Organised session:
Fiscal space for health: New evidence on drivers and measurement

Chair: Aparnaa Somanathan, Program Leader for Human Development, World Bank

Panellists:

- Helene Barroy, Senior Health Financing Specialist, WHO
- Jacky Mathonnat, Professor of Economics, University of Auvergne, CERDI, France
- Jacob Novignon, Lecturer, University of Science and Technology, Accra, Ghana
- Jane Doherty, Lecturer and health economist, University of Cape Town, South Africa

Abstract:

The concept of fiscal space has gained increased visibility in both health economics research and policy dialogue, where it is recognised as an important issue that all countries must take into consideration as they seek to make progress towards universal health coverage (UHC). The roots of this concept can be traced back to Heller’s 2005 definition of general fiscal space as “the availability of budgetary room that allows a government to provide resources for desired public purposes without impairing fiscal sustainability”. Despite the existence of a general conceptual framework, a variety of metrics and methods have been used in applied research on the topic. Against this backdrop, the proposed organised session aims at presenting new evidence on the actual drivers of fiscal space for health expansion, and to contribute to the research and policy discussion on how to measure and assess fiscal space expansion to inform health financing reforms towards UHC. The session consists of four presentations: the first two presentations are about new global evidence on the drivers of fiscal space for health expansion in low- and middle-income countries (LMICs) based on mixed quantitative and qualitative methods, while the other two focus on bringing evidence from middle-income countries in light with their recent attempts to sustain and expand fiscal space for health from both the revenue and expenditure sides.
Session description

The concept of fiscal space has gained increased visibility in both health economics research and policy dialogue, where it is recognised as an important issue that all countries must take into consideration as they seek to make progress towards UHC. First defined by Heller in 2005, fiscal space is the budgetary room allowing a government to provide resources for public purposes without impacting fiscal sustainability, that is to say without threatening government solvency given existing fiscal conditions and long-term requirements. The possible sources or channels of fiscal space expansion that Heller laid out include: taxation, increase in priority expenditures, borrowing, seigniorage and external resources. Building on Heller's framework (2005), Tandon and Cashin (2010) elaborated on the sources that could be used to generate fiscal space for health and included: (i) conducive macroeconomic conditions, (ii) reprioritisation of health within the government budget, (iii) an increase in health sector-specific resources (i.e., earmarked funds), (iv) health sector-specific grants and foreign aid, and (v) an increase in the efficiency of existing health expenditure.

Despite these conceptual efforts, confusion remains with regard to the precise significance of the concept for health financing reform. More specifically, there is a lack of clarity regarding the way to effectively assess the potential for, and then actually realise fiscal expansion for the sector. In practice, considerations of fiscal space for health have generally focused on calls for additional resources, while efficiency-enhancing measures (a key aspect of Tandon and Cashin’s approach though), have been largely overlooked. Moreover, the absence of precise guidance on how to characterise and measure the room available for expanding fiscal space for health has led to wide variations in the application of the concept.

A recent review by World Health Organization (WHO) of existing fiscal space for health analyses enabled to provide an overview of the projected sources of expansion in the size of fiscal space for health in 44 LMICs from each identified source. The paper also analysed methodological approaches used to assess fiscal space for health expansion by each source, identifying the common strengths and weaknesses of existing methods. The findings of the review pointed to the value of this analytical approach in supporting health financing policy dialogue. It also underlined the need to increasingly use fiscal space for health analysis as a means of informing realistic health financing reforms within the context of macro-fiscal constraints and opportunities. The review called for refinements in methodological approaches in order to strengthen the relevance and applicability of studies’ results.

In light with this review and other ongoing, non-published work conducted by the WHO and partners around the topic, the proposed organised session aims at providing new evidence on the actual drivers of fiscal space for health expansion, and to contribute to the research and policy discussion on how to measure and assess fiscal space expansion in the context of health financing reforms. The session will feature four presentations: the first two presentations will present new global evidence on the drivers of fiscal space for health expansion in LMICs based on mixed quantitative and qualitative methods, while the other two will focus on bringing evidence from middle income countries, namely Ghana and South Africa, in light with their recent attempts to sustain and expand fiscal space for health from both the revenue and expenditure sides. The discussion will be moderated by Aparnaa Somanathan, Program Leader for Human Development at the World Bank (WB). The session will pay specific attention to generate discussion with the audience. Each of the four presentations will be limited to 10 minutes, to allow sufficient discussion time at the end of the session.
Fiscal space for health: a mixed-methods approach to assess sources of expansion in low- and middle-income countries

