

HEART

HEALTH & EDUCATION ADVICE AND RESOURCE TEAM

Fiscal space for health

OPM seminar series on health financing for UHC

Fiscal space, in its broadest sense, refers to ‘the capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position’.¹ It refers to the effort to create room within the budget for additional spending while at the same time not jeopardising the fiscal stability of the economy.

For some, ‘fiscal space’ is defined less in terms of the emphasis on the ‘gap’ or ‘room’ in the budget for ‘additional’ spending and more in terms of political economy factors. They define fiscal space as ‘*the financing that is available to government as a result of concrete policy actions for enhancing resource mobilisation, and the reforms necessary to secure the enabling governance, institutional and economic environment for these policy actions to be effective, for a specified set of development objectives*’.² This definition implies a long term outlook and is more pragmatic in terms of integrating an analysis of feasible policy options in light of exiting political settlement in the country.

The concept has come to the fore in the debate regarding what constitutes sound fiscal discipline. It is often an argument for increased prioritisation of spending on areas that have not traditionally been viewed as prudent investments when governments are attempting to improve their financial wellbeing; health for example. The argument is that ‘fiscal space’ should be created for health investments because spending in these areas creates productive assets that pay for themselves over the long term; i.e. healthier, more productive workers.

OPM’s work on fiscal space for health has provided Ministries of Health with strong arguments when negotiating annual budget allocation with Ministries of Finance. The analysis provides country-specific evidence to promote the priority of health expenditures for economic well-being. There is growing evidence and recognition that investments in health are essential for sustainable growth as well as social and macro stability in the longer run. Indeed, recent findings published in *The Lancet* suggest that returns to investing in health are substantial: “*reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries*”.³

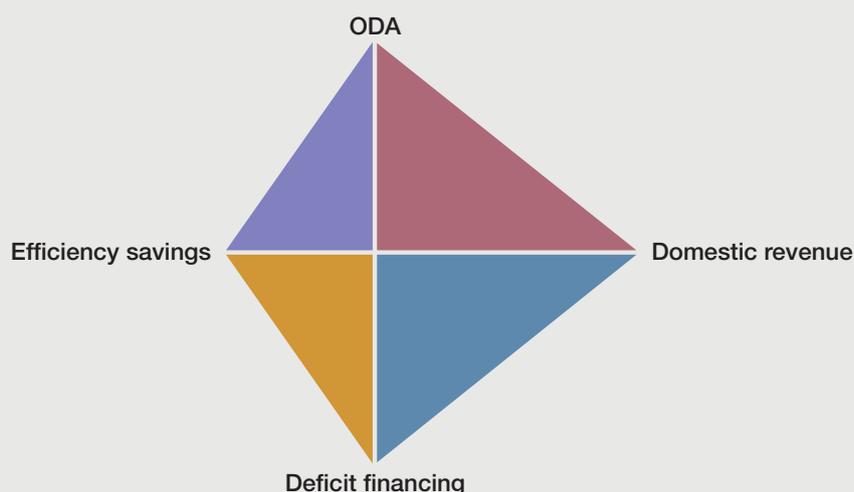
What are the sources of fiscal space?

There are four sources through which a government can expand fiscal space, but it must do this without compromising either macroeconomic stability or fiscal sustainability. It must ensure that in creating fiscal space it has the short-term and longer-term capacity to finance its desired expenditure programmes while at the same time being able to service its debt. The sources are shown in Figure 1 and listed below:

1. **Overseas Development Assistance (ODA)**, through aid and debt relief;
2. **Domestic revenue mobilisation**, through improved tax administration or tax policy reforms;
3. **Deficit financing**, through domestic and external borrowing; and
4. **Increasing efficiency** of expenditures.

The shape of the fiscal space diamond reflects the relative contribution of each of the sources to the available budgetary room. In low-income aid-dependent countries with a weak tax system, ODA will be large in comparison with domestic revenue. In times of fiscal austerity, governments typically increase efficiency savings. When government spending is in excess of government revenue, the resultant budget deficit is plugged by borrowing, often with a view to stimulate economic activity, which then in turn increases tax revenues to pay of the debts incurred.

Figure 1: Fiscal space diamond



Source: Adapted from Roy, Heuty and Letouze (2007).

How can governments increase fiscal space for health?

