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REPUBLIC OF GHANA

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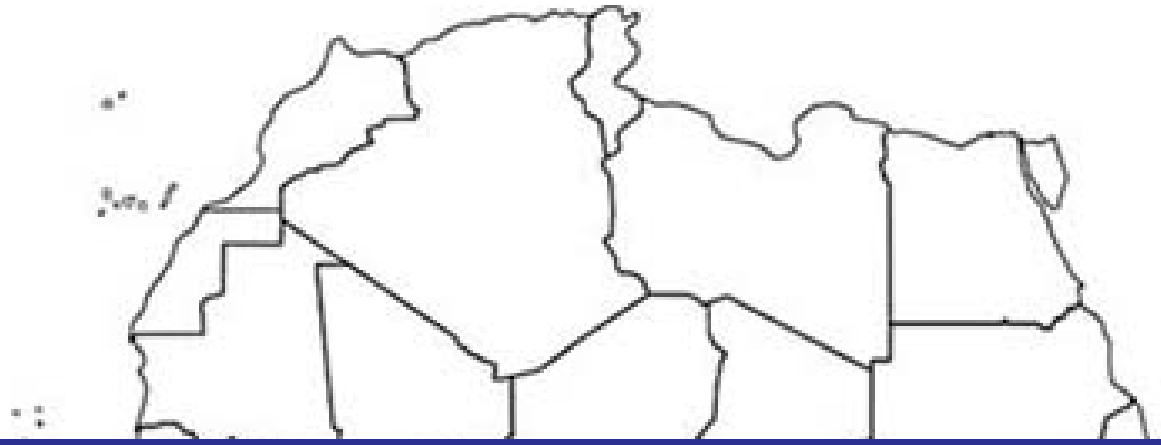
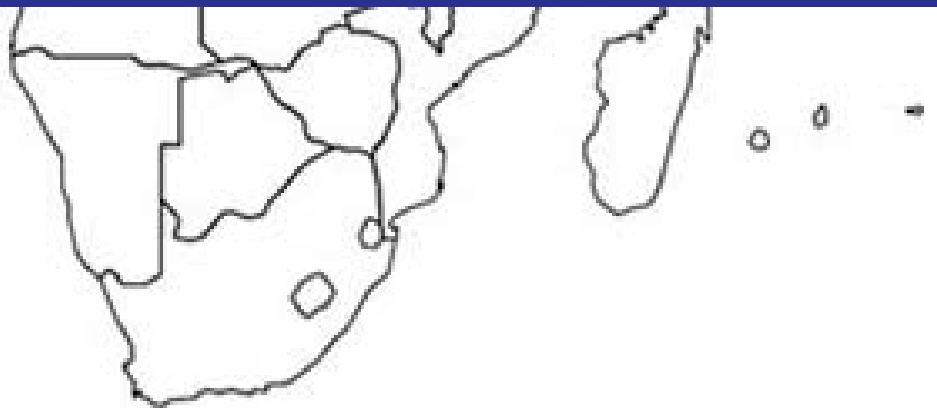


FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE:
PEER-TO-PEER LEARNING WORKSHOP
FINDING SOLUTIONS TO COMMON CHALLENGES

FEBRUARY 15-19, 2016

ACCRA, GHANA

Day 1, Session V.



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HEALTH SYSTEMS GOVERNANCE & FINANCING

Expenditure management for UHC

Helene Barroy, WHO

Financial Protection and Improved Access to Health Care Workshop,

16 Feb 2016, Accra, Ghana

World Health Organization

Why it matters?

« Why shall I care?

