Public Financial Management and Health Spending

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Fiscal Affairs Department
IMF
PFM in Health Sector Management

Outline of Presentation

I. Challenges in Health Sector Management
II. Public Financial Management
III. How PFM supports allocative efficiency?
IV. How PFM supports productive efficiency?
V. Conclusions
I. Challenges in Health Sector Management

- **Fragmentation of financing in the health system**
  - Revenues (central and local governments)
  - Social insurance
  - User charges
  - Donors

- **Demographic changes**

- **Income growth**

- **Technological change**

- **Expanding coverage**

- **Mix of public and private providers**

- **Many stakeholders (health workers, international community, etc.)**
It is a system of processes by which government plans, allocates, and implements its budget (from medium-term budgeting to preparation of an annual budget to its execution)

In policy terms this means:

The translation of government policy into sustainable budget and policy targets, and implementation of the budget in a manner that supports service delivery including health (from national and sectoral planning, to program based budgeting)
II. Public Financial Management

PFM comprises several tools and principles which in combination ensure sustainable finances, purposeful planning, and effective implementation, such as:

- Strategic planning
- Medium-term budget frameworks
- Budget comprehensiveness
- Spending reviews
- Program-based budgeting
- Oversight over SOEs
- Commitment control
- Cash management
II. Public Financial Management

PFM in the health sector

• IMF provides technical assistance to more than 100 countries every year, ranging from low-income (including fragile states) to emerging market and advanced economies

• The PFM tools are well established and can accommodate the needs and demands of the health sector

• The presentation shows how these tools have been successfully applied to the health sector in both high and low-income countries
III. PFM and allocative efficiency

Allocative efficiency seeks to ensure sufficient funding for priority sectors, such as health care

The challenges are:

1. Ensuring consistency between macro-fiscal and health sector policy making
2. Over time, maintaining a sustainable fiscal position to guarantee funding for health care
3. Creating fiscal space by improving efficiency of spending and raising more revenue, in line with potential
4. Ensuring most funds are channeled through PFM systems to promote effective allocation within the health sector and minimizing duplication
5. Ensuring effective spending and expanding coverage of health care
III. PFM and allocative efficiency

Integrated fiscal and health policy planning

• Realistic health planning requires recognition of fiscal constraint

• This requires better mutual understanding of fiscal and health policy perspectives

• Ghana’s Health Sector Medium-Term Development Plan is a good example in which sector strategies are costed over the medium term and compared to available funding

• however a funding gap is identified which has to be closed either with additional revenues or non-priority projects to be excluded from the budget
Comparison of projected funding with estimated cost shows a marginal deficit of 7.84 to 9.83 percent in the first two years of the plan with funding gap rising to 10.23 percent in 2016 and 11.02 in 2017 respectively.

### III. PFM and allocative efficiency

**Integrated fiscal and health policy planning**

Source: Ghana: Health Sector Medium Term Development Plan 2014 - 2017

**Table 12: Fiscal Space Projections (in millions of Ghana Cedi)**

<table>
<thead>
<tr>
<th>Sources</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Finance and Economic Planning (MoFEP), Ministry of Health (MoH)</td>
<td>4,932.26</td>
<td>5,548.80</td>
<td>6,221.38</td>
<td>6,578.35</td>
</tr>
<tr>
<td>National Health Insurance Authority (NHIA)</td>
<td>2,340.62</td>
<td>3,242.94</td>
<td>4,861.80</td>
<td>6,077.63</td>
</tr>
<tr>
<td><strong>Projected public health expenditure (domestic financing)</strong></td>
<td><strong>7,272.89</strong></td>
<td><strong>8,791.74</strong></td>
<td><strong>11,083.18</strong></td>
<td><strong>12,653.98</strong></td>
</tr>
<tr>
<td>Projected Development Partners’ (DP’s) contributions</td>
<td>1,354.40</td>
<td>1,611.10</td>
<td>1,576.60</td>
<td>1,588.60</td>
</tr>
<tr>
<td><strong>Total Public Health Expenditure</strong></td>
<td><strong>8,627.29</strong></td>
<td><strong>10,402.84</strong></td>
<td><strong>12,659.78</strong></td>
<td><strong>14,242.58</strong></td>
</tr>
</tbody>
</table>

**Figure 9: Projected Funding Gap (Ghana Cedi Millions)**

Comparison of projected funding with estimated cost shows a marginal deficit of 7.84 to 9.83 percent in the first two years of the plan with funding gap rising to 10.23 percent in 2016 and 11.02 in 2017 respectively.
### III. PFM and allocative efficiency

