FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE:
PEER-TO-PEER LEARNING WORKSHOP
FINDING SOLUTIONS TO COMMON CHALLENGES
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#access2care #NHISAfrica16
Expenditure management for UHC

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Why it matters?

« Why shall I care?
I don’t even spend half of my budget! »
Key questions

- Why expenditure management matters for UHC?
- To what extent managing health expenditure is a core PFM issue?
- How can PFM and health purchasing be connected?
- What can be learned from country experiences?
Why public expenditure management matters for UHC?

- Countries tend to focus more on resource mobilization: inherited policy choices and institutional arrangements can potentially lead to unmanageable costs escalation.

- Most of the resources for UHC will/should come from public budgets; optimizing public expenditure management is critical for UHC.

- Public resources are not infinite: level and growth of public health spending is determined by fiscal constraints and policy priorities.

- While financial sustainability might not be an objective for health system, it shall navigate within this constraint (Thomson et al, 2009).
Managing public health expenditure better is also a matter of equity

**Chad:** Benefit incidence of public subsidies by income level

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Bar Height</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richest</td>
<td>46.5</td>
</tr>
<tr>
<td>Upper middle</td>
<td>15</td>
</tr>
<tr>
<td>Middle</td>
<td>10</td>
</tr>
<tr>
<td>Low middle</td>
<td>6.1</td>
</tr>
<tr>
<td>Poorest</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Health Status Report, Chad, World Bank, 2013

**DRC:** Distribution of public health expenditure by province, per capita (CDF)

<table>
<thead>
<tr>
<th>Province</th>
<th>Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katanga</td>
<td>546</td>
</tr>
<tr>
<td>Sud Kivu</td>
<td></td>
</tr>
<tr>
<td>Kasai Oriental</td>
<td></td>
</tr>
<tr>
<td>Province Orientale</td>
<td></td>
</tr>
<tr>
<td>Nord Kivu</td>
<td></td>
</tr>
<tr>
<td>Kasai Occidental</td>
<td></td>
</tr>
<tr>
<td>Equateur</td>
<td></td>
</tr>
<tr>
<td>Maniema</td>
<td></td>
</tr>
<tr>
<td>Bandundu</td>
<td></td>
</tr>
<tr>
<td>Bas Congo</td>
<td>2431</td>
</tr>
<tr>
<td>Kinshasa</td>
<td></td>
</tr>
</tbody>
</table>

Source: Barroy et al, DRC Health PER, World Bank, 2014
Under-execution is also a symptom of poor financial management

- There is either a problem in the allocation or in the execution system, or in both!

- Evidence shows that better execution of budgeted resources — combined with efficiency-related gains — are likely to unlock sizeable financial space for UHC-related goals in most LMICs.

- But better executing is not only about increasing the volume of flows but also directing existing funds to targeted priorities, services.

**Benin: Execution rate of health budget allocations, in %**

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>59.3</td>
<td>61.3</td>
<td>83.0</td>
<td>95.3</td>
<td>94.4</td>
</tr>
</tbody>
</table>
Key questions

- Why expenditure management matters for UHC?
- To what extent managing health expenditure is a core PFM issue?
- How can PFM and health purchasing be connected?
- What can be learned from country experiences?
Managing health expenditure starts with budgeting

- In many LMICs, policy making, planning, budgeting (and costing) take place independently of each other.
- Multi-year policy-based budgeting (MTEF) can help re-connect sectoral allocations/ceilings with policy priorities.
- Line-item, inputs-based budgets create « blind » allocations.
- A more operational classification could enable funds to flow to prioritized health services, « programs ».

### DRC: Strict line-item classification

<table>
<thead>
<tr>
<th>SECTOR</th>
<th>BUDGET SUB-CATEGORY</th>
<th>ALLOCATION</th>
<th>EXECUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 PUBLIC HEALTH</td>
<td>3 STAFF</td>
<td>22 962 137 938</td>
<td>20 923 253 212</td>
</tr>
<tr>
<td></td>
<td>4 GOODS AND MATERIAL</td>
<td>2 755 321 981</td>
<td>9 076 113 470</td>
</tr>
<tr>
<td></td>
<td>5 SERVICES</td>
<td>800 897 380</td>
<td>64 326 032</td>
</tr>
<tr>
<td></td>
<td>6 TRANSFERS</td>
<td>2 748 928 019</td>
<td>3 600 321 271</td>
</tr>
<tr>
<td></td>
<td>7 EQUIPMENTS</td>
<td>15 378 553 712</td>
<td>17 283 497 714</td>
</tr>
<tr>
<td></td>
<td>8 CONSTRUCTION AND REHABILITATION</td>
<td>4 964 056 766</td>
<td>3 040 546 781</td>
</tr>
</tbody>
</table>

Source: Ministry of Budget, DRC, 2014
Program budgeting: what does that mean for health sector?

