Otherwise, expectations on the magnitude of such gains needs to be realistic. In particular:
    - Cost control policies are likely to produce only modest cost savings. Applied to overall health expenditure, these savings are equivalent to 0.1 percentage point of GDP.
    - Policies that improve healthy ageing are expected to provide somewhat larger savings, equivalent to 0.4 percentage points of GDP. While welcome, these are not enough in themselves to fundamentally alter the upward trajectory of health spending.
    - More ambitious and transformative policy changes are therefore needed to rein in health spending growth whilst still strengthening resilience and maintaining high quality, accessible care for all. If countries are successful in eliminating half of the ineffective and wasteful spending identified in earlier OECD analysis, projections point to a far more modest increase in total health expenditure, to an average of 10.6% of GDP in 2040 (a saving equivalent to 1.2 percentage points of GDP).
- In this challenging context, good budgeting practices are critical to maximise the efficiency of current spending and as an enabler of more ambitious policy changes in the medium to longer-term. Good budgeting practices across the budget cycle facilitate better decisions on whether, when and by how much public funding for health can increase, as well as identifying efficiency gains and where priorities can be shifted.

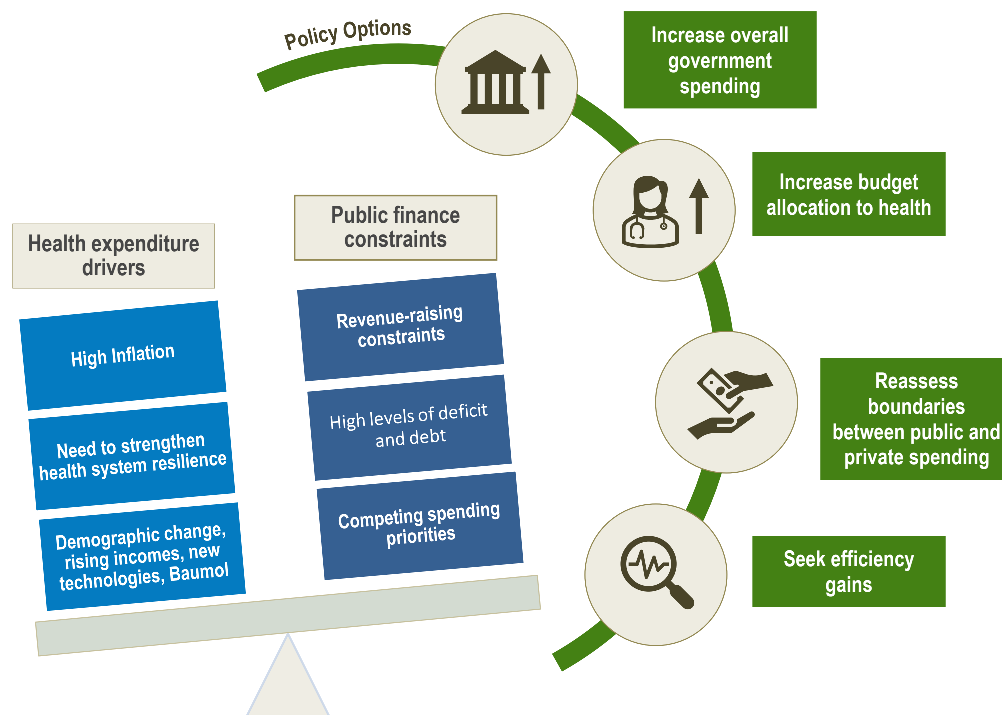
1.1. Introduction

Improving the quality and accessibility of healthcare for all while respecting public finance constraints is a difficult balancing act. Raising sufficient public funds for health to continue to meet ever-growing needs is challenging enough, given the inherent cost pressures. On top of this, the pandemic made it clear that additional spending is needed to strengthen the resilience of health systems to future crises (OECD, 2023[1]). Yet, at the same time, many OECD governments are operating in a particularly constrained fiscal environment. Higher and less predictable inflation, coupled with an uncertain economic outlook, adversely impacts government budgets with knock-on effects to the health sector.

Within this context, policy makers need to clearly lay out the options for meeting the growing price tag of sustainable and resilient health systems, with serious conversations needed about the willingness to pay for health by government and society at large. The pressing policy question is how to find a fiscally sustainable path to fund needed increases in health spending, as illustrated in Figure 1.1.

Funding more resilient health systems requires finance and health authorities[1] to find common solutions that combine raising additional funds with efforts to free up current resources by reducing wasteful spending in health systems. Such solutions require forward-looking, multi-year commitments. This is not straightforward, but the rewards are immense. Strengthening health system resilience protects economies from destabilising health shocks, as well as protecting people from ill health and premature death.

Figure 1.1. The challenge of raising sufficient funds for health within public finance constraints



The remainder of this chapter is structured as follows. The next section assesses the health spending pressures and public finance constraints faced by OECD countries today and in the coming decades. Section 1.3 explores fiscally sustainable policy levers for financing more resilient health systems. Section 1.4 summarises the role of good budgeting practices in improving public resource allocation decisions and in increasing efficiency of public health spending. Section 1.5 concludes. Box 1.1 provides definitions on the main technical terms used in this chapter.

Box 1.1. Fiscal sustainability, efficiency, resilience and related terms – definitions and scope

Fiscal sustainability: the ability of a government to maintain public finances at a credible and serviceable position over the long term. Fiscal sustainability implies governments can maintain policies and expenditures into the future, without major adjustments and excessive debt burdens for future generations (OECD, 2015[2]). Fiscal sustainability is not about health objectives per se. Rather, it is about ensuring public spending on health respects public finance constraints (whilst seeking to realise health objectives).

Financial sustainability: the ability of an organisation to have sufficient revenues to cover financial obligations in the long term.[1] See Gleißner, Günther and Walkshäusl (2022[3]) for an in-depth discussion of the term. Applying this term to the health sector, it can refer to private as well as public organisations engaged in financial transactions in healthcare. This includes households (a household's income and assets need to be sufficient to cover out-of-pocket health expenses), private purchasers such as health insurance firms (a firm's insurance premiums need to be sufficient to cover its reimbursement obligations), private health providers (revenues need to be sufficient to cover its costs), as well as government.

Public expenditure on health: spending by governments directly and/or by social health insurance, consistent with System of Health Accounts definitions of health financing schemes (OECD/Eurostat/WHO, 2017[4]).

Efficiency: obtaining the best possible outputs from available inputs. For health, this can involve reallocating resources within the health system (allocative efficiency) or, less disruptively, obtaining a given result at the lowest possible cost (productive efficiency) (OECD, 2017[5]; OECD, 2010[6]).