I don't even spend half of my budget! »

Key questions

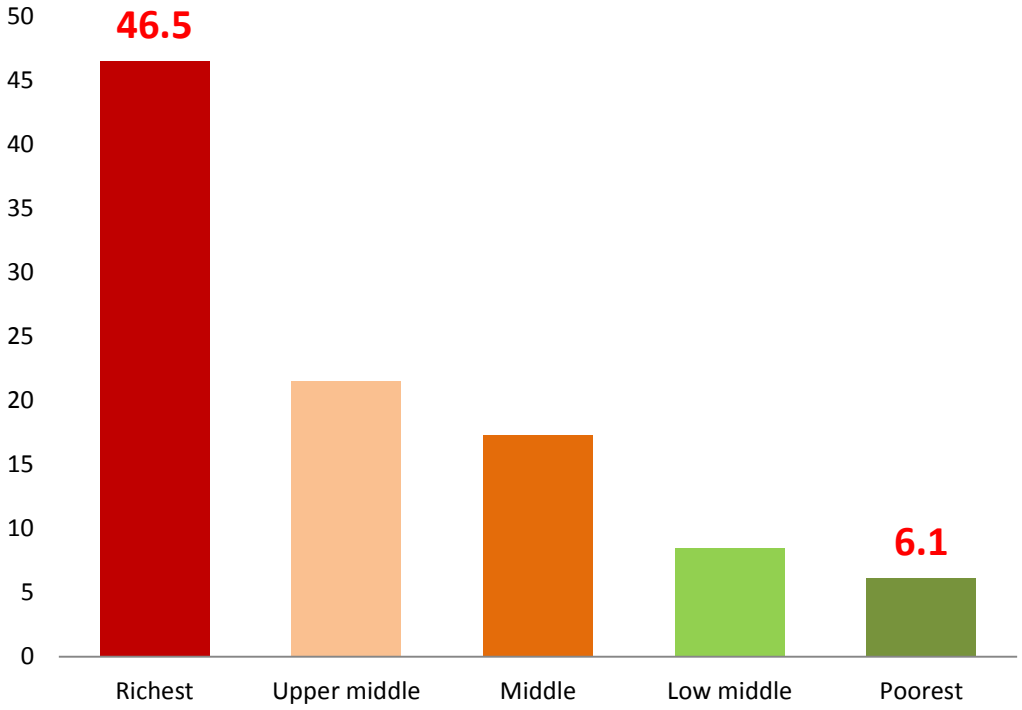
- Why expenditure management matters for UHC?
- To what extent managing health expenditure is a core PFM issue?
- How can PFM and health purchasing be connected?
- What can be learned from country experiences?

Why public expenditure management matters for UHC?

- Countries tend to focus more on resource mobilization: inherited policy choices and institutionnal 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 unfinite: 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)

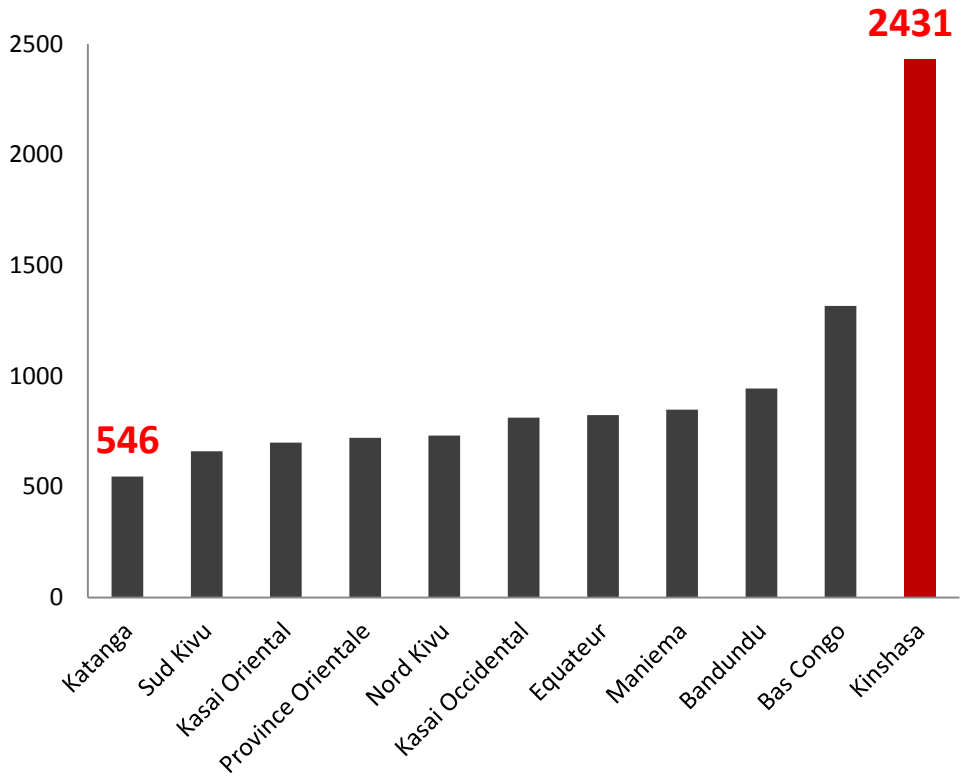
Managing public health expenditure better is also a matter of equity

