1st Health Systems Joint Network Meeting for Asian Countries

Tokyo, 15-16 May 2017

Synthesis note

OECD

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1st HEALTH SYSTEMS JOINT NETWORK MEETING FOR ASIAN COUNTRIES

The financial sustainability of health systems – improving the dialogue

15-16 May 2017, Tokyo, Japan

Organised by the OECD, the Asian Development Bank Institute; the Asian Development Bank; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Organization of Economic Cooperation and Development; the World Bank; and the World Health Organization

SYNTHESIS NOTE

In 2015, countries in the Asia region adopted the Sustainable Development Goals (SDGs), committing to "Ensure healthy lives and promote well-being for all at all ages" (SDG No. 3). Furthermore, an increasing number of the countries in the Asia region are making commitments to Universal Health Coverage (UHC) by 2030. In the context of ageing populations, slowing global economic growth rates, and growing demand from citizens for access to quality healthcare, the UHC goal will place considerable pressure on the national budget, and will require a carefully balanced strategy to achieve equitable expansion of health coverage while ensuring fiscal sustainability. In addition, for a number of countries in the region which have traditionally relied on external aid to finance some of their health programmes, economic development and transition from such a support also requires strengthening national health financing systems.

The OECD, in collaboration with the Asian Development Bank, the Global Fund, the World Bank and World Health Organization, convened the first meeting of the Joint Network of Senior Budget and Health Officials on Fiscal Sustainability of Health Systems for the Asia Region. This policy dialogue brought together budget officials from the finance and health ministries to discuss challenges in health system budgeting, and identify effective policies to ensure the financial sustainability of health systems in the context of changing demographic, epidemiologic and economic conditions.

The meeting gathered 53 participants from 12 countries (Australia, Bangladesh, India, Indonesia, Japan, Korea, Lao PDR, Myanmar, New Zealand, Philippines, Thailand, Vietnam) and international organisations. Participants were primarily high-level officials from health and finance ministries with a specific knowledge on budgeting and health financing.

The following topics were explored in depth:

- How is the **health financing system** organized and governed and how does this affect the costs of health care? Who are the main actors (including social security agencies and local governments), and how are the operational and financial responsibilities shared among them?
- How is the health sector **budget formulated**, approved and monitored? How does the governance structure influence how the budget is allocated and the availability of funding?
- How is **execution** of the budget managed and supervised? What are the major constraints to efficient budget execution? How are budget execution and the effect of spending monitored and evaluated?
- How can smart budgeting practices improve health system **performance**? Can performance-based budgeting lead to better health outcomes?
- Special thematic sessions addressed the concerns of: (a) **countries in transition from external support** to help them develop sustainable responses for epidemic control and successful transition; and (b) **countries facing ageing populations** to help develop fiscal policies and strategies to manage the mounting costs and demand for healthcare.

Opening Remarks & Session 1. Introduction and Overview

The importance of an effective dialogue between health and finance officials to ensure sustainable universal health coverage was stressed by all agencies in their opening remarks. Central to this was a well-structured budget process, where public financial management rules not only ensure financial transparency and accountability, but also are not so rigid as to impede health service delivery. The additional complexities of countries in transition from external resources were also emphasised.

This session also set out the objectives of the meeting and provided an overview of the OECD Joint Network on Fiscal Sustainability of Health Systems. In a round table, country participants and international partners also raised some of the key issues they wished to discuss during the meeting. These included implications of the budget process for health, and a particular interest in transition – on how to financially adapt to changing demographics, and for low and middle income countries on how to transition from reducing external assistance.