Programme-based budgeting is a means of enabling more efficient use of resources by grouping inputs around objectives and providing more flexibility to funds managers.

- A « programme » can be: health insurance, primary care, prevention, cancers
- Limited evidence of the actual effects of alternative budget structures on health spending performance; what we know:
  - It can help provide more managerial autonomy in health spending
  - It increases compatibility with purchasing
  - Can add new silos (program budget as « disease programmes »)
  - Modifying the budget structure will not be sufficient to drive flows toward the expected results.
- Looking beyond the budget structure: equally important are personnel management and structure of government that provide incentives and accountability for improved performance.
Executing health budgets: navigating through PFM restraint and flexibility

- PFM can create rigidities and delays for execution: e.g. concentrated spending authority, ex-ante controls, heavy procurement systems, opacity in spending information

- Health sector can distort: e.g. parallel executing, reporting, auditing systems to limit fiduciary risks for donor investments

- A « win-win » health expenditure/PFM system would allow:
  - Pooled health resources
  - Purchased health services with adequate payment incentives
  - Predictable releases and flexible execution procedures
  - Integrated financial management information system
  - Institutionalized budget evaluation and health policy adjustment
Combining financial management with health purchasing requirements

What priorities?

Smart expenditure targets
- Adequate volume and structure: by levels of care, priority services

Strategic purchasing
- Appropriate provider payments (performance-based)

Priority package of services
- Pre-defined benefit package, cost-effective interventions, PHC

How to purchase?

What to purchase?
Key questions

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DRC: health as a pilot sector for PFM reform

- Sectoral MTEF
- Attempts to formulate budget according to health priority policies (PHC, hospitals, MCH, vaccines, nutrition)
- Capacity building for expenditure management within MoH to transfer spending authority from treasury to MoH
- Reforms and simplifies procurement system, including for drugs
- Strenghtens public financial management information/reporting/auditing system to allow health donors to use a single, integrated PFM plateform
- Institutionnalizes PBF as an instrument to purchase essential benefit package-PHC services
## Thailand: setting an enabling environment for strategic health purchasing

<table>
<thead>
<tr>
<th>Large pooling and purchasing agency</th>
<th>Reformed payment systems</th>
<th>Strategic purchasing and negotiations</th>
</tr>
</thead>
</table>
| - National Health Security Office pools resources and purchases services for \( \frac{3}{4} \) of the population (for UCS scheme) | - Capitation for ambulatory care  
- DRG for hospital care  
- Active gatekeeping system through « prefered doctor » enrollement | - Contracted providers  
- Providers networks  
- Negotiations for providers tariffs and drugs prices |
## Situation

Among the highest public health expenditure in the world

- Close-to-single purchasing agency but…
- Open-ended payment systems (fee for service for ambulatory care)
- Leading to large accumulated SHI deficits
- History of independent management of SHI funds

## Reforms

- Parliament-set spending targets by levels of care
- Rigorous monitoring and early warning system, with post-adjustement of tariffs
- Piloting performance-based payment mechanisms for ambulatory care
- Stricter care-pathways: gate-keeping system, higher deductibles
Key messages

- Managing health expenditure is as important (if not more) as raising new resources to move toward UHC.

- Health expenditure management is not about « cuts », or even just « costs »: is how to set up a financial management system that allows purchase the priority health services within an allocated enveloppe.

- What matters is really the combination of sound, flexible PFM processes and a functioning, strategic purchasing system (in or off budget);

- It implies engaging on MoH/MoF dialogue on public finance issues.

- Building institutional capacity for expenditure management is essentiel, within MoH and HI funds, if any.
Thank you