Wasteful spending: services and processes that are harmful or do not deliver benefits; and costs that could be avoided by substituting cheaper alternatives with identical or better benefits. It falls within the broader concept of efficiency, corresponding to the notion of 'productive efficiency' above (OECD, 2017[5]).

Cost containment policies: efforts to contain the growth of expenditures. Such policies are not necessarily efficient, notably when cost containment policies simply reduce outputs. For example, blanket cuts to public budgets for health will contain costs (at least in the short run), but at the expense of worse access and quality of care (OECD, 2015[2]).

Health system performance: the ability of a health system to achieve health-related objectives. Notwithstanding differences in health system performance assessment approaches, health-related objectives typically include the intermediate objectives of maximising the access to and quality of healthcare, with people's health outcomes as the final goal (OECD, 2024[7]).

Resilience: the ability of systems to prepare for shocks, absorb disruptions while maintaining performance, recover quickly, and adapt by learning lessons to improve and manage future risks (OECD, 2023[1]). In terms of scope, this concept of resilience includes but goes beyond preparedness.

1. Distinct from the term 'sustainable finance', which is increasingly used to refer to the incorporation of environmental considerations when making finance decisions (OECD, 2020[8]).

1.2. Countries face upward pressures on health spending, now and in the future

The pandemic demonstrated the need for additional spending to strengthen health system resilience…

Governments across the OECD allocated unprecedented financial resources to the health sector to combat COVID-19. Average health spending growth was 5% in real terms in 2020, and accelerated to 8.5% in 2021, as significant funds were made available to track the virus, increase system capacity, develop treatment options, and eventually roll out vaccines to the population. At its peak in 2021, spending linked directly to COVID-19 consumed around 9% of total public spending on health, on average. For some OECD countries the extra spending was an emergency short-term fix for chronic underinvestment in health workforce and capital as a side effect of government austerity and cost-containment policies in the health sector (Partnership for Health System Sustainability and Resilience, 2023[9]).

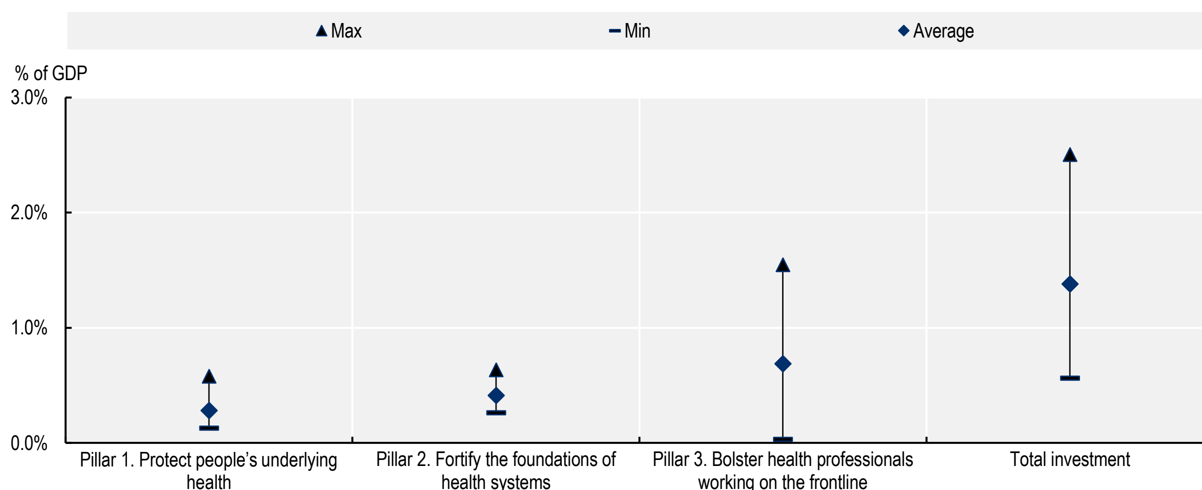
Much of this additional spending was in the form of emergency funding. Contingency funds were drawn upon or supplementary budgets were advanced. Accelerated contracting frameworks were put in place to speed up disbursement of needed funds. This helped ensure a rapid acquisition of supplies. However, shortcutting the usual budgetary and procurement processes introduces a greater risk of inefficiencies, such as unnecessary purchases or paying elevated prices (OECD, 2020[10]).

Indeed, internal evaluation and audit by some countries point to sub-optimal spending, especially early in the crisis. In Ireland, for example, an official review found that not following traditional procurement procedures led to a reported loss of more than EUR 370 million on personal protective equipment (PPE) (Health Service Executive, 2020[11]). In the United Kingdom, over 40% (GBP 22 billion) of the government's additional health spending commitments for COVID-19 in 2020 were allocated to the NHS Test and Trace Programme. However, a parliamentary report concluded that despite the significant resources spent, it appeared to have made little measurable difference to stem the spread of the virus (UK Parliament, 2021[12]). In Germany, the Federal Court of Audit stated that payments to hospitals to compensate for postponed activity in 2020 were not sufficiently targeted, leading to a substantial overcompensation of reduced hospital income (Bundesrechnungshof, 2021[13]).

These experiences during the pandemic demonstrated that short-term firefighting approaches, while necessary, were often inefficient, therefore emphasising the importance of a longer-term vision to strengthen health system resilience built on smarter spending. A recent major publication by the OECD, identified the pressure points in existing health systems, and estimated the additional funds needed to strengthen health system resilience (OECD, 2023[1]). Such additional spending was calculated to be equivalent to around 1.4%[2] of pre-pandemic GDP, on average, ranging from 0.6% to 2.5% across OECD countries, depending on existing country-specific provisions and spending levels (Figure 1.2).

Three broad priority areas to strengthen health system resilience were highlighted. Bolstering health professionals working on the frontline, accounting for half of this overall investment, at around 0.7% of GDP. Additional spending on preventive care could be expected to cost about 0.3% of GDP, on average. Foundational investments in core equipment and a digital transformation of health systems would cost a further 0.4% of GDP, on average.

Figure 1.2. How much would it cost to strengthen health system resilience?



Source: Morgan, D. and C. James (2023[14]), "Investing in Health System Resilience", https://doi.org/10.1787/648e8704-en.

