Health and the budget 2007 – How healthy is our budget?

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The federal budget for 2007 will be presented on June the 9th, subsequent to which a special parliamentary session will be convened to debate the budget. Within this context, this article focuses on budgetary allocations for the health sector with a focus on four areas: aggregate level of allocations, quality of expenditures, allocation distributions and the issue of leakages and pilferage from the system, with a view to lending impetus to a dialogue on the short and long term imperatives of allocations in the health sector.

At the outset, it must be recognized that a discussion on budgetary allocations for health is important for a specific reason. Health is fundamental to the social sector and in countries where macro policy decisions are largely shaped by geopolitical realities and market forces, allocations for the social sector are a true reflection of any government's commitment to meet the equity objective.

First, with respect to total allocations, it is well recognized that there have been unprecedented increases in budgetary allocations in recent years; the forthcoming allocation of Rs. 13 billion is a positive development, indeed. However, even as it currently stands, public sector spending on health amounts to roughly US $ 4 per capita after adjustment for population growth and inflation. There is, therefore, still a wide gap to be bridged between this and the internationally recommended public sector spending of US $ 34 per capita – a level at which the delivery of a package of essential health services to populations becomes possible. In other words, it would then become possible to achieve goals such as the MDGs and others articulated in the MTDF.

Theoretically, this would necessitate a five-fold increase of the existing budget or a 50% increase every year for the next 10 years. Pakistan's Fiscal Responsibility Act does not stipulate such an increase. As a first step, therefore, we must set a 5-10 year plan for gradual but substantial increases in the health budget. Here it is important to address the next question: even if we achieve this impossible fiscal target within the existing health system, would we have the ultimate cure for our health woes? The answer is clearly a 'No' because of issues inherent to utilization capacity, an important indicator of which is the allocation versus expenditure lag. Budgetary lapses in the social sector are ascribed to lack of utilization capacity; this connotation masks systems challenges, which make the utilization of budgets challenging – excessive centralization of operational decision-making, onerous financial and administrative procedures and lack of accountability for delays in decision making, which have implications for fund flows are to mention a few. Coupled with this is limited capacity to plan and implement, which further negatively impacts the limited ability to expend. Therefore, alongside budgetary increases in aggregate and in program-specific categories, it is critical to set aside dedicated funds for procedural reforms.

Linked to this is the issue of quality of expenditure and expenditure targeting. A careful tracking of fund flows in the health sector shows a predominance of expenditures in the month of May and June before the financial year ends. In addition, there are no mechanisms in place to evaluate the impact of given allocations on outcomes vis-à-vis the equity objective and the poverty reduction strategy focus, which should be the core objective of the state health sector. Enhancing quality and appropriate targeting of expenditures is closely linked with governance, which creates yet another imperative for dedicated budgetary allocations to strengthen governance structures that enable the delivery of programs. A core prerequisite for sound governance is reliance on timely

and appropriate information for decision-making. Again, this flags the need to provide substantial budgetary support to bridge the current gap in Pakistan's health information system. There are several components of a health information system already in place, albeit with many gaps; however, there are also clear opportunities where the right investments in structures and technology in particular can enhance connectivity in the existing health management information system; enable building infrastructure for hospital information systems both in the public and private sectors; improve death registration and enhance the potential within existing survey instruments. It would be logical to make investments in these areas where gains can be achievable in the short term. This would require enhanced allocations over and above what has been currently budgeted for the National Plan for Disease Surveillance and the National Health Information Resource Center; reliable sources indicate that this amounts to Rs. 10 million and Rs. 28 million respectively. Additionally it is important to earmark funds for policy research, at least in areas where contemporary evidence is badly needed such as in the case of the post WTO impact on prices of drugs and the impact of WHO' International Health Regulations 2007 at a country level.

The third area, which must form the substrate for the budget debate is the distribution of allocations in the budget of 2007. With reference to allocations within preventive health domains, a careful analysis reiterates the need to enhance allocations in certain areas. According to reliable sources, the health budget allocates 500 million each for blindness, maternal and child health and hepatitis; 350 million for HIV/AIDS, 100 million for malaria, and 205 million for tuberculosis. As opposed to this, only 5 million have been allocated for the prevention and control of non-communicable diseases (high blood pressure, diabetes, heart diseases and stroke).
It would be important to look at these distributions in the