**Medium-term budgeting**

*Operationalizing national and health plan through medium-term allocations*

<table>
<thead>
<tr>
<th>Frame</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Government offices</td>
<td>77</td>
<td>76</td>
<td>76</td>
<td>76</td>
</tr>
<tr>
<td>24. Foreign ministry</td>
<td>1 258</td>
<td>1 251</td>
<td>1 226</td>
<td>1 257</td>
</tr>
<tr>
<td>25. Justice ministry</td>
<td>806</td>
<td>823</td>
<td>813</td>
<td>798</td>
</tr>
<tr>
<td>26. Interior ministry</td>
<td>1 231</td>
<td>1 163</td>
<td>1 132</td>
<td>1 133</td>
</tr>
<tr>
<td>27. Defense ministry</td>
<td>2 449</td>
<td>2 389</td>
<td>2 294</td>
<td>2 288</td>
</tr>
<tr>
<td>28. Finance ministry</td>
<td>15 126</td>
<td>15 123</td>
<td>15 109</td>
<td>14 991</td>
</tr>
<tr>
<td>29. Education and culture ministry</td>
<td>6 056</td>
<td>5 960</td>
<td>5 887</td>
<td>5 881</td>
</tr>
<tr>
<td>30. Agriculture and forestry ministry</td>
<td>1 815</td>
<td>1 797</td>
<td>1 762</td>
<td>1 701</td>
</tr>
<tr>
<td>31. Communication ministry</td>
<td>2 083</td>
<td>1 879</td>
<td>1 902</td>
<td>1 806</td>
</tr>
<tr>
<td>32. Labor and industry ministry</td>
<td>2 461</td>
<td>2 381</td>
<td>2 355</td>
<td>2 216</td>
</tr>
<tr>
<td>33. Health care ministry</td>
<td>8 651 (20.4%)</td>
<td>8 658 (20.7%)</td>
<td>8 670 (20.8%)</td>
<td>8 746 (21.2%)</td>
</tr>
<tr>
<td>35. Environment ministry</td>
<td>243</td>
<td>233</td>
<td>229</td>
<td>211</td>
</tr>
<tr>
<td>36. Debt interest</td>
<td>2 093</td>
<td>2 342</td>
<td>2 649</td>
<td>2 941</td>
</tr>
<tr>
<td>Sum of frames</td>
<td>42 435</td>
<td>41 907</td>
<td>41 624</td>
<td>41 271</td>
</tr>
<tr>
<td>Expenditure ceiling</td>
<td>42 801</td>
<td>42 319</td>
<td>42 007</td>
<td>42 133</td>
</tr>
</tbody>
</table>

Source: Finland Medium Term Budget Framework 2013 - 2016
III. PFM and allocative efficiency

Medium-term budgeting

• Some scholars have criticized that health allocations are not totally transparent

• But the PFM good practice suggests improvements:
  1. Understanding costs of ongoing and new policies and the underlying cost drivers
  2. Focusing on high priority programs and avoid starting too many new projects as resources are scarce
III. PFM and allocative efficiency

Comprehensive budgeting

1. **All components of funding should be consolidated**
   - To ensure prioritization
   - To avoid duplication
   - To evaluate trade-offs

   **TABLE 4.10B**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>GoU Funding</th>
<th>Off Budget</th>
<th>Unfunded</th>
<th>Plan total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>1,152,490</td>
<td>1,263,840</td>
<td>1,334,120</td>
<td>1,429,230</td>
<td>1,790,240</td>
<td>6,969,920</td>
<td>323,173</td>
<td>3,312,841</td>
<td>10,605,934</td>
</tr>
</tbody>
</table>

   Source: National Development Plan (NDP) 2010/11-2015, Uganda

2. **Aligning domestic and donor funding ensures best policy outcomes**
III. PFM and allocative efficiency

Long-term projections as basis for health planning

- Fiscal sustainability reports: Comprehensive projections of all expenditures and revenues over next 50 – 80 years, based on current policy assumptions
- Transparently listing required allocations for health on the basis of cost drivers (demographic trends, technology etc.)
- Good practice in advanced countries and South Africa recently introduced, but an important information base for emerging markets and LIC economies

Source: UK OBR: Fiscal Sustainability Report, June 2015
III. PFM and allocative efficiency

Spending reviews

- Scope for efficiency gains exist within the health sector, but it will take time and investment to realize these gains
- Emerging countries such as Romania, Croatia, Ukraine, South Africa have started spending review initiatives
- Spending reviews help thinking about efficiency gains systematically and realize them:
  - Built on in-depth analytical work
  - Are medium-term oriented
  - A collaborative effort, between Ministry of Health, Ministry of Finance, other stakeholders, and external expertise
  - Also help enhancing productive efficiency
III. PFM and allocative efficiency
Spending reviews