These costs, set in the context of the pre-pandemic situation, would have amounted to around 9% of the total that OECD countries spent on health in 2019, or the equivalent of USD 460 per capita. To put this in context, this is similar to what OECD governments spent on prescription drugs in 2019. One might point to the 0.9 percentage point jump in the health spending to GDP ratio between 2019 and 2021 as a significant step towards this target. However, this increase was driven just as much by the significant fall in GDP and the emergency funding in response to the pandemic, rather than any long-term sustained and targeted spending plan. Indeed, 2022 has seen a subsequent drop in the health-to-GDP ratio in many OECD countries, and if direct COVID-19 spending is stripped out of the total, then average per capita health spending in 2022 is likely to have fallen below pre-pandemic trends (see Chapter 2).

…but finding sufficient additional funds for health in the current economic context is challenging

Despite the large sums spent on combatting COVID-19, many OECD countries continue to face significant health spending pressures now and in the short term. Part of these spending pressures reflect ongoing pandemic-induced backlogs for certain health services. This includes the impact of delayed care and treatment leading to the need for more costly care. For example, COVID-19 disrupted cancer prevention efforts and routine cancer care (Fujisawa, 2022[15]). Further, waiting times for elective surgery remain higher than they were pre-pandemic, across all countries with available data (OECD, 2023[16]).

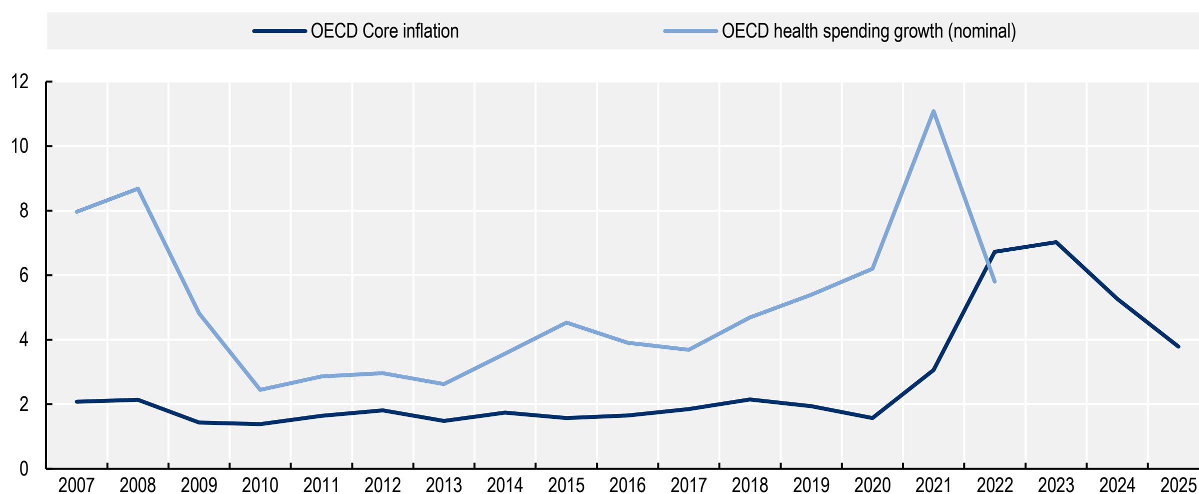
But even as backlogs start to clear, the current political and economic environment continues to have major consequences for the health sector (Spiegel, Kovtoniuk and Lewtak, 2023[17]). Competing priorities, such as the cost-of-living crisis, have squeezed health budgets, leading to a downturn in real health spending growth in many countries.

While inflation may have fallen from its 2022 peak, it has remained at higher-than-expected levels. This increases health provider input costs (e.g. for energy and food) with a knock-on effect of higher labour costs on top of the existing challenge to retain and attract health professionals. The Austrian Medical Chamber, for example, estimated that energy costs in outpatient practices increased by 500% in 2022 compared to the previous year (OTS, 2022[18]). The hospital federation in France predicted additional inflation-related costs of EUR 1 000 million for all public health providers (of which EUR 750 million for hospitals), with a further 600-650 million for long-term care facilities (Les Echos, 2022[19]). In Germany, the

hospital federation claimed additional expenses due to inflation of energy prices and other inputs of around EUR 15 billion for 2022 and 2023 (Deutsche Krankenhausgesellschaft, 2022[20]).

Yet finding the funds needed to maintain historical trends in health spending growth, let alone to strengthen health system resilience, is challenging. Examining health expenditure data shows that for average health spending growth to outpace OECD core inflation at the same rate as that observed over the period 2010-19 (i.e. post-global financial crisis and pre-pandemic) – that is, by around 2 percentage points – would have implied an average nominal growth rate in health spending across OECD countries in 2022 at around 8.5%, followed by a similar increase in 2023 and only dropping in 2024 and 2025, as projected inflation is set to stay well above pre-pandemic levels (Figure 1.3). After the exceptional growth in 2021, average nominal health spending growth in 2022 actually dropped below core inflation, resulting in an average real term decrease of 1.5%. While health budgets may be set to return to growth in nominal terms, they risk resulting in a cut in real term spending in the face of higher-than-expected inflation, at least in the short term (see Chapter 2).

Figure 1.3. Will health spending continue to outpace inflation in the short term?



Note: Projected core inflation for 2023 and 2024. Average OECD nominal health spending growth excludes Türkiye.
Source: OECD Health Statistics 2023, https://doi.org/10.1787/health-data-en; OECD Economic Outlook No. 114, https://doi.org/10.1787/62ec50a4-en.

In the coming decades, OECD countries face a dual challenge of upward pressures on health spending and constraints on government revenues

Looking further ahead, OECD projections show that over the next two decades, growth in health spending from public sources is likely to be twice the average growth in government revenues (in a 'base' scenario). This reflects underlying cost pressures such as rising incomes, population ageing, potential productivity constraints and technology. It also reflects constraints on the revenues that governments can expect to raise (these projection results are discussed in detail in Chapter 3).