1. **Domestic Revenue Mobilisation:** Refers to generating additional revenue by increasing taxes or improving tax collection. There are three main methods of opening fiscal space through domestic revenue mobilisation:
 - i. **Taxes generated by improved economic growth or widening the tax base:** A larger tax to GDP ratio will raise the total amount available to spend on the national budget, and so raise the nominal monies available to health. For countries with low ratios of government revenue to GDP, broadening the tax base and improving tax administration in order to raise the revenue share in GDP are likely to be important long term objectives.
 - ii. **Prioritising health within the government budget:** Fiscal space for health can be raised by increasing the share of the total budget going to the health sector. Cross-country comparisons show a wide variation in government spending on health, even among countries with a similar income.⁴ The allocation of the budget is a highly politicised process and decision-makers are faced with competing needs for which compelling cases are being put forward. Arguing for a reallocation of a larger share of the budget to health is therefore typically not an easily attained source of fiscal space in most countries. However, the Abuja Deceleration signed by the majority of African Heads of State suggests 15% of the total budget should go to health.

iii. Taxes earmarked for health and SHI: Earmarking can involve dedicating an entire tax to fund a particular programme or setting aside a fixed portion of a particular tax to fund the programme. Regardless of the approach, their purpose is the same: to increase the resource base for public spending on health. The levying of ‘sin taxes’ – taxes on goods that have adverse health effects, notably tobacco and alcohol – is an example of earmarking. Such taxes are considered justified as they represent the imposition of a consumption charges on those who use them in lieu of the costs that these products generate and the impact their use has on society beyond those who simply consume them. Social Health Insurance (SHI) can provide another source of health sector-specific fiscal space. SHI collects mandatory financial contributions from designated segments of the population, typically through payroll taxes, and pools these contributions in independent funds to pay for services on behalf of the insured to finance public health care and to improve financial risk protection. Earmarking is often viewed as imposing an unnecessary constraint on fiscal policy-making, one that reduces flexibility and allocative efficiency. Thus, while it is not unusual that calls be made to introduce earmarked taxes as a way to insulate health spending from other competing publicly funded activities, these calls are generally supported by political rather than economic arguments.

2. External grants for health: ODA provides an additional source of fiscal space which many developing countries have come to rely on. The challenge with ODA, however, is that only a sustained and predictable flow of grants can create the potential for a scaling up of expenditure that can be maintained by the recipient government beyond the expiration of the ODA. Most development partners are unwilling to commit to funding beyond a one- or two-year timeframe. This uncertainty, coupled with concern about exploiting readily available but short-term ODA, rightly discourages recipient countries from accepting such funds to scale-up programmes, particularly where such programmes have high costs of downsizing (e.g. antiretroviral treatment). Other factors affecting ODA as a sustainable long term health funding source are: volatility of grants, displacement of domestic health resources, limitations to off-budget support (not aligned with government priorities), and absorptive capacity of large external resource inflows (inflation and exchange rate fluctuations). Thus, while attractive, the fiscal space opportunities offered by ODA might be less attractive than they appear on the surface. They can however, fill short term financing gaps whilst medium to longer term domestic taxation measures are put in place.

3. Efficiency improvements in the health sector: Simply defined, inefficiency refers to a failure to fully exploit available resources. At the most basic level efficiency gains can be thought of as achieving one of two things:

- i. better outcomes for the same level of investment; *or*
- ii. the same outcomes at a reduced level of investment.

While efficiency gains may reduce the costs of service delivery the objective is to contain costs without reducing outcomes. Efficiency, therefore, includes a measure of both the quality and the quantity of outputs (i.e. immunisation rates) for a given level of input (i.e. immunisation budget) and is not simply about ‘cutting costs’. More often it is about making better use of existing resources so as to expanding coverage of and access to health services. Efforts to improve efficiency, then, should be considered in order to increase the domestic resources available for health spending. Fiscal space created through efficiency improvements can take a variety of forms, including increasing the efficiency with which services are delivered or transfers targeted, introducing policies that reduce corruption and improve governance, and achieving greater alignment and harmonisation of donor resources.

4. Borrowing: Borrowing provides the government with additional resources early on, while constraining its resources later through interest payments and as loans are repaid. For this reason, borrowing does not create additional fiscal space, rather, it changes its availability over time. High rates of borrowing over a long period of time to finance a government's regular operations are generally not advised. An increasing level of debt servicing would progressively erode the government's financial resources, and the high levels of government spending would eventually become unsustainable. Yet what is an acceptable level of borrowing? This, of course, is a matter of debate. In practice, debt sustainable depends on a number of factors. The IMF uses a 40% long-term debt-to-GDP ratio as the ceiling that developing countries should not exceed in order to ensure fiscal sustainability and macroeconomic stability. Others suggest a higher threshold (e.g. 60 per cent according to Reinhart and Rogoff 2010).⁵ Still, another approach is to view an optimal debt-to-GDP ratio as arbitrary since public debt can be beneficial over the long term if interest payments are less than the annual increase in nominal GDP (UNCTAD 2011).⁶ These sustainability levels are benchmarks and other factors such as the cost of borrowing, any grace period (period of delayed repayment) that can be obtained, and so on, will play a role in determining a sustainable level of debt.