Chad: Benefit incidence of public subsidies by income level



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

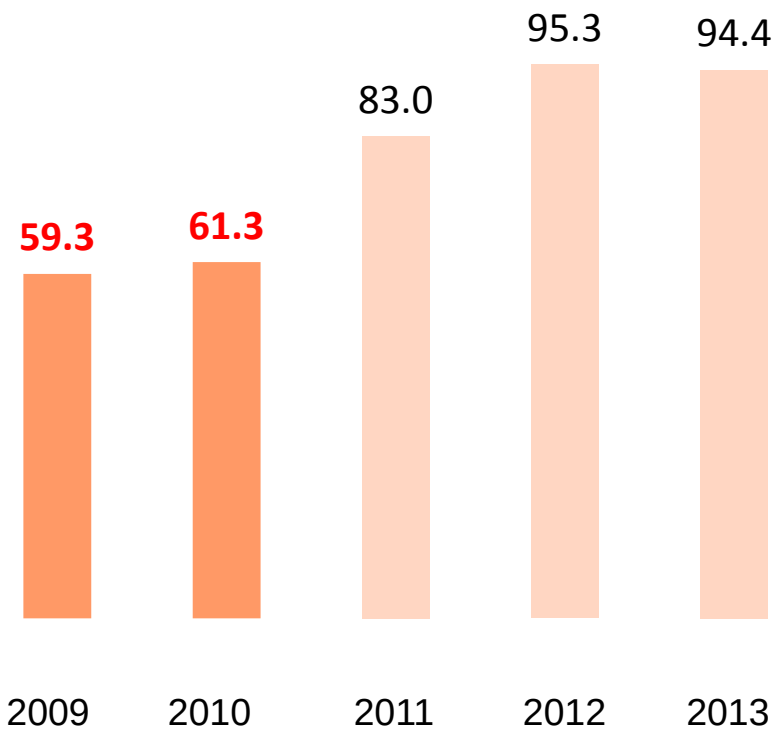
DRC: Distribution of public health expenditure by province, per capita (CDF)



Source: Barroy et al, DRC Health PER, World Bank, 2014

Under-execution is also a symptom of poor financial management

Benin: Execution rate of health budget allocations, in %



- 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

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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

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

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 adjustement

Combining financial management with health purchasing requirements

What priorities?

Smart expenditure targets

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

How to purchase?

Strategic purchasing

- Appropriate provider payments (performance-based)

What to purchase?

Priority package of services

- Pre-defined benefit package, cost-effective interventions, PHC

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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

Large pooling and purchasing agency

- National Health Security Office pools resources and purchases services for ¾ of the population (for UCS scheme)

Reformed payment systems

- Capitation for ambulatory care
- DRG for hospital care
- Active gatekeeping system through « prefered doctor » enrollement

Strategic purchasing and negotiations

- Contracted providers
- Providers networks
- Negotiations for providers tarrifs and drugs prices

France: a mix of macro-level and payment reforms to curb public health spending

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.

HEALTH SYSTEMS GOVERNANCE & FINANCING

Thank you

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