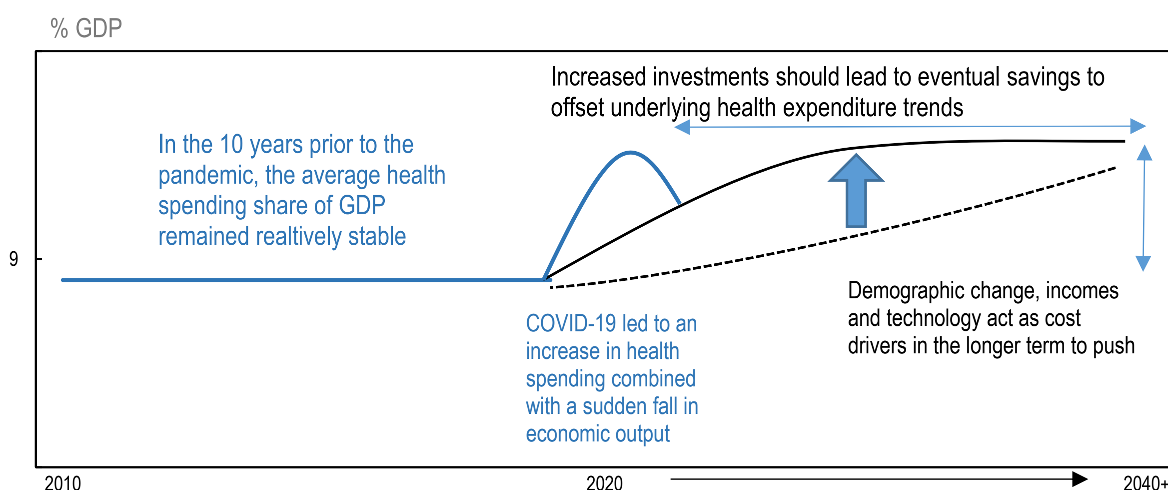
Growth in health spending is also expected to outstrip economic growth over this period, leading to a growing share of the economy allocated to health. Extending this base scenario to overall health spending could see an average 2.4 percentage points added to the pre-pandemic health-to-GDP ratio by 2040. That is, total health expenditure is projected to reach 11.2% in 2040, on average across OECD countries (up from 8.8% of GDP in 2018).

This base scenario does not include the additional spending needed to strengthen health system resilience. A long-term trajectory to include this additional investment would increase overall spending on

health in the medium term but could be expected to lead to a plateauing in the health spending to GDP ratio at some point down the line. This reflects that such spending should lead to eventual returns on investment, as illustrated in Figure 1.4. For example, OECD microsimulations estimate the effective implementation of cost-effective interventions to combat obesity and related unhealthy lifestyles. Overall, for each USD PPP invested in one of the policy packages, a return of USD PPP 1.3 to USD PPP 4.6 can be expected in the form of economic benefits (OECD, 2019[21]). Stronger and more resilient systems will also save many lives and help build stronger, more resilient economies.

Combining this additional spend on strengthening resilience to projections of health spending, total health spending is, without any other major policy changes, projected to increase by 3.0 percentage points compared to pre-pandemic levels, to reach 11.8% of GDP in 2040, on average across OECD countries.

Figure 1.4. Strengthening health system resilience – cost implications over time



Note: The blue line represents the 2010-19 average health spending to GDP ratio across OECD countries followed by the short-term impact of COVID-19. The black dashed line represents the projected increase due to underlying cost pressures such as demographic change. The solid black line indicates the trajectory resulting from increased investment in health system resilience.
Source: OECD Secretariat calculations, adapted from Morgan, D. and C. James (2022[22]), "Investing in health systems to protect society and boost the economy: Priority investments and order-of-magnitude cost estimates", Paris, https://doi.org/10.1787/d0aa9188-en.

1.3. Countries have four broad policy levers to finance more resilient health systems

Considering both the immediate pressures on the health budget (linked to high inflation and competing pressures on government budgets), and longer-term drivers of health spending (linked to population ageing, rising incomes, potential productivity constraints and technological change, and the need to spend more to strengthen health system resilience), questions about the fiscal sustainability of health systems are likely to become ever more challenging to address.

OECD countries have four broad (non-exclusive) policy levers to finance more resilient health systems:

1. Increase government spending and allocate part of these additional funds to health
2. Increase the allocation to health within existing government budgets
3. Reassess the boundaries between public and private spending
4. Find efficiency gains

The extent to which each of these options is feasible will depend on the economic context and relative political priorities, as discussed further below.

Policy lever 1: Increase government spending and allocate part of these additional funds to health

> *Dependent on the state of public finance, more feasible in countries with low tax burdens and debt levels*

This option requires either an increase in government revenues (mostly taxes) or additional debt financing. Yet many OECD countries have high levels of government debt, with associated higher costs of borrowing, which are important public finance constraints. Furthermore, trying to raise taxes during a cost-of-living crisis is politically challenging and unpalatable, at least in the short term. There may also be more scope to increase taxes that tend to reduce inequalities or target environmental improvement.

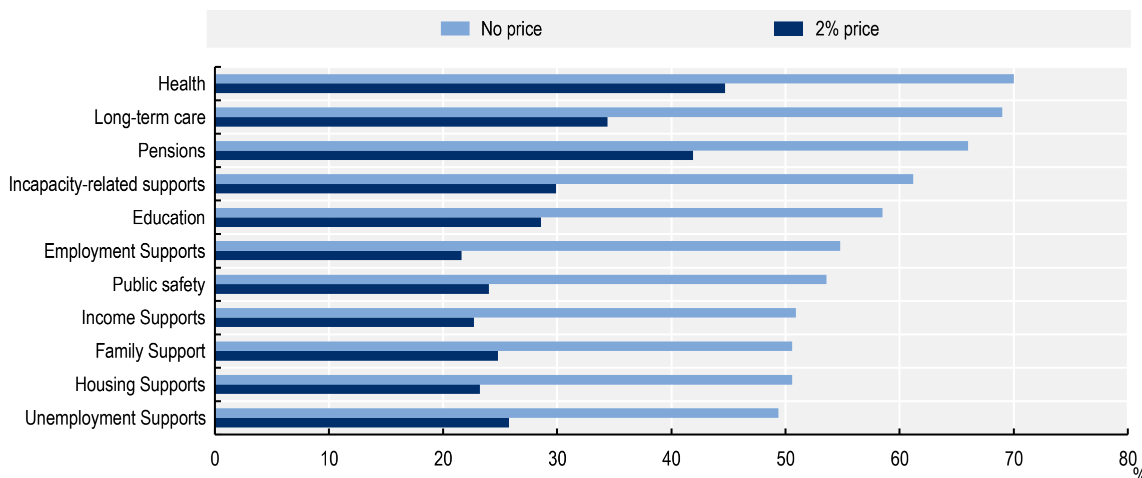
Countries could also raise more health-specific taxes, notably through increased social insurance contributions, notwithstanding concerns about reducing labour competitiveness. A key issue here is to assess whether the social insurance contribution base can be broadened, for example to cover pensions or personal capital income (if these are not yet included). Health taxes are also an option, and although they have proven health benefits in reducing consumption of harmful products, their revenue-raising potential here is far more limited due to a smaller tax base.