Main panellists

- David Dole, Asian Development Bank Institute
- Jon Blondal, Head, Budget and Public Expenditures Division, OECD
- Michael Borowitz, Chief Economist, The Global Fund to Fight AIDS, Tuberculosis and Malaria
- Ajay Tandon, Lead Health Specialist, the World Bank
- Ke Xu, Coordinator, Health Policy and Financing, World Health Organization Western Pacific Regional Office
- Ivor Beazley, Chris James and Akiko Maeda, OECD

Session 2 Structure and Governance of Health Financing System

There is great variation in the structure and governance of the health financing systems in Asia: while some countries rely more on general tax revenues, others depend on social health insurance or mandatory private health insurance schemes. Private, out-of-pocket payments for health services play a significant role in financing health systems in Asia, and voluntary private insurers are also becoming a growing presence in a number of countries. This session explored the challenges faced by countries in response to major policy changes and reforms to the structure and governance of the health financing systems.

Key messages

- Many countries have multiple financial schemes reflecting programmes which had been developed to meet the needs of different population groups and for types of services. This can create difficulties in coordinating, monitoring and improving performance across the health system. Some countries have moved toward consolidating the multiple schemes under a unified programme (Indonesia), while others are investing in developing a common performance framework for measuring patient outcomes (Australia).
- In Australia, the Commonwealth (central government) and the States and Territories have varied responsibilities in the funding of different types of health services, resulting in a complex and fragmented health financing system. With the ageing population and rising cost of care, there is a heightened urgency to measure and evaluate the impact of reforms on the overall fiscal burden. The Commonwealth is investing in initiatives to develop and strengthen health performance framework to monitor and evaluate the impact of value-based reforms to improve patient outcomes that are intended to improve health outcomes and ensure the system remains fiscally sustainable.
- In the Philippines, the additional revenue from the Sin Tax has significantly expanded the overall health budget, yet the Department of Health has faced capacity limitations and has

been unable to execute the full budget. Part of the challenge lies with fiscal decentralization, which has devolved the provision of local health services to the Local Government Units. Health budget is not a required allocation and it is left to the CEO of each LGU to decide on their local priorities. Although funds are available for financing healthcare, in many communities the shortage of health workers and lack of health care service providers limit the use of those funds. Segmentation of responsibilities for various health programmes between LGUs and Department of Health also point to the structural problems in ensuring an effective allocation and use of budget.

- Indonesia recently consolidated its multiple health financing schemes under the Universal Health Insurance programme, and has expanded the overall size of the health budget. However, Indonesia also faces difficulties in achieving full budget execution. As in the Philippines, part of the challenge lies with the decentralization of health care services and division of responsibilities between the central and the provincial governments. The central government is developing a common approach across the provinces to measure health systems performance to inform budget allocation decisions.

Main panellists

- **Structure & Governance of Health System Financing: an Overview** - Akiko Maeda, OECD
- **Health Care Financing in the Philippines** - Achilles Gerard C. Bravo, Undersecretary of Health, Office for Administration, Finance and Procurement, Department of Health, Republic of the Philippines
- **Fiscal Sustainability of the Health and Aged Care System: The Australian Health System – Governance and Financing -** Shannon White, Assistant Secretary, Health System Financing, The Department of Health, Australia
- **The Indonesian Health System: Governance and Financing** - Purawanto, Director of Budget of Human and Culture Development Sector, Directorate General of Budget Ministry of Finance

This session was moderated by Lluis Vinals Torres, Health Financing Regional Officer, Southeast Asia Regional Office of WHO.

<u>Session 3 Budget Planning, Formulation and Execution</u>

This session examined alternative processes for budget formulation and different budget structures. In particular, it aimed to understand the sequence and the complex interactions that take place during the various stages of the budget formulation process for the health sector, the roles played by key actors, and how these various factors affect allocation decisions and health expenditure levels.

Key messages

- The budgetary process for health is complex because of the many stakeholders involved. Alongside central finance and health ministries, social security agencies and sub-national governments also play a key role in many Asian countries. In some countries, development partners also contribute significant funds, but in doing so add another layer of complexity. This multitude of actors makes budget planning and formulation challenging. In this regard, establishing clear lines of accountability is a difficult but crucial way of improving the effectiveness of the budget process.
- Poor budget execution is also a concern in many countries. It worsens service delivery by delaying, or limiting flexibility of, funds to frontline health providers. This is often due to rigid public financial management rules, and health providers not always having the authority to manage budgets.