light of contemporary evidence on mortality (deaths) and morbidity (disease). The Burden of Disease Studies conducted to date by the World Bank and US-based academic institutions show that both communicable and non-communicable diseases (NCDs) share an equal burden in terms of morbidity. In terms of mortality, data from the Pakistan Demographic Survey of the Federal Bureau of Statistics show that the percentage of deaths attributed to NCDs has increased from 34.1% in 1992 to 54.9% in 2003. Critics argue about the validity of the Pakistan Demographic Survey data and refer to issues inherent to the validity, and accuracy of these statistics. But does it make sense to disregard local data completely, particularly when global trends and independent international evaluations also validate the same trends? Critics also argue that these diseases are not part of the MDGs; however, even if the MDGs are taken as a yardstick, we must be reminded of the fact that Goal 6 refers to the 'other disease categories' on the premise that countries would have the indigenous capacity to determine what constitutes a locally-suited priority. Non-communicable diseases should clearly be a public health priority, given that they kill more people than malaria, tuberculosis and HIV/AIDS combined. The point is not to question the validity of investments in these areas but to argue for increased investments for NCDs in addition. NCDs are equally important and merit due attention.

To date, the prevention and control of NCDs has been addressed through a very small program at the Ministry of Health, which is supported technically through the pro-bono contributions of an NGO and the partnership of professional associations. However, it is time for the Ministry of Health to develop a full program on NCDs.

Turning now to infrastructure in the distribution of allocations domain: there has been news of allocations for 900 (803) proposed heath care centers in the urban settings on the premise that these would decrease the workload burden on

existing tertiary care hospital sites. This warrants revisiting a fundamental question in health which relates to the role of the state in health? The state should clearly be a 'financier' and 'regulator' of services; however, it need not be a 'provider' of services. Lessons learnt from the lack of sustainability and failure of the BHU initiative launched in the 1980's should be instructive in this regard. This experience indicates that it might be best for the state to stay away from being a provider of services and focus on creating structures, which enable it to leverage the outreach of the private sector to deliver services. True that options for revitalizing existing state-owned healthcare infrastructure must be explored as in the case of the BHU restructuring arrangements given that something has to be done with the 'existing' infrastructure; notwithstanding, 'future investments' in infrastructure should weigh the benefits of 'government provision of services' vis-à-vis 'government financed private provision'; the latter appears more plausible in a country where the law of the land lets the private sector operate. The same argument applies to another area in the current budget. The federal government will be paying for a tertiary care facility in NWFP, the annual recurring cost of which could enable the government to purchase services from market to achieve the equity objective. These options reiterate the need to revisit some fundamental policy standpoints – continuing to make investments in infrastructure vis-à-vis exploring alternative modes of financing, which can make service delivery more equitable.

Last but not the least is the issue of leakages from the system – an outcome of various forms of financial and moral corruption. There is anecdotal evidence of various practices, which lead to leakages from the system – kickbacks, over-invoicing, and outright graft in the contracting process, collusion among bidders in the procurement process and theft from central stores in hospitals are to mention a few. These occur as a result of poorly managed expenditure systems and

poor fiscal controls over flow of public funds. Improving governance is critical to addressing these issues; from the budgetary standpoint, however, allocations in certain areas can give quick dividends. For example, electronic public expenditure tracking procedures and electronic equipment and supply inventories can track leakages from the system and a nationwide database for matching staff and wage payments can maintain up-to-date personal records and as such can assist in eliminating abuses such as paying ghost workers. Budgetary allocations should therefore leverage technology to enhance efficiency and promote greater transparency in health systems and to eliminate wastage of scarce resource, which lead to poor quality of care, compromised safety and efficiency and de-motivation of the staff.

To summarize, the budgetary increase this time around is commendable. However, as a short-term measure it is also important to reanalyze priorities for allocation and pay attention to systems strengthening with the understanding that these investments will not be visible for a while – quite unlike physical infrastructure. Over the long term, strategic planning exercises in the Ministry of Health, the Planning Commission and civil society think-tanks should focus on the following from a budgetary perspective:

Firstly, an essential package of health services should be carefully costed; the government should then make a five-year plan to enhance allocations to a level where the delivery of these services becomes possible. Simultaneously, they should also enhance their capacity to utilize funds, both through procedural as well as personnel reforms. Secondly, they should look carefully into policy and strategic directions both for the provision of essential health services for all citizens as a public good as well as other services for the under privileged who are not covered under any pre-payment scheme. In this connection, they should clearly articulate a policy on infrastructure vis-à-vis provision through the market and in

the event of the latter, aim for the creation of an enabling and transparent regulatory environment. Thirdly, they should analyze alternative means of health financing by leveraging the potential within existing arrangements – mainstreaming safety net resources for health and insurance-based arrangements.

As the Parliament gets into session to debate the budget for 2007, they must be mindful of the fact that it is not enough to put money in programs; unless the systems to deliver them are reconfigured and strengthened, programs will never deliver on objectives.

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