The OECD Risks That Matter Survey provides an insight on whether people are willing to support governments spending more on health and other social programmes, even when this means an increase in their tax burden or social contributions (OECD, 2023[23]). The latest survey results for 2022 show that health continues to be the area where respondents are most willing to increase government spending. On average, 74% of respondents said they supported greater spending on public health services – when primed with a general reminder of the costs of social programmes. With a specific price tag of an additional 2% of income in taxes and social contributions, support for more spending dropped to 43% on average, though this was still the highest level of support across all social programmes (Figure 1.5).

These survey results for 2022 are very close to the 2020 results (where the respective figures were 70% and 45% of respondents supporting more public spending on health). They demonstrate the high priority citizens continue to give to governments spending more on health, even during the current difficult economic climate.

Trends show that since the Global Financial Crisis and up to the pandemic, government spending growth has, on average, been slightly lower than GDP growth. However, the pandemic and subsequent economic downturn has led to expanded government deficits in many OECD countries. Across the OECD, while countries' borrowing needs have fallen since the peak levels during the pandemic, borrowing and debt levels remain much higher than pre-pandemic levels. In 2022, borrowing needs were 43% above the 2011-19 average, with total outstanding debt 10 percentage points of GDP above the average over that same period. Almost half of this debt will need to be repaid or refinanced in the next three years (OECD, 2023[24]). Higher levels of inflation have led to central banks increasing interest rates, further increasing the cost of borrowing for governments.

Figure 1.5. Willingness to spend more on health services as compared with other social programmes



Note: Results based on nationally representative surveys conducted in 27 countries in 2022. Results show unweighted cross-country average. Respondents were asked if they would like to see less, the same, or more government spending in these different social policy areas – first with a general reminder of the costs of social programmes (light blue bar), then with a specific price tag of an additional 2% of income in taxes and social contributions (dark blue bar).
Source: OECD Secretariat, using the OECD Risks That Matter Survey (2022), www.oecd.org/social/risks-that-matter.htm.

This difficult public finance context will constrain how much governments can increase government spending (particularly through deficit-financing), and consequently how much more public funds will be available for health and other sectors. Indeed, the current state of public finance in many OECD countries points to a sizeable share of any increase in government revenues needing to be used to reduce fiscal deficits and manage government debt. Whilst both the latest OECD and IMF outlooks for the world economy point to a slight improvement in GDP growth, as inflation moderates and real incomes strengthen, growth rates are uncertain and still projected to be below trend in the coming years (OECD, 2023[25]; International Monetary Fund, 2023[26]). This has knock-on effects to public budgets, given tax revenues are closely tied to economic growth.

Large increases in overall government spending will, therefore, be difficult to realise, despite the willingness of citizens for governments to spend more on health.

Policy lever 2: Increase allocation to health within existing government budgets

> *Dependent on political priorities, but more viable in countries with relatively low allocations to health*

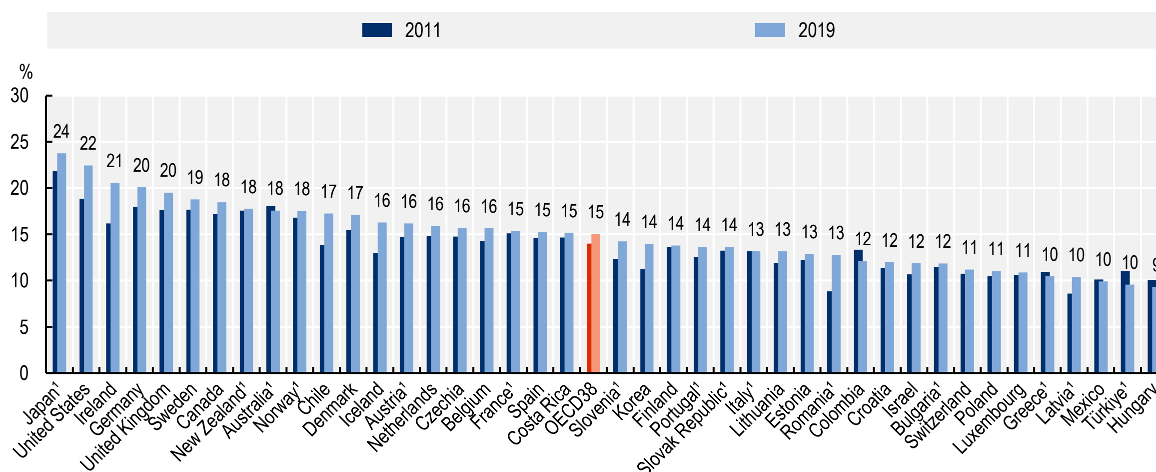
In contrast to the first policy lever, this option has a more neutral impact on the overall sustainability of public finance. Therefore, the extent to which this policy lever is viable depends more on political priorities than on fiscal sustainability concerns. Although the political landscape clearly is country-specific, in many OECD countries health is competing with some common new spending priorities. These include the rising direct costs of energy; government support for households and enterprises to (partially) protect them from rising costs; moves to invest more into the green transformation; and for some countries, a pressure for higher defence spending.

Historical trends provide some further insights. They show that the relative priority given to health in government budgets has, on average, seen a modest increase in 1 percentage point to 15% of total

government spending between 2011 and 2019. Even in 2020 and 2021, despite much higher public spending on health due to COVID-19 the share allocated to health did not increase significantly, due to increases in other government spending (see Chapter 2). Note that data include spending by social health insurance funds. Expecting large shifts in the relative priority afforded to health in government budgets therefore seems unlikely.

Nevertheless, in countries with comparatively low budgetary allocations to health, health authorities could use this as political leverage to push for increased budget allocations. This is most discernible for countries on the right-hand side of Figure 1.6 – Greece, Latvia, Mexico, Türkiye and Hungary – where health expenditure comprised around 10% or less of total government expenditure in 2019, an allocation substantially lower than the OECD average. Furthermore, Greece, Türkiye and Hungary also show some reduction in the relative allocation to health over the last decade.

Figure 1.6. Pre-pandemic trends in health expenditure from public sources as a share of total government expenditure



1. Public funding is calculated using spending by government schemes and social health insurance.
Source: OECD Health Statistics 2023, https://doi.org/10.1787/health-data-en.

Looking ahead, whether countries are willing and able to increase budgets for health – either through increasing overall government revenues and allocating large portions of this to health and/or the share of public budgets allocated to health – and if so, to what extent, is ultimately a political choice. This political choice will be shaped by societal preferences and constrained by economic realities, and how rapidly each of these can change.

Policy lever 3: Reassess the boundaries between public and private spending

While this option can free up government resources, it also entails major risks

Over the last two decades, the ratio of private to public spending has remained relatively constant, on average across OECD countries. However, this average trend hides some different patterns – countries that have in recent decades moved to expand or deepen health coverage have increased public spending on health and reduced private out-of-pocket payments over time.