- In most of the non-OECD countries present, under-spending relative to the budget is a major issue, notably in the areas of capital spending and procurement. Yet at the same time overall allocations to health are often low. Some of the main reasons identified for under-spending were poor infrastructure planning, complex procurement processes, very detailed budget lines with inflexibility to move between these budget lines, and capacity constraints in public financial management.
- In New Zealand, budget planning includes both medium and long-term perspectives. The central health ministry and district health boards are required to prepare 4-year plans, based on provided spending envelopes and reflecting specific financial pressures they are facing. Long-term planning includes projections of health care spending for the next 40 years, taking into account key cost drivers. But in practice the budget process is focused on the forthcoming year and on marginal expenditure, with little attention to the base such as spending on core staff and other essential operational expenses.
- In Lao PDR, the budget process has become more centralised since 2013. Priority and sub-priority programmes are clearly defined, and the budget planning stage includes all levels of government for health, with a clear reporting logic (e.g. plans by health centres and district hospitals consolidated by district health offices). However, the reality is that in Lao PDR most of the public budget is allocated to personnel, leaving little budget for other operating costs. Budget lines are closely monitored but delays in budget execution is a major concern, with important resources only being received late in the year.
- In Myanmar, the budget formulation process involves many layers of scrutiny, and is a mix of bottom-up planning and top-down budgeting. This has improved stakeholder engagement and transparency of budget allocations. However under-execution of the received budget remains a significant challenge, especially for capital expenditures.

Main panellists

- **Budget planning, formulation and execution in the health sector.** Chris James, OECD.
- **Long-term budget planning and projections in New Zealand.** Ben McBride, Manager, Health and ACC, Treasury, New Zealand.
- **Lao PDR's processes of budget planning, formulation and execution.** Kotsaythoune Phimmasone, Deputy Director General, Department of Finance, Ministry of Health, Lao PDR.
- **Budget management in Myanmar.** Naw Wilmar OO, Director, Budget Office, Ministry of Planning and Finance, Myannmar.

This session was moderated by Soonman Kwon of the Asian Development Bank.

Session 4 Performance budgeting, spending reviews and program evaluation

The session looked at performance based budgeting, how this approach can contribute towards improved management of resources and achievement of health outcomes, how it is working out in practice in OECD countries, and what issues need to be taken into consideration in the health sector.

Key messages

- Performance budgeting is a reform that has been widely adopted in OECD countries, but it has remained a challenging reform to implement and the benefits have often not matched the original expectations.
- Evidence from OECD countries suggests that performance budgeting works best through creating greater transparency and accountability for results, rather than when it is used as a tool for reallocating expenditure, but countries should define what they want to get out of it.
- Other budget processes, such as MTEFs and spending reviews may be more effective for reallocating resources.

- In-depth programme evaluation is essential to understand the reasons for under or over-performance and the correct responses. These may be policy changes, management changes, institutional changes or changes to budget resources, or any combination of these.
- Performance measurement creates its own implicit and explicit incentives. Incentives around performance need to be chosen carefully and monitored in a way that minimizes the risks of gaming behaviour, or even fraud. Generally softer management type incentives seem to work better than financial rewards and sanctions.
- Where PB has achieved better results, this seems to be associated with defining a fairly narrow set of priority objectives that enable politicians and managers to remain focused.
- Goals and indicators that aid comparability, for example international benchmarks related to health, and indicators that enable performance to be compared across regions, hospitals etc. are more likely to create positive incentives (peer pressure) to improve performance.
- Future efforts to contain health care costs are likely to depend on strategic policy shifts, such as promoting healthy ageing, that require joined up approaches.