Dr Helene Barroy, Senior Health Financing Specialist, WHO

Despite convergence on the sources of potential fiscal space for health in the literature, there are no commonly agreed upon methods or metrics associated with assessing fiscal space for health. As result, there has not been a systematic effort to summarise the findings of related analyses or provide cross-country quantitative evidence as to which of these five sources has the potential to expand the health sector resource envelope. To fill this gap in the literature, this study combines both qualitative and quantitative methods to assess the viability of each of the sources to drive fiscal space for health expansion. First, it analyses the more than 35 studies that have been conducted to analyse potential fiscal space for health. This qualitative review is then complemented with a quantitative analysis that specifically examines the possible magnitude of health sector budget expansion that could be derived from increased domestic public sector revenues, improved efficiency of health spending, and a greater prioritisation of health in the overall budget. From a literature review perspective, we found there is converging evidence that macroeconomic growth, budget reprioritisation and efficiency enhancements are the overall main drivers of fiscal space for health expansion. Among the most common sources explored in the fiscal space for health literature, these are the three channels offering the greatest scope for expansion in LMICs. Conversely, there is scarce evidence regarding the possible role of earmarked funds to provide large-scale, sustained expansion of fiscal space for health. From the few fiscal space studies that assess potential from public health taxes, social health insurance contributions and other types of indirect taxes, they all conclude about the limited potential relative to the other domestic sources, despite some possible financial gains in absolute terms. The quantitative analysis provides three key conclusions. First, we found that the overall potential for fiscal space for health expansion is substantial in all LMICs, i.e., public spending on health could double in LMICs (median expected gain= 0.97). Specifically, through concurrent improvements in general government revenue raising, efficiency of spending, and prioritisation of health, public spending on health per capita could increase by 83% in low-income countries, 84% in upper-middle-income, and 123% in lower-middle-income countries, with 2014 as the reference year. Second, in general, an increase in general government revenues is the largest source of potential fiscal space for health expansion irrespective of income level, followed by prioritisation and efficiency. When disaggregated by income group, potential from increased general government revenues is more promising in lower-income groups, as compared to upper-middle-income countries. Still, results indicate that, even without new general government revenues, relying on re-prioritisation and improved efficiency alone could significantly expand fiscal space for health, amounting to an approximate 70% increase in public spending on health per capita in LMICs (compared to a 97% increase if new revenues are generated). This indicates that fiscal space for health could potentially increase significantly in the absence of macro or fiscal expansion.

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Co-Authors: Susan Sparkes and Elina Dale, WHO
Fiscal space for health expansion and efficiency: concept and application

Pr Jacky Mathonnat, Professor of Economics, University of Auvergne, Centre d'Études et de Recherches sur le Développement International (CERDI), France

An increasingly recognised approach to expanding fiscal space for health is by improving efficiency and reducing wastages in the use of resources in the health sector. The relationship between efficiency and expansion of fiscal space can very be summarised as follows. If a country produced a health result X when spending 100 in t0, and if its efficiency to produce the same result X (and the quality remaining unchanged) is improved by spending 80 in t+1 instead of 100, the 20 of it "saved" are all freed resources that can be devoted to finance other health activities among others, contributing for example to the deepening of the health coverage. The study proposed to estimate the efficiency gains of health expenditure for the period 1997-2014 for a sample of 120 low- and middle-income countries. Because Data Envelopment Analysis (DEA) is sensitive to outliers, several models have been proposed, including partial frontier models referred to as order-m (Cazals et al., 2002), and Frontier Analyst. We used an input orientation approach. Efficiency of health expenditure is dependent on the context of each country which is heterogeneous in terms of many socio-economic characteristics ("environment"). Therefore, the efficiency scores have been calculated with and without incorporating socio-economic variables (Gross Domestic Product (GDP) per capita and urbanisation rate) as non-discretionary or incompressible inputs in the production function. Next, these efficiency scores were used to compute potential gains from improving efficiency for each country included in the analysis. Potential gains are calculated as the distance from each country to the production frontier. The potential efficiency gain showed how much could be saved in terms of health expenditure at maximum efficiency. This was used to represent available fiscal space for health from increased efficiency. Overall, we found that for many countries, efficiency improvement margins are important. For the whole sample, the scores averaged between 0.7 and 0.8, indicating that on average, countries could achieve the same results with 20-30% less resources, in light with what is achieved by the top performing countries. There is a decreasing efficiency from low-income countries, to lower-middle and then upper-middle-income countries. In terms of fiscal space implications, it was estimated that countries could save on average, for the same results, the equivalent of more than 10% of the public expenditure spent on health in 2014 for the low-income countries and of one-third for the upper-middle-income countries, for example. Furthermore, efficiency gains not only generate a significant volume of resources for health, but depend widely on endogenous factors and create positive externalities for other sectors, though not estimated in this study, since some of the necessary measures are not specific to the health sector, but will benefit all sectors. Therefore, improving efficiency should be one of the top priorities at the forefront of the enlargement of the fiscal space for health.