- In Chile, for example, public spending on health increased from 3.5% of GDP in 2010 to 5.7% in 2019. This largely reflected the AUGE reform, designed to increase health services covered by public funds (Aguilera et al., 2015[27]).

- Similar increases in public spending were observed in Korea, where the benefit package was extended and deepened for services related to cancer, cardiovascular and rare diseases (Lee, Oh and Kawachi, 2022[28]).
- Costa Rica, Mexico and Türkiye also saw big shifts from private out-of-pocket payments to government schemes or social health insurance. All these country examples had in common a political drive to deepen health coverage.
- In contrast, countries with well-established universal health systems have seen the relative share of private spending go up since 2011, most notably in Greece, Italy, Spain and Portugal.

While a shift to greater private spending could reduce fiscal pressures, it is unlikely to contain overall health spending growth. Further, such a shift risks reducing access to and the quality of publicly funded healthcare, and exacerbating health inequities, with knock-on effects to the wider economy. Blanket increases in cost-sharing will impede access and increase the risk of financial hardship, particularly for the less well off (WHO Regional Office for Europe, 2023[29]). Increases in certain co-payments that include exemptions could be considered. However, these are unlikely to generate substantive revenues or cost-savings.

Alternatively, more spending could be channelled through voluntary health insurance. Although it does not carry the same financial risks as out-of-pocket payments, voluntary health insurance is often not offered at an affordable price for lower-income families and for people with underlying health conditions (Sagan and Thomson, 2016[30]). It therefore risks exacerbating inequities within health systems.

Nevertheless, a debate on longer-term directions on the public-private boundary needs to be had, particularly in terms of what are the best buys for limited public budgets. Better use of Health Technology Assessments (HTAs) will help ascertain if existing and new services, medicines, and medical equipment offer good value-for-money at current prices (Auraaen et al., 2016[31]). Consequently, HTAs can be used as the basis to exclude cost-ineffective interventions from public financing. Moreover, the public and private sector will need to collaborate to overcome health system challenges, such as eradicating diseases through health research programmes, modelled on the COVID-19 vaccine effort (World Economic Forum, 2023[32]).

Policy lever 4: Find greater efficiency gains

Can be a politically appealing solution, but requires bold reforms to deliver substantial cost-savings

Much of the OECD's work on health is geared towards analysing how countries can enhance value-for-money within their health systems. For example, the OECD report on "Tackling Wasteful Spending on Health" showed that there are areas of spending that do not deliver better outcomes, with up to one fifth of spending ineffective or wasteful (OECD, 2017[5]).

Proven approaches to increase productivity include policies on health workforce, pharmaceuticals, and new technologies. For example, laws and regulations that extend the scope of practice for non-physicians (such as nurses and pharmacists) can produce cost savings with no adverse effects on quality of care (OECD, 2020[33]). For pharmaceuticals, price, market entry and prescribing regulations have all helped increase penetration of generics in the market, thereby saving costs. Digitalisation can support new care delivery models, notably in the form of telemedicine and robotic tools for some limited procedures, with better use of health data improving the management of critical care resources (OECD, 2023[34]). Reducing harmful clinical decision-making should also be a priority, with policies to reduce medical errors, the inappropriate use of antimicrobials, and unwarranted variation in medical practice all having a large impact on improving the effectiveness of health spending. Finally, from a tax policy perspective, countries with

subsidies for additional voluntary private health insurance could consider removing or reducing these subsidies and use these to help finance the health budget.

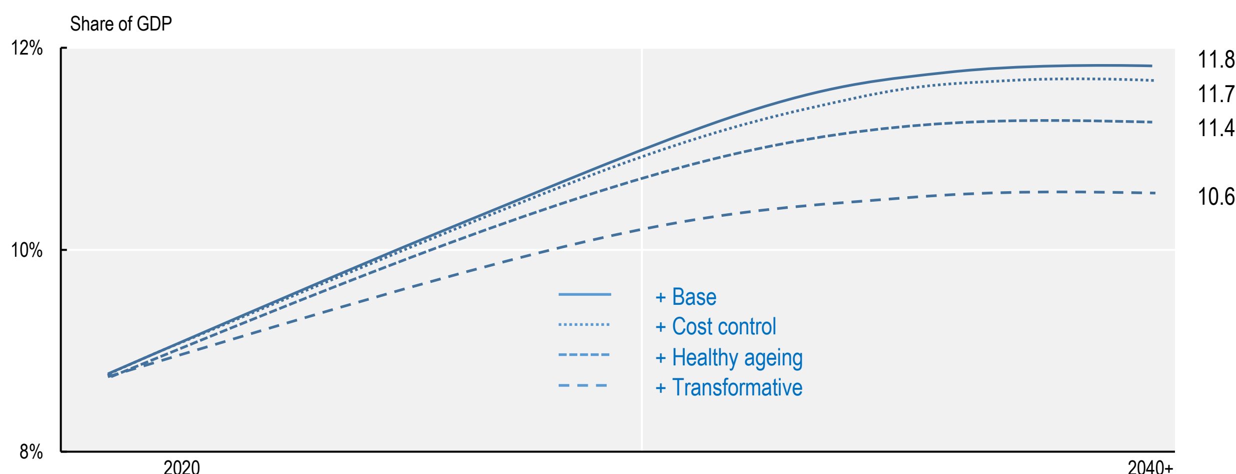
Such bold efforts to cut waste are required, since a conservative approach to improve efficiencies in the health sector is unlikely to yield sufficient savings. For example, when the latest OECD projections examine health spending growth under a 'cost control' scenario as compared to the 'base' scenario, only very modest savings are generated. This cost control scenario reflects effective policies to increase productivity and rein in some healthcare demand. Applying this to total health expenditure, on average these savings shave only 0.1 percentage point off the health-to-GDP ratio by 2040 of GDP. With additional spending on strengthening health system resilience, total health expenditure is therefore still projected to increase to 11.7% of GDP on average (as opposed to 11.8% of GDP) in 2040.

Policies that improve healthy ageing are expected to provide somewhat larger savings. Applied to total health expenditure, they are expected to cut just over 0.4 percentage points from the projected 2040 share of GDP. Such policies include actions to promote healthier lifestyles both within and beyond healthcare. For example, cost-effective alcohol prevention policies include taxation, regulations on opening hours, advertising and drink-driving, alongside primary care interventions within the health sector (OECD, 2021[35]). Many of these public health measures are included in the pinpointed smart investments to increase resilience, therefore these cost savings are expected to be realised as part of the roll-out of the additional spending. While welcome, these are not enough in themselves to fundamentally alter the upward trajectory of health spending. After additional spending on strengthening resilience, total health expenditure is projected to increase to 11.4% of GDP on average in 2040.