Main panellists

- **Performance budgeting, spending reviews and program: an overview** – Ivor Beazley, OECD
- **New Zealand's approach to performance budgeting and how this works in the health sector** – Ben McBride, Manager, Health and ACC, Treasury, New Zealand.

This session was moderated by Ajay Tandon of the World Bank.

Session 5 Group Discussion

In this session, countries discussed in greater depth the major bottlenecks to an effective budgetary process for health, from both health and finance ministry perspectives. Each country was then asked to highlight one or two key challenges they face. Some of the common challenges voiced by countries included:

- A *lack of predictability* in the overall budget to be received. This included for certain countries significant cuts at the end of the budget process, after the planning and formulation phase. Large differences between medium-term expenditure framework indicative budgets and actual budgets received were also noted.
- *Structural rigidities.* For budget planning, this included strict ceilings for certain types of spending (e.g. low ceilings on the share of the budget that can be spent on personnel). For budget execution, rigidities are particularly notable in terms of complex procurement and infrastructure rules, and hiring procedures.
- *Delayed and misaligned budget submissions*, particularly between different levels of government, were also commonly voiced problems. Fixing budget timelines so that central and local government planning occur at a similar time was one suggested quick-win that would improve alignment and reduce delays.
- *Inadequate justifications* of why additional funds are needed and how these funds will be used ("telling the story behind the programme"). This includes providing better supporting documents that are transparent on why increases are needed, and why certain programmes were given priority.
- *Capacity constraints.* A more general point raised was not having enough staff skilled in public financial management, particularly within Ministries of Health. This adversely affects all aspects of the budget process, from planning and formulation through to budget execution.

Special sessions on Fiscal Sustainability and Transition

Sessions were held on fiscal sustainability and transition in light of (1) reduced external assistance for HIV/AIDS, TB and malaria programmes, and (2) ageing societies. These sessions were introduced in the morning in plenary, with more detailed discussion in parallel afternoon sessions.

Main panellists for plenary session

- **Conceptualizing the Health Financing Transition.** Ajay Tandon, World Bank.
- **Sustainability and Transition - Why? How? When?** The Global Fund.
- **Fiscal sustainability in an ageing society.** Akiko Maeda, OECD.

This session was moderated by the Global Fund.

1) Afternoon session on fiscal sustainability and transition from reduced external assistance

As countries shift from low-income to lower and upper middle income countries, external assistance is expected to decline. A key policy challenge facing countries is that of strengthening their health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to UHC while effectively managing the transition from external financing.

This session provided information on how the World Bank, The Global Fund, Asia Pacific Leaders Malaria Alliance (APLMA) and UNAIDS aims to support sustainable responses for epidemic control and successful transition. We also heard from Japan on their experiences in strengthening their health systems through disease programs like Tuberculosis.

Main panellists

- Geir Lie, Health Financing Specialist, The Global Fund to Fight Aids, Tuberculosis and Malaria - Facilitator
- Hon Keizo Takemi, Member, House of Councillors, Japan - T-Shaped Approach to strengthening health systems through disease programs like Tuberculosis: The case of Japan
- Emiko Masaki, Senior Economist, The World Bank - Integrating Externally-financed Health Programs: Lessons from East Asia and Pacific Countries.
- Benjamin Rolfe, Executive Director, and Patrik Silborn, Senior Director Resource Mobilization and Health Financing, Asia Pacific Leaders Malaria Alliance (APLMA). - Financing and malaria elimination in the Asia Pacific, Transitions, Options including scope for grant/loan/blended financing
- Nertila Tavanxhi, UNAIDS - Challenges of integrating HIV & AIDS services into health financing systems

