

# The Health Budget 2006 – the policy context

Dr. Sania Nishtar

Budget 2006 is just around the corner with an indication that there would, both, be aggregate as well as program-specific enhanced allocations for health. This raises the question of whether these can translate into improved health outcomes over the short term. Here it must be understood that the relationship of health indicators does not necessarily parallel the level of resource inputs particularly if considerations relating to the utilization of funds and a reconfiguration of the health system are not brought to bear. Within this context, three questions emerge: how should we interpret and analyze the current allocations – per se; do we need to focus on how budgets can be utilized better and do we need alternate modes of health financing, and if so, why?

*Firstly, interpreting the ballpark figures:* the Government of Pakistan has been spending 0.6 to 1.19% of its GDP and 5.1 to 11.6% of its development expenditure on health over the last 10 years. However, these figures reflect spending by the Ministry of Health and the departments of health and do not take into account other public sector health services, and the private sector; if these are taken into account, the total expenditure can roughly be placed at 3.5% of the GDP. Utilization issues notwithstanding, the total public sector health expenditure was shown to double in the period 1991/92 to 1997/98 with a 100% increase over the last five years and a probable increase this time round. However, budgetary increases should be viewed in the context of inflation and population growth and the real per-capita expenditure. Enhanced allocations must also favorably impact the ratio between development and non-development budgets. A comparison of the 2003/04 and 2004/05 federal and provincial development and non-development budgets shows a major dominance of non-development budget in the provinces. This gap appears to have widened over the last 10 years whereas at the federal level, trends have been comparatively favorable. Budgetary allocations for health must also factor a favorable ratio between prevention and tertiary care allocations; within this context, a comparison of the primary healthcare budgets with clinical health programme budgets in successive Five-Year Plans shows that clinical services have consistently consumed more than 45% of the total health budget. Along the same lines a balance between financing health in the rural vs. the urban areas should be an area of concerted focus not only for the conventional adage – seventy percent of Pakistan's population lives in the rural areas – but also given that recent surveys in 2005 have reported significant rural-urban disparities in key health indicators. For example, the Under-5 (years of age) Mortality Rate in the rural areas of Sindh has been reported at 117 compared to 68 in the urban areas and 55 per live births in the city of Karachi.

*The second question relates to why we need to focus on the utilization of budgetary allocations.* This is simply because issues with fund release, their utilization and the resultant budgetary lapses are well known. And it is here that striking a balance between minimizing costs, controlling costs and using resources more efficiently and equitably – in other words, getting the best value for the money, on the one hand, and increasing the pool of available resources, on the other, becomes important. Specific interventions such as the promotion of transport financial

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Policy-makers need to think beyond increased budget allocations for health if the sector has to really deliver



### Money as a cure

By Dr Sania Nishtar

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administration, budgeting and cost controls and enhancing the capacity to overcome onerous financial management procedures and decentralizing decision-making become important. There is also the need for greater financial procedural clarity at the federal-provincial district interface.

The third question relates to why there is a need for alternate modes of financing health when the budget is on the way to being increased? It is important to understand why this is so. Pakistan currently principally uses three modes of financing health – taxation, out of pocket payments and donor contributions. However, ground realities warrant that we revisit this paradigm for a number of reasons. Taxation as a mode of financing health demands an extensive tax collection capacity and is possible largely in formal economies whereas in Pakistan the informal sector of the economy is predominant. It is likely that as the volume of economic activity increases and if the current growth is sustained the population will move into the formal sector and the tax base and taxation capacity of the country will broaden; however meanwhile, alongside efforts to reallocate existing tax resources for health other options will have to be considered.

The second major mode of financing health is out of pocket payments. The total *per-capita health expenditure* in Pakistan is reported to be between Rs. 750 to 800; while no official figures exist, experts believe that 25% of this is contributed by the public sector and 75% through private out-of-pocket fee-based funding mechanism (Rs. 570). The monthly household out-of-pocket expenditure on health has been reported at Rs. 358 in Pakistan. This is equal to 5.2% of the total monthly household expenditure and translates into an annual per-capita health expenditure of Rs. 570; this is clearly a significant burden for a sizable chunk of the Pakistani population which lives below the poverty line. Clearly this highlights the need for mainstreaming social health insurance as a mode of financing health; within this context, the recent Social Protection Strategy needs to be revisited to broaden its scope on health given that the only area where it alludes to health is in the section on employees social insurance which is just one dimension and that too for the formally employed.

The third source of financing health has been donor contributions; foreign aid as a percentage of total health sector allocation has officially ranged from 4-16% over the last several years. However, over the long term there should be a shift away from reliance on donor contributions given that they bring in their wake many challenges; for a start, donor contributions prioritize resource-allocations in specific programme-based areas rather than systems-strengthening interventions, which are the need of the day; undue reliance on donor resources can also be detrimental to programme sustainability given that donor support is generally dependent on political and general conditions prevalent geographically.

Given these considerations alternate sources of financing health are now a strategic imperative; there are many already many existing sources within Pakistan which need to be further built upon. For instance we know that the employees social insurance which currently secures 3.06% of the workforce can be broadened; philanthropy through Zakaat and Bait ul mal, which has contributed less than 3% to public contributions in health, can be mainstreamed by structuring a conducive tax configuration and that corporate support can be mobilized within the framework of corporate social responsibility, albeit with safeguards.

Above all it must be recognized that the health financing patterns are shaped by the macroeconomic environment not only because they can enable the allocation of more resources but also because they can reconfigure how financing patterns are determined; the recent example of countries where economic booms have created opportunities for global employment practices thereby creating an environment where employers subscribed to health benefits is a case in point. It is hoped that as Pakistan economically prospers, such new options will become available. However, the policy challenge then would then relate to how well these match against considerations of equity given that after all, health – at least priority services – should be delivered by the State as a public good.

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