Assessing Fiscal Space and Financial Sustainability for Health

Ajay Tandon
Senior Economist
Global Practice for Health, Nutrition, and Population
World Bank
Washington, DC, USA
E-mail: atandon@worldbank.org

Montreux, December 9, 2014
What is Fiscal Space?

- The difference between current revenue and the peak of the Laffer curve (i.e., the maximum revenue) [Park (2012)].

- The difference between a country’s current level of debt and the maximum level of debt, the latter implied by the country’s historical record of fiscal adjustment [Ostry (2010)].

- “…financing that is available to government as a result of concrete policy actions for enhancing resource mobilization, and the reforms necessary to secure the enabling governance, institutional, and economic environment for these policy actions to be effective, for a specified set of development objectives.” [Roy et al (2007)].

- “…the government’s ability to collect tax and to spend funds for desired purposes.” [Tangcharoensathien et al (2011)].

- Actual government expenditures as a share of GDP [Xu et al (2011)].
One Good Practical Definition

- “…room in a government’s budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.” [Heller (2005)].

- Strong link to the idea of financial sustainability, i.e., to the capacity of governments, in future, to finance desired expenditure programs, service debt, and ensure solvency.

- Definition does not specify fiscal space for what, e.g., there is no sector specification; generally presumed to be for some “meritorious” purpose, or for financing public investments for aiding economic growth.
Fiscal Space for Health

- Availability of budgetary room for increasing government spending in order to make progress towards achievement of UHC in a financially sustainable manner.

- Can be assessed by (typically) focusing on five different pillars:
  - Conducive macroeconomic conditions.
  - Sector-specific sources of revenue.
  - Re-prioritizing health within the government budget.
  - Development assistance for health.
  - Increasing efficiency of health outlays.
Conducive Macroeconomic Conditions

- Assessment of macro-fiscal context of health financing.
  - Interplay between broader macroeconomic environment (e.g., economic growth, deficit, debt, inflation/medical inflation, unemployment, informality trends, etc.) and impact on government/public health expenditures.
  - Is necessary to “situate” health financing; can be used to derive business-as-usual scenarios.

- Economic growth matters for fiscal space for health, even if nothing else changes.
  - India: Government health expenditure per capita more than doubled in real terms over 1995-2010, even though government health spending remained ~1% of GDP over same period.
Summarizing Key Macro-Fiscal Variables

Key macro-fiscal indicators for Indonesia, 2001-2018

- Gross general government debt
- Expenditures
- Revenues
- General government balance
- Inflation rate
- Economic growth rate
- Unemployment rate

Source: WB & IMF
General Inflation vs Medical Inflation

Figure 7-1: Health Prices vs Overall Consumer Price Index in Indonesia (1996-2006)

Source: BPS
Sector-Specific Sources of Revenue: Earmarking Payroll Taxes

- SHI often introduced as a way to collect additional revenues for health, especially from employers.

- Increasing contribution rates often a key fiscal space question.

- Challenge implementing mandates and collecting contributions in economies with large levels of informality.

- Interplay: SHI and informality.
Sector-Specific Sources of Revenue: Earmarking Non-Payroll Taxes

- Use of “sin taxes” on tobacco and alcohol increasingly prevalent for financing health.

- Often justified from health as well as fiscal perspective, despite sometimes being regressive.

- Impact on revenues can vary, dependent on elasticity of response including impact on smuggling/evasion.

- Earmarking of VAT: Ghana, Chile.

- Unpopular with ministries of finance: introduces rigidities in allocations across sectors, often viewed as second-best option.

- Is earmarking the only way to increase priority for health?

- Issue of additionality is also key.
Sector-Specific Sources of Revenue: Out-of-Pocket Spending

- OOP spending remains dominant share of total health spending in most low-income and middle-income countries:
  - **Low-income**: OOP 44% of total health expenditure.
  - **Lower middle-income**: OOP 38% of total health expenditure.
  - **Upper middle-income**: OOP 29% of total health expenditure.

- Large untapped source of revenues that should ideally be pooled, especially from those who are non-poor and not only from those who are adversely selected.
Prioritizing health in government budget often linked to difficult political economy considerations.

Can "unproductive" expenditure be reduced to make space for health, e.g., expenditure on fuel subsidies?

Literature suggests factors such as level of democratization, income inequality, ethno-linguistic fractionalization, etc., are important determinants of the degree to which health is prioritized by governments.
Benchmarking for Re-Prioritization?

- Abuja Declaration: 15% of government budget for health in sub-Saharan African; only handful of countries realized to date.

- WHO’s WPRO and SEARO member countries: government health spending should be 5% of GDP; WHO’s EMRO countries: 8% of budget should go to health.

- India: 2-3% of GDP; Lao PDR: 9% of government spending; Bhutan: 9% of government revenue.
Vietnam: government health spending to increase at a higher rate than increase in total government expenditure. Enshrined as legal decree, resulted in increase in prioritization.

Brazil: matching earmarks for health spending at both federal and local government levels.
Development Assistance for Health

- Large increase in development assistance for health, especially following the 2000 adoption of MDGs.
- Critical for financing interventions related to HIV/AIDS, immunization, MCH, etc.
- Key challenges with regard to harmonization, predictability, alignment with national priorities, as well as financial and institutional sustainability when countries transition away from donor financing.
Efficiency

- Improvements in efficiency can increase effective fiscal space and also attract additional resources from ministries of financing and planning.

- Often significant room to improve both allocative and technical efficiency of government health expenditures, e.g.,:
  - Better geographic and other targeting.
  - More resources for primary care.
  - More effective purchasing.
  - Public financial management considerations.
Some Additional Considerations

- Fiscal space assessment should ideally comprise: (i) needs assessments that clearly link additional financing with attainment of measurable improvements in UHC; (ii) pros and cons of different options, and the potential for generating fiscal space from each; (iii) deeper dives into the most viable options moving forward.

- Key to situate fiscal space within broader assessment of a country’s health financing system where the objectives are to (efficiently and equitably) raise sufficient resources that are pooled and utilized (efficiently and equitably) in order to enable countries to make progress towards UHC.