Key Messages

- Targeting of investments to disease-specific vertical programs and targeting the broader goal of health system strengthening should not be divided, such a division is a false dichotomy because the two are strongly interdependent
- Disease-specific approaches are important not only in relation to their core goal of fighting communicable diseases but also as entry points to strengthening health systems and promoting UHC. It is not a choice between vertical or horizontal or a compromise (diagonal) but rather two strong lines that depend on each other
- National ownership and political commitment are imperative for a sustainable transition away from reliance on external resources, as is close collaboration between government and international partners
- As countries prepare plans to manage the transition process, both the fiscal and programmatic responsibilities previously supported by donors, countries will need to put in place

mechanisms to be able to contract with NGOs to manage prevention for key populations through the public financial management system, be able to procure drugs through national systems at affordable price and quality, and they will need governance arrangements to ensure on-going representation of NGOs.

- As country grow and develop, countries are experiencing a "health financing transition": an increase in the level of total health expenditures accompanied by a rise in the prepaid/pooled share of total health expenditure, while access to development assistance falls. Health financing transition varies by country both the level and the pace but often coincides with major reforms and change in health and health systems. Therefore, the transition needs to be carefully managed.
- Transition from external financing can entail challenges in both financial and programmatic sustainability. Financial sustainability implications of transition from external financing are different and non-linear across countries. Efficiency in how revenues are both raised and spent is a key in helping realize additional public financing for health during the transition.
- Implementing countries are still heavily reliant on external financing, especially from the Global Fund, which finances over 50 % of all malaria expenditures in the region. Medium to long-term external grant support to the region will decline. Transition is not only about replacing external resources for domestic resources, but it also about sustaining programs that work. Programs addressing key populations affected by malaria and communicable diseases are often delivered by community-based organizations and financed by external actors. Even when countries are ready to take over the costs of such programs, there are often barriers that prevent the public sector to contract with non-public sector providers. This means that preparing for transition takes time, and must involve other actors beyond Ministries of Health, e.g. legislators, MOF, etc.
- It is critical to anchor the malaria elimination goal, as well as other communicable disease goals, in broader domestic health financing strategies including in the emerging UHC agenda and in the health security agenda. This is particularly true for MICs and UMICs, which are increasingly focusing on addressing NCDs for the urban and emerging middle-class. Key population disproportionally affected by communicable disease risk being left behind if communicable diseases are not part of UHC.
- Increasingly important to identify efficiencies in malaria and health financing and programming. Declining levels of grant financing and the emergence of new technology will be two important drivers.
- Issues around integration of HIV financing into broader health financing can be group around: 1) the off budget external aid reliance of HIV financing with parallel systems of financing, service delivery and purchasing; 2) the public and private good nature of HIV responses; 3) the key population effect in concentrated epidemics typical in Asia; 4) the treatment liabilities and entitlement effect in generalised epidemics typical in Africa.
- The off budget execution of donor external assistance through parallel systems creates problems with pooling of resources and for as long as donor resources are not pulled with country own resources integration of financing will be difficult.
- HIV response is comprised of both private and public goods - while private goods can be easily delivered through an insurance type health financing scheme (e.g. treatment), there have to be provisions through dedicated financing streams for the public goods, which normally cannot be delivered through an insurance type scheme or sometimes even fall outside the health system (e.g. behavioural change interventions, adherence groups).
- In concentrated epidemics, the disease is concentrated in key populations which normally will not get any priority in government funding and have low rates of enrolment in social/health insurance schemes - provisions will have to be made so that this people access the available services and this can range from contracting with tailored providers to changing the personal information requirements of insurance entities.

- In generalised epidemics, the existence of international aid has enabled access to treatment to many people. Once these people are initiated with treatment with almost non-existent co-payments the governments become liable to related costs and patients become entitled to get the services under similar conditions. This can place real burdens on financing schemes/ premiums and direct government transfers should be considered to mitigate the effects

2) Afternoon session on fiscal sustainability in an ageing society

Asia is undergoing one of the most profound demographic shifts in the world. The speed and scale of change in the region is creating, and will continue to create, significant health, social and economic challenges. Current health systems of Asia and the Pacific need to be transformed to respond to the complex health and social needs of older people, ranging from home-based care and support for functional disability to institution-based intensive medical interventions, rehabilitation and health management. Healthy ageing, the management of the end stage of life, community-based care system, and the coordination of care between health, long-term care and social services are emerging as important determinants of fiscal spending in an era of ageing societies.