More ambitious and transformative policy changes are therefore needed to rein in health spending growth whilst still strengthening resilience and maintaining high quality, accessible care for all. If countries are successful in eliminating half of the ineffective and wasteful spending identified in earlier OECD analysis, then significantly larger cost savings can be realised – equivalent to 1.2 percentage points of GDP. This leads to a far more modest increase in total health expenditure, to an average of 10.6% of GDP in 2040.

Figure 1.7 shows the effect of these different scenarios on the trajectory of health spending, with Box 1.2 providing further details on the approach used to produce these results.

Figure 1.7. Financing more spending on resilience: the impact of different 'efficiency' scenarios



Note: Resilience spending is assumed to reach a maximum level by 2035 after which the annual ongoing spending on resilience is offset by a reduction in the underlying spending under each scenario, such that the resulting health-to-GDP ratio remains constant.
Source: Authors' calculations.

Box 1.2. Combining resilience spending and health spending projection scenarios

Projected health spending to 2040 is derived from the average projection of public spending based on 33 OECD countries (as detailed in Chapter 3) and expanded to cover total health spending (public and private) for all 38 OECD countries. That is, the private share of health spending is assumed to grow at the same rate as public spending for OECD countries as a whole over the period 2018-40. This assumption is based on a review of historical changes in which the overall public-private share of spending did not significantly change between 2003 and 2018.

The average projected annual growth rates in health spending (under each scenario) and GDP are assumed to be constant over the projection period up to 2040.

The increase in health spending is combined with an incremental linear increase in the additional investment expenditure to reach the maximum level equivalent to 1.25% of GDP by 2035, noting that the other 0.13% of GDP is attributed to capital spending and thus separate from recurrent spending.

From 2035 onwards, the additional spending on resilience is assumed to offset the underlying increase in health spending (under each scenario) such that the health-to-GDP ratio remains constant thereafter.

The 'cost control' scenario assumes an increase of 20% in productivity (compared to a 10% increase in productivity in the 'base' scenario) and a decrease of 10% in the income elasticity of health spending over the projection period. The 'healthy ageing' scenario assumes that all gains in life expectancy over time are spent in good health rather than in ill-health. Further details on these scenarios can be found in Chapter 3.

The final 'transformative' scenario assumes that countries are successful in eliminating half of the ineffective and wasteful spending identified in earlier OECD analysis in an incremental way, such that this reaches a reduction of 10% of total health spending by 2035 and remains at this level thereafter.

It is important to note, though, that even if some or all of these efficiency gains are realised, country experience indicates there is no guarantee that such gains will automatically feed back into additional budgetary space for health. The risk from a health system perspective is that efficiency gains are instead used to fund non-health government spending, thereby resulting in budget cuts for health (Barroy et al., 2021[36]). To avoid such an outcome, good budgeting practices for health – as discussed further in the following section – are essential, ensuring there are clear processes and an agreement between health and finance authorities on how any cost-savings are used.

These four policy levers are not mutually exclusive

The first two policy levers outlined above – increasing overall government spending and/or existing budgetary allocations to health – raise additional public funds for health. While the last two policy levers – reassessing public/private boundaries and seeking efficiency gains – can free up resources from existing health spending.

While each of these policy levers entail different economic and political risks, all four policy levers can be considered together. That is, they are not mutually exclusive. Rather, it is more about the extent to which each of these options are pursued to ensure sufficient resources for health, rather than being a binary decision-making process. Indeed, in discussions within the OECD Joint Network of Senior Budget and Health Officials, some participants noted how recent agreements on additional funding in priority areas were tied to structural reforms that aimed to find cost-savings. In Canada, for example, the federal government put forward a ten-year funding plan to increase healthcare investment by almost CAD 200 billion. Part of this new federal funding was provided through tailored bilateral agreements to

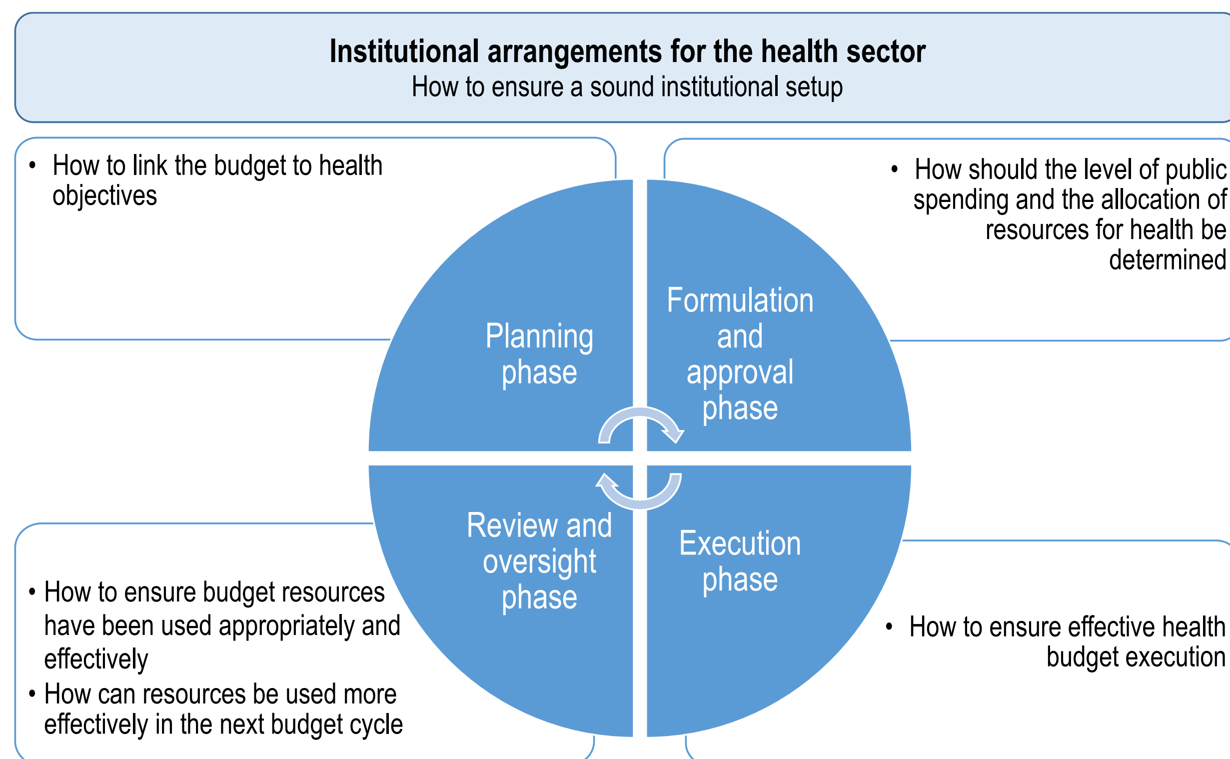
priority areas, which included commitments to efficiency-focused reforms, notably efforts to modernise health data collection and reporting (www.canada.ca/en/health-canada/services/priorities.html).