• Well articulated priorities and objectives at the start of a spending review are key

“The Coalition: our programme for government

“We will guarantee that health spending increases in real terms in each year of the Parliament”

“We restore the earnings link for the basic state pension from April 2011”

“We will honour our commitment to spend 0.7% of GNI on overseas aid from 2013”

“...while recognizing the impact this will have on other departments”
III. PFM and allocative efficiency

Spending reviews require analysis

**Spending \Rightarrow Outcomes in NHS**

**International Comparison:**
- General Practitioner Pay
- Branded Drug Prices

*NHS Efficiency Plan*

“Brown to tackle £100,000 a year GPs over pay & hours”
*Daily Mail 14/5/07*

“NHS price plans surprise drug companies”
*Financial Times 2/8/07*

“NHS push for 10% drug price cut”
*Financial Times 7/1/08*
IV. PFM and productive efficiency

- Productive efficiency focuses to achieve best value for money for resources spent in the health sector.

- Efficiency gaps exist: some countries achieve more with the same inputs.

![Health Efficiency Frontier, Latest Value Available](image)
IV. How to improve productive efficiency?  
From line item to program-based budgeting

- Difficulty to match health spending with priority population and services, if budgets are based on inputs and organizations, rather than on results

<table>
<thead>
<tr>
<th>Organizational classification</th>
<th>Economic classification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FEDERAL MINISTRY OF HEALTH</strong></td>
<td><strong>2014 APPROPRIATION ACT</strong></td>
</tr>
<tr>
<td>NO</td>
<td>CODE</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
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<tr>
<td>1</td>
<td>0521001001</td>
</tr>
<tr>
<td>2</td>
<td>0521002001</td>
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<tr>
<td>3</td>
<td>0521003001</td>
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<tr>
<td>4</td>
<td>0521005001</td>
</tr>
<tr>
<td>5</td>
<td>0521007001</td>
</tr>
<tr>
<td>6</td>
<td>0521008001</td>
</tr>
<tr>
<td>7</td>
<td>0521009001</td>
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<tr>
<td>8</td>
<td>0521010001</td>
</tr>
<tr>
<td>9</td>
<td>0521011001</td>
</tr>
<tr>
<td>10</td>
<td>0521012001</td>
</tr>
</tbody>
</table>

MDA = Ministries, Departments, Agencies

Source: Nigeria, Health Budget 2014
IV. How to improve productive efficiency?

Program-based budgeting

- Program-based budget organizes spending around outcomes to be achieved, thus allocating according to priorities

<table>
<thead>
<tr>
<th>Administered expenses</th>
<th>Estimated available appropriation</th>
<th>Estimate of prior year amounts available in</th>
<th>Proposed at Budget</th>
<th>Total estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014-15$'000</td>
<td>2015-16$'000</td>
<td>2015-16$'000</td>
<td>2015-16$'000</td>
</tr>
<tr>
<td><strong>Ordinary annual services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome 1: Population Health</td>
<td>325,597</td>
<td>-</td>
<td>320,545</td>
<td>320,545</td>
</tr>
<tr>
<td>Outcome 2: Access to Pharmaceutical Services</td>
<td>755,243</td>
<td>-</td>
<td>726,663</td>
<td>726,663</td>
</tr>
<tr>
<td>Outcome 3: Access to Medical and Dental Services</td>
<td>578,800</td>
<td>-</td>
<td>636,136</td>
<td>636,136</td>
</tr>
<tr>
<td>Outcome 4: Acute Care</td>
<td>96,496</td>
<td>-</td>
<td>79,783</td>
<td>79,783</td>
</tr>
<tr>
<td>Outcome 5: Primary Health Care</td>
<td>2,194,393</td>
<td>-</td>
<td>2,322,360</td>
<td>2,322,360</td>
</tr>
<tr>
<td>Outcome 6: Private Health</td>
<td>2,247</td>
<td>-</td>
<td>2,328</td>
<td>2,328</td>
</tr>
<tr>
<td>Outcome 7: Health Infrastructure, Regulation, Safety and Quality</td>
<td>340,438</td>
<td>-</td>
<td>296,080</td>
<td>296,080</td>
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<tr>
<td>Outcome 8: Health Workforce Capacity</td>
<td>1,351,366</td>
<td>-</td>
<td>1,318,641</td>
<td>1,318,641</td>
</tr>
<tr>
<td>Outcome 9: Biosecurity and Emergency Response</td>
<td>58,005</td>
<td>-</td>
<td>58,642</td>
<td>58,642</td>
</tr>
<tr>
<td>Outcome 10: Sport and Recreation</td>
<td>47,796</td>
<td>-</td>
<td>26,948</td>
<td>26,948</td>
</tr>
</tbody>
</table>

Source: Australia, Health Budget 2015-16
IV. How to improve productive efficiency?