Among many countries in Asia, long-term care for older people has been provided by family care givers (informal care providers). With the increasing labour participation of family members and erosion in traditional family structures, the role of the state is becoming crucial in the financing and provision of long-term care. Most OECD countries have introduced some form of social insurance or subsidies through general taxation to finance long term care. Japan and Korea, for example, introduced social insurance for long-term care, while New Zealand relies primarily on general taxation. The rapidly growing burden of healthcare and long-term care is putting a great strain the budget systems of most OECD countries.

Many OECD countries are seeking new approaches to achieve a more effective and fiscally sustainable care system with better coordination between health services, long-term care and other social services. As many of the emerging economies of Asia are also facing an ageing population, it would be timely to examine the fiscal implications of ageing societies in Asia, and explore possible solutions to this shared challenge.

Main panellists

- **Overview of Ageing, Health System and Long-Term Care in Asia.** Soonman Kwon, Technical Lead (Health), Asian Development Bank.
- **Fiscal Sustainability of Health Care in Ageing Societies – OECD Perspectives.** Akiko Maeda, Senior Economist, OECD.
- **Ageing population and Healthcare System in Japan.** Junichi Izumi, Director, Ministry of Health, Labour and Welfare, Japan.
- **Fiscal Sustainability and Ageing in Low- and Middle-Income Countries.** Sarah Barber, Director, WHO Kobe Centre.

Key messages

In developing an effective strategy for fiscal sustainability in an ageing society, the following points should be addressed:

- Ageing populations will lead to a decline in revenue base (smaller working population) and an increase in health spending, Countries will need to be pro-active in developing long-term strategies to address fiscal sustainability by changing the revenue structure, reducing wasteful

spending, changing incentives and the care delivery system toward active lifestyle and active ageing.

- Build financial sustainability from the start by diversifying the revenue base for health, accounting for ageing; introducing policies to improve efficiency and effectiveness in health spending while maintaining quality, safety and access; and developing the right tools to monitor and evaluate policies for fiscal sustainability.
- Be innovative with service delivery, and shift the focus from disease-centred care toward value-based, person-centred care, with life course approach to active ageing.

Conclusions and next steps

This session first presented the OECD budgeting practices for health survey for Asia. The survey offers a useful tool to compare different instruments and methods used across countries to improve public financial management and budgeting practices for health.

Participants were keen to discuss and learn from other countries on their experiences in budgeting practices for health. Countries identified some practices that could be improved. For low and middle-income countries, budget under-execution was a key challenge, driven by both capacity and structural problems in the budget process. Many noted that the weak execution was caused by weak planning, delays in the procurement process, and slowness and unpredictability in the disbursement process. Among the lower middle income countries, the issue of transition from external assistance to domestic budget was of high interest and importance. The highly decentralised countries of Indonesia and the Philippines faced particular challenges in effective budget planning, given the sometimes duplicative roles of central and local governments – both countries appreciated hearing about the Australian experiences in improving coordination of health budgets among the Commonwealth (central government) and the States and Territories. The challenges of implementing performance budgeting described by New Zealand was also of great interest among the higher income countries.

On the next steps, there was a general agreement to hold the next meeting as part of a larger Asia regional event. One option that was discussed included the bi-Regional Asia Regional meeting organized by WPRO and SEARO on health financing. Such a pairing could be mutually beneficial, since it will allow a more focused and in-depth discussion on fiscal issues within the broader health financing policy context, and it will also a more efficient for the participants to have the two events held together.

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