Budget 2006-07 – an ode to health

Dr. Sania Nishtar

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Evidently, increases in budgetary allocations are a sine-qua-non of improving health outcomes. But clearly not the only! As the most complex of the social sectors, health necessitates in tandem systems and financing restructuring, for which budgetary allocations can act as the *key tool* in addition to being the critical *input*. With this as a context, three questions have been addressed within the context of the recent increases in budgetary allocations for health.

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BLUECHIP:
Vol3. Issue 25 - June, 2006

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The first question relates to whether improvements in health outcomes can be achieved with aggregate increases in budgetary allocation, per se?

Utilisation 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 further 21.3% increase this year. Admirable indeed. However *firstly*, it is imperative for this to continue and with sharper increments so as to bridge the current disparities in health expenditures particularly with reference to regional comparisons. *Secondly*, while this is vital, it also needs to be emphasised that specific aspects of health systems development are a stronger determinant of health status achievement compared with total health expenditure; budgetary allocations should therefore be viewed and used as a tool with the realisation that they can assist in enhancing the performance of the health system by transforming the management of individual facilities, the management structure of the staff and the institutional environment in terms of the capability to plan and deliver.

Thirdly, it is imperative to underscore the importance of fund utilisation. Issues with fund release, their utilisation and the resultant budgetary lapses are well recognised. And it is here that striking a balance between minimising costs, controlling costs and using resources more efficiently and equitably — in other words, getting the best value for money, on the one hand, and increasing the pool of available resources, on the other, becomes important. Specific interventions such as the promotion of transparent financial administration, budgeting and cost controls and enhancing the capacity to overcome onerous financial management procedures, decentralising decision-making and ensuring accountability are relevant. Though these efforts have been initialized under the umbrella of civil service and other reform measures, they need to be expanded to the public service context in order to comprehensively impact health — and indeed social service delivery.

Fourthly, budgetary increases should be viewed in the context of inflation and population growth and the real per-capita expenditure; with respect to allocations per-se, it is not just the aggregate increase but the ratios between the development and non-development budgets, allocations for prevention vs. cure and the balance between financing interventions for rural vs. the urban areas, which need to be taken into account. Trends have been comparatively favorable in relation to the ratio between development and non-development budgets at the federal level over the last 10 years but the provinces have shown a worrying trend with a major dominance of non-development budgets in the provinces — a gap which seems to have widened over the years. Prevention and cure disparities are evidenced in the successive Five Year Plans, where clinical services have consistently

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The second question relates to the federal and provincial roles and prerogatives and the manner in which these create impediments and opportunities particularly with reference to the fiscal interface?

Under the Constitution and the rules of business, which clearly defines roles and responsibilities, both of the provinces as well as the Federation in health, the Federal government is mandated with responsibilities for policy-making, legislation, coordination, resource distribution and acquiring foreign assistance whereas the provincial ministries have legal responsibility for delivery and management of health services; however provinces can also legislate in many areas under the Concurrent Legislative List. Within this framework, the Federal Legislative List opened avenues for the Federal Government to create institutes and hospitals on provincial territory and develop national programmes that are 'integrated' with the provincial health delivery systems.

Allocation decisions for the provincial health budgets are made by the provinces independently out of the provincial development budgets, which are financed by the federal government en-bloc through the National Finance Awards as unconditional federal grants. Provincial non-development budgets are, in theory, funded from provincial government revenues. During the SAP years, part of the recurrent budget was also made available by the federal government; however, this has since been largely discontinued. However, the Federal Government also supplements provincial development budgets through conditional or tight grants and in contrast to the former this enables the federal government to allocate resources in specific areas such as in the case of the federally-led public health programs.

However over the years, despite these stipulations being straightforward, overlapping services have created ambiguities between federal and provincial roles and responsibilities and administrative authority; these issues have been compounded by conflicts over sharing of resources and financial arrangements. Owing to these problems, the federal-provincial interface has become one of the overarching systems-level thorny issues in the health sector – a problem, somewhat 'complicated' further after the passage of the Local Government Act.

It is perceived that gaps in understanding provincial requirements and/or prerogatives create problems with budgetary allocations. These and other considerations also create issues with the implementation of federally-led public health programs in the provinces. At a provincial level, it is perceived that federal programmes do not clearly analyze their implications on overall recurring costs. Moreover there is a certain level of lack of ownership

of federal public health programs at the provincial level; the recent reluctance on part of Punjab to sign up to the Maternal, Neonatal and Child Health Program along the lines of the centrally funded initiative is a case in point and highlights the need to use the budget as a financial instrument for enhancing provincial performance and stimulating innovation, even if it means radically reconfiguring some programs.

Now the third question of why the need for alternate modes of financing health when the budget is on the way to being increased?

It is important to recognize that this would be a strategic imperative. Pakistan currently principally uses three modes of financing health – taxation, out of pocket payments and donor contributions of which the latter is the least significant in terms of size. 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 (Pak. Rs. 570). However, a number of considerations warrant that we revisit this paradigm for a number of reasons.

Firstly, taxation as a mode of financing health demands an extensive tax collection capacity and is possible largely in formal economies. In Pakistan, the informal sector of the economy is predominant and general taxation accounts for less than 20% of the GDP. In all likelihood, judging from the current trends, it is most likely that the volume of economic activity will increase and if the current growth is sustained and the population moves into the formal sector, 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 monthly household out-of-pocket expenditure on health has been reported at Rs. 358. This is equal to 5.2% of the total monthly household expenditure and translates into an annual per-capita health expenditure of Rs. 570 – clearly a significant burden for 23.9% of the Pakistani population which according to the recent poverty estimates lives below the poverty line. This highlights the need to mainstream social health insurance as a mode of financing health. In all fairness, budget statements such as *"the government is using its resources to reduce difficulties for the deserving citizens"* and *"to provide non invasive Angiography, MRI and dialysis to deserving people free of cost at federal government hospital, latest machinery is being provided"* are evidence of the commitment to strengthen safety nets for health service delivery for the disadvantaged; however, these will have to be carefully structured. Importantly within this context, the recently launched 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.
Social health insurance also necessitates feasible and pragmatic organizational management to boost pre-payment and build enabling mechanisms for the development of a large pool of fund for which a number of steps need to be taken. As a preliminary step, the budget could have signaled the importance of this through the creation of a Health Fund, which would have indicated the government's commitment to providing per-capita cost-sharing in subsequently launched social health insurance arrangements; following this the feasibility of channeling *Zakat* funds and philanthropic grants into such a fund could have been explored.

The **third** source of health financing 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 be detrimental to programme sustainability as donor support is generally dependent on political and general conditions prevalent geographically.

In the **fourth** place, changes in the public-private roles, which are interlinked with the broader changes in the macro-economy merit consideration; within this framework, it is crucial to develop health financing options which are alive to contemporary realties on the one hand and protect the interests of the disadvantaged to which the state is committed to provide health as a public good – as it should. The contribution of the private sector to health cannot be ignored if public and private expenditures on health as a percentage of GDP are taken into

consideration. The government currently spends 0.8-0.7% of its GDP on health whereas the total expenditure can roughly be placed at 3.5% of the GDP. These considerations necessitate, exploring mixed arrangements for the delivery of health.

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 patters 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 some priority services – should be delivered by the State as a public good.

Moreover it is hoped that in years to come the social sector and options for strengthening delivery would be centre stage during the pre- and post-budget deliberations as it is only through an increase in the demand for these services that the State will be more responsive to the need for strengthening them.

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