Program-based budgeting

- Program-based budgets clearly define responsibilities in the fragmented system

<table>
<thead>
<tr>
<th>The Hon Sussan Ley MP</th>
<th>Senator the Hon Fiona Nash</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister for Health</td>
<td>Assistant Minister for Health</td>
</tr>
<tr>
<td>Minister for Sport</td>
<td></td>
</tr>
</tbody>
</table>

**Portfolio Responsibilities**

*Department of Health:*
- Outcomes: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10

*Entities:*
- ACSQHC, AIHW, ASADA, ASC, ASF, CA, IHPA, NHFB, NHMRC, NHPA, NMHC, PHIAC, and PSR

*Australian Radiation Protection and Nuclear Safety Agency*

**Dr Carl-Magnus Larsson** Chief Executive Officer

**Outcome 1.** Protection of people and the environment through radiation protection and nuclear safety research, policy, advice, codes, standards, services and regulation.

Source: Australia, Health Budget 2015-16
IV. How to improve productive efficiency?

Program-based budgeting

- Program-based budgets holds actors accountable for finances and **measurable** outputs/outcomes

### Outcome 1. Population Health

A reduction in the incidence of preventable mortality and morbidity, including through national public health initiatives, promotion of healthy lifestyles, and approaches covering disease prevention, health screening and immunisation.

<table>
<thead>
<tr>
<th>Quantitative Indicators</th>
<th>2014-15 Revised Budget</th>
<th>2015-16 Budget Target</th>
<th>2016-17 Forward Year 1</th>
<th>2017-18 Forward Year 2</th>
<th>2018-19 Forward Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people invited to take part in the National Bowel Cancer Screening Program who participated.¹</td>
<td>41%</td>
<td>41%</td>
<td>41%</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Percentage of women 50-69 years of age participating in BreastScreen Australia.²</td>
<td>55%</td>
<td>55%</td>
<td>55%</td>
<td>55%</td>
<td>55%</td>
</tr>
<tr>
<td>Percentage of women 70-74 years of age participating in BreastScreen Australia.³</td>
<td>51%</td>
<td>53%</td>
<td>55%</td>
<td>55%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Source: Australia, Health Budget 2015-16
IV. PFM and productive efficiency
How to improve the implementation of health budgets?

Problems can be addressed by existing PFM systems:

- **Overdetailed line items can restrict reallocations required for priorities**
  - Reduce the granularity of allocation and group according to programs

- **Unrealistic budget envelopes can lead to ad hoc in-year adjustments of the budget**
  - Realistic planning and limit adjustments to unforeseeable events

- **Incongruent planning of investment and operational costs** (e.g., purchase of equipment and no salaries for competent personnel)
  - Planning of investment and recurrent costs together over the medium term
IV. PFM and productive efficiency

Performance Monitoring

- Program-budget set objectives for health outcomes which allow monitoring progress regularly and compared with peers

Health Outcomes

Source: OECD
IV. PFM and productive efficiency

Oversight of different sectors

• **Local governments:**
  – Oversight and coordination of different sectors is an integral part of PFM systems
  – Formula-base health allocations can stabilize health budgets for LGs and set incentives
  – Policy dialogue between central and local governments, including social security and other stakeholders required for coordination

• **Social insurance and state-owned enterprises (e.g., hospitals):**
  – Potential fiscal risks, if loss making
  – Good oversight of finances and outcomes
  – Control efficiency and potential rents
IV. PFM and productive efficiency
Cash management and commitment control

- Effective PFM systems provide cash management and commitment control systems
- Shortages of cash and lack of control over medium-term contracts can lead to arrears which in turn can lead to disruption of health services

Portugal 2011
Arrears: 3.0 % of GDP

Greece 2011
Arrears: 4.3 % of GDP
V. Conclusions

• Public Financial Management does not provide for budget shortages, but ensures more deliberate planning and better value for money

• No separate PFM system for health is required, but health is best managed as integral part of public finances

• Policy making needs to make health care a priority, then PFM systems support allocative and productive efficiency

• PFM systems include mechanisms for protecting priority spending, such as health
Thank you for your attention!