Raising fiscal space for health to what level?

From a global analysis of Universal Health Coverage (UHC) financing the World Health Report 2010 suggested a target of around 5% of GDP to be spent on health. This is in line with recommendations for increased development aid for countries to achieve the minimum targets made by both the 2001 Commission on Macroeconomics and Health and the 2009 High-Level Taskforce on Innovative International Financing for Health Systems. McIntyre and Meheus (2014)⁷ found that *'it is difficult to get close to universal [health] coverage at less than 4-5% of GDP, although for many low- and middle-income countries, reaching this goal is aspirational in the short term and something to plan for in the longer run'*.⁸ Indeed, for low income countries 5% of GDP would not raise the minimum \$86 per capita required to deliver UHC. The conclusion then is that the four sources for generating fiscal space for health should not be regarded as independent of each other and should be employed together. A mix of the four funding sources to create short-, medium-, and long-term financing policies will be required to achieve UHC over time.

Findings from OPM fiscal space for health analyses

OPM has experience of conducting fiscal space analyses in health across a number of countries. These have ranged from long term sustainability financing for health financing strategies (Ethiopia, Rwanda, Sierra Leone and Tanzania), emphasis on modelling of health insurance schemes (Morocco), rapid analysis of health financing options (Benin), disease-specific financial sustainability analysis (HIV in Kenya, Uganda, and 25 Fast Track UNAIDS countries), and regional evaluations for developing financial framework for sustainable financing of UHC (SADC and EAC).

These analyses have shown that there are a variety of ways that governments can use to increase fiscal space. The decision about how to do so is a policy choice dependent upon how consistent that source is with the country's macroeconomic fundamentals. The choice is inherently country specific. It requires '*detailed assessments of a government's initial fiscal position, its revenue and expenditure structure, the characteristics of its outstanding debt obligations, the underlying structure of its economy, the prospects for enhanced external resource inflows and a perspective on the underlying external conditions facing an economy*'.⁹

If governments are to generate fiscal space for health, how are they to go about doing so? The first thing to note is that only ODA and efficiency are within the sole, respectively indirect and direct, sway of the Ministry of Health.¹⁰ However, country findings show that the largest impact on sustainable financing is to increase the government budget to health.

Therefore, as government budget/taxation (and borrowing) fall within the remit of the Ministry of Finance, the Ministry of Health must become adept at lobbying the Ministry of Finance with a strong case for increased spending on health. Achieving this will require an understanding of how the Ministry of Finance considers fiscal space, budgetary priorities, medium term development plans, and proving performance (i.e. through M&E). Ministries of Health need to present a very convincing case to Ministries of Finance as to why the health sector needs more government resources. Also key in this regard, is having the credibility that comes with a record of good governance, good past and present performance in public expenditure management and high absorption capacity during implementation.¹¹

In sum, a different mix of financing policies are suitable for each country. We can make some generalisations based on income status:

Low income countries do not have the domestic resources to provide UHC in the medium term. Increasing the share of budget to health is insufficient for supplying all health needs. Countries can benefit from preparing solid health care plans inclusive of financing strategies which can show donors their commitment to health and how their plans can provide strong returns to investment. This can be crucial in advocating for additional international aid in resource-constrained countries. Efficiency saving have great potential but countries may need technical assistance to achieve these.

Middle income countries could domestically fund UHC if budgetary share were increased or taxes raised (general tax base, or through earmarked taxes). This however may take ten or more years to see adequate growth in the tax base, ensure absorption capacities in the health sector and limit impact to other sections of the economy. In the medium term advocating for greater donor assistance, (or at times short term concessional borrowing), are options as well as assessing efficiencies.

High income countries can domestically fund UHC but many need to reprioritise their spending to ensure equitable health coverage. Fiscal space for increased budgetary shares or earmarked taxes has been found but additionally, there can be great gains from health sector reforms including national health insurance schemes. Again a focus on efficiency can provide fiscal space and these countries have the greatest capacity for borrowing for health.

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- 10 For external grants this is when those committed grants are disbursed and flowing through the MoH budgetary system as per treasury funds.
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