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Efficiency of primary care and fiscal space implications in the context of Ghana

Jacob Novignon, Lecturer, University of Science and Technology, Accra, Ghana

Health centres in Ghana play an important role in health care delivery especially in deprived communities. They usually serve as the first line of service and meet basic health care needs. Unfortunately, these facilities are faced with inadequate resources. While health policy makers seek to increase resources committed to primary healthcare, it is important to understand the nature of inefficiencies that exist in these facilities. Therefore, the objectives of this study are threefold: (i) to estimate efficiency among primary health facilities (health centres), (ii) to examine the potential fiscal space from improved efficiency (iii) to investigate the efficiency disparities in public and private facilities. Data was from the 2015 Access Bottlenecks, Cost and Equity (ABCE) project conducted by the Institute for Health Metrics and Evaluation. The Stochastic Frontier Analysis (SFA) was used to estimate efficiency of health facilities. Efficiency scores were then used to compute potential savings from improved efficiency. Outpatient visits was used as output while number of personnel, hospital beds, expenditure on other capital items and administration were used as inputs. Disparities in efficiency between public and private facilities were estimated using the Nopo matching decomposition procedure. Average efficiency across all health centres included in the sample was estimated to be 0.49. Also, average efficiency was estimated to be about 0.60 and 0.48 for private and public facilities, respectively. Significant disparities in efficiency were identified across the various administrative regions. With regards to potential fiscal space, we found that, on average, facilities could save about GH₵11,450.70 (US$7,633.80) if efficiency was improved. Rural and urban facilities could save GH₵7,491.86 (US$4,994.57) and GH₵22,761.65 (US$15,174.43) of total revenue, respectively, on average. Similarly, private and public facilities could save GH₵45,491.98 (US$30,327.99) and GH₵10,141.42 (US$6,760.95), respectively, if best practices were followed. The study findings confirmed the importance of looking at possible efficiency gains for resource-constrained countries aiming to identify realistic sources of fiscal space for health expansion.

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Co-Author: Justice Nonvignon, Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon-Ghana
Domestic tax collection and effectiveness of fiscal space for health expansion in South Africa

Jane Doherty, Lecturer and health economist, University of Cape Town, South Africa

One way of creating fiscal space is through raising additional revenue, e.g., through tax measures or strengthening tax administration. It is often assumed that LMIC cannot increase tax funding because of weak administrative capacity, high levels of tax evasion and the structure of the workforce, in which most people work in the informal sector. However, some African countries have shown that fiscal space can be expanded by strengthening the tax administrative system; yet, there is little documentation of these experiences. This study looks at expanding fiscal space by increasing the effectiveness of tax collection systems in South Africa. Quantitative methods were used to quantify trends in general tax revenue, government spending on the health sector and on other sectors and to compare growth in these variables relative to growth in GDP. Qualitative methods were used to explore the contextual factors, tax policies, actors and processes accounting for improved tax revenue and remaining challenges for sustainable tax revenue generation, as well as to understand whether, how and why allocations to the health sector were affected by improved tax revenue generation. We found that despite the fact that South Africa was able to increase tax revenue rapidly following the demise of apartheid, the fiscal space for health shrank for most of the subsequent years. This study showed also that political and administrative factors explained these trends to some degree. It also highlighted the importance of macroeconomic policy in constraining the overall resource envelope, including for the health sector, particularly constraining the tax to GDP ratio, lowering tax rates and rapid repayment of government debt.

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Co-Author: Di McIntyre, Professor of Economics, University of Cape Town