Ultimately, the choices made by policy makers will be influenced by the political and economic feasibility for change in their country, especially in the short to medium term.

1.4. Good budgeting practices facilitate a better dialogue between finance and health authorities on how to finance more resilient health systems

In this challenging context, an effective dialogue between finance and health authorities is critical, so that a fiscally sustainable solution to fund more resilient health systems can be agreed. Such a dialogue takes place within the budget process, from planning and negotiations for setting the upcoming budget, through execution of the budget, and to a review phase that then feeds into the next budget cycle (Figure 1.8). This includes decisions on government transfers to social health insurance funds, in countries where health insurance is the principal purchaser of health services.

Figure 1.8. Good budgeting practices for health throughout the budget cycle



Source: Vammalle, C., C. Penn and C. James (2023[37]), *Applying Good Budgeting Practices to Health*, https://doi.org/10.1787/b280297f-en.

Budgeting is not simply about controlling spending. Rather, good budgeting practices facilitate realising health policy objectives whilst respecting fiscal sustainability – with a focus on maximising the efficiency and effectiveness of spending.

High-level insights and recommendations are summarised below, with Chapter 4 analysing in detail budgeting practices for health in OECD countries, and Chapters 5 and 6 focusing on specific aspects (medium-term financial planning and programme/performance budgeting for health respectively).

An effective budget process improves decisions on whether, when and by how much public funding for health can increase

The pre-budget agreement stages of the budget process are important in reaching agreement on the budget for health. Within a 'planning' phase, the medium- and longer-term spending needs for health are set out. Building on this, in a 'formulation and approval' phase, the overall level of public spending on health for the upcoming budget year is set, and how resources will be allocated across different health policy areas and priorities. Good budgeting practices across these two phases help finance and health authorities decide together on how much to allocate to health. High-level recommendations include to:

- Develop medium-term health expenditure projections that are grounded to the budget process, reflecting baseline needs and the impact of policy decisions
- Develop medium-term revenue projections for health (when relevant), and compare with expenditure projections to assess the extent of any funding gap
- Specify the medium-term priorities for health in a way that is coherent with the budget by estimating their financial impact
- Use medium-term expenditure frameworks for health as a tool to link funding to medium-term priorities
- Ensure consistency with national fiscal constraints when developing estimates of budgets for health
- When evaluating health expenditure needs, distinguish between the baseline (the cost of maintaining current coverage and quality levels) and new policy proposals
- Consider using explicit criteria to facilitate discussion on the overall level of health expenditure

An effective budget process improves how well the health budget is spent

Good budgeting practices across the full budgetary cycle can help countries to realise efficiency gains for health. Pre-budget agreements help ensure allocation decisions reflect current priorities (rather than being solely based on a historical and incremental basis). Then once the health budget has been approved, timely execution and monitoring of health spending and appropriate review mechanisms help ensure funds are spent as planned and contribute to strategic health objectives. High-level good budgeting practices recommendations include to:

- Classify the health budget into programmes that align with strategic priorities of the health sector (avoid pure input-based budgeting). This includes incorporating performance information within or alongside the budget
- Release funds as allocated in the health budget, with a clear disbursement schedule
- Monitor health expenditures during the fiscal year in a timely manner, to allow for the early implementation of correction mechanisms to keep the budget on track
- Produce health accounts to provide a comprehensive and consistent view of health spending over time
- Provide independent fiscal and audit institutions with a mandate to review health expenditures, to promote greater transparency and accountability
- Integrate spending reviews as part of the budget preparation process, rather than on an ad hoc basis, ensuring that results of the review feed into formulation of the next budget

1.5. Conclusions

Finding sufficient resources to fund stronger, more resilient health systems is challenging both in the current economic climate and looking further ahead. In the short term, tight public finances, exacerbated by high inflation and fragile economic growth, limit the scope of governments to increase spending,

including on health. There are also many competing urgent priorities, including protecting vulnerable households from the cost-of-living crisis, and the need to invest more into the green transformation. Longer term, cost pressures from ageing societies and rising incomes and population expectations will continue to exact from public resources which themselves are expected to be subject to shrinking revenues.

This context does not mean that change is impossible. But it does require political leadership that balances the financial constraints with the need for additional funds. To this end, dialogue between health and finance authorities is critical. Finance authorities should set out clearly the fiscal constraints within which they are operating. Health authorities need to demonstrate the wider benefits – of good health and healthcare being a driver of economic growth, and resilient health systems critical to protecting society in the face of future shocks – alongside the intrinsic value of better health. Health authorities also need to reassure finance authorities that any additional funds will be spent effectively, and at the same time demonstrate their commitment to take bold action to cut wasteful spending. The rewards from the transformative power of AI and digital tools across the health sector need to be fully realised.

Health and finance authorities alike must be cognisant of the risks of governments not spending enough on health, including knock-on effects beyond the health sector. How much governments spend on health, though clearly shaped by economic constraints, is ultimately a political choice. But good budgeting practices for health informs the political debate, by showing what is fiscally feasible, where additional funds should be concentrated, and how efficiency gains can be part of the funding solution.

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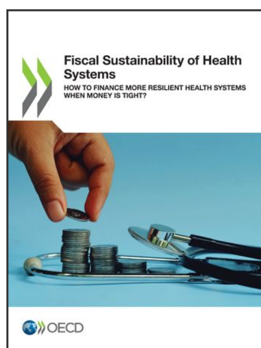
Notes

[1] In this chapter, the term 'health authority' refers to the government agency/agencies that are primarily responsible for the health system. This is typically the ministry of health and/or social health insurance fund. 'Finance authority' refers to the government agency responsible for the overall government budget at the national level. This is typically the ministry of finance, treasury, or central budget authority.

[2] Of the 1.4%, 1.25% of GDP on average is allocated to an increase in annual recurrent spending and 0.13% of GDP as an annual increase in capital spending in the health system.



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