Fifteen years later: moving forward Heller’s heritage on fiscal space for health

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Abstract

Economist Peter Heller, writing a seminal paper published in Health, Policy and Planning in 2006, identified five opportunities for expanding fiscal space for health: raising revenue, reprioritizing expenditure, borrowing, using seigniorage and mobilizing external grants. The development of the initial framework marked a significant conceptual advancement in health financing, by situating health reforms within a broader macro-fiscal context. Fifteen years later, fiscal space for health is not viewed simply as a question of finding additional revenues but also as a matter of improving public financial management (PFM) in the health sector, specifically for publicly funded health systems. This paper advances the concept of budgetary space for health, which explores available resources generated through greater overall public expenditure, prioritized budget allocations, and improved PFM. The paper adds a critical component, unpacking the ways through which PFM improvements can maximize budgetary space for health. The approach fits the realities of public finances in the era of the Sustainable Development Goals. The key implication is that PFM aspects should be systematically included in assessments of budgetary space to inform more effective country dialogues between the finance and health sectors.

Keywords: Health financing, public policy

Introduction

Peter Heller, an economist who worked at the International Monetary Fund (IMF), defined fiscal space as ‘the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government’s financial position’ (Heller, 2005). A year later, he explored the concept of fiscal space specifically for the health sector. Heller wrote a seminal paper in Health, Policy and Planning, identifying five opportunities for expanding fiscal space for health: (i) raising revenue, (ii) reprioritizing expenditure, (iii) borrowing, (iv) using seigniorage and (v) mobilizing external grants (Heller, 2006). In 2010, the World Bank refined this concept by recognizing five pillars for fiscal space for health expansion in low- and middle-income countries (LMICs): (i) economic growth, (ii) budget prioritization, (iii) earmarking of certain revenues, (iv) improved efficiency of spending in health and (v) external resources (Tandon and Cashin, 2010).

The development of the initial framework marked a significant conceptual advancement in health financing, by situating health reforms within a broader macro-fiscal context. This deepened the understanding of macro-fiscal realities within the health community. Empirical studies in about 40 countries since the development of the framework have shown that the macro-fiscal performance of an economy is an important consideration behind rising public funding for health. Further evidence suggests that increasing the share of a budget dedicated to health has the potential to significantly expand health sector resources where the initial allocations are low. Earmarked revenues provide relatively fewer resources overall for the sector (Barroy et al., 2016; 2018c). The fourth pillar in Tandon and Cashin’s approach, the efficiency component, has provided mixed evidence on the extent to which efficiency gains can be translated into more resources for the sector (Zeng et al., 2020).

Studies on fiscal space for health have also exposed gaps in understanding and applying the concept to country realities. The authors have varied widely in how they interpret and assess the concept. The absence of commonly accepted metrics has resulted in variations and inconsistencies in the analytical approaches used (Barroy et al., 2016; 2018c).
Economist Peter Heller, writing a seminal paper published in Health, Policy and Planning in 2006, identified five opportunities for expanding fiscal space for health: raising revenue, reprioritizing expenditure, borrowing, using seigniorage and mobilizing external grants.

Fifteen years later, this paper advances the notion of budgetary space for health, which explores available resources generated through greater overall public expenditure, prioritized budget allocations and improved public financial management (PFM).

This definition is the outcome of a growing understanding among academia and policy-makers that resources available in the health sector depend not only on the level of funding but also on how funds are allocated, formulated within health budgets and managed through the PFM system.

The added PFM component is particularly relevant considering the growing evidence that PFM weaknesses can alter the availability of resources within the health sector, mostly due to bottlenecks in budget formulation and execution.

By expanding the focus beyond revenue to include the rules and practice of budget use, health authorities can engage in a more comprehensive and effective budgetary dialogue with finance authorities to support progress towards universal health coverage and the COVID-19 response.

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**KEY MESSAGES**

- Economist Peter Heller, writing a seminal paper published in *Health, Policy and Planning* in 2006, identified five opportunities for expanding fiscal space for health: raising revenue, reprioritizing expenditure, borrowing, using seigniorage and mobilizing external grants.
- Fifteen years later, this paper advances the notion of budgetary space for health, which explores available resources generated through greater overall public expenditure, prioritized budget allocations and improved public financial management (PFM).
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- The added PFM component is particularly relevant considering the growing evidence that PFM weaknesses can alter the availability of resources within the health sector, mostly due to bottlenecks in budget formulation and execution.
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**Methods**

The proposed approach is derived from an extensive review conducted from 2017 to 2020 of the literature and data. The review of the literature consisted of unpacking conceptual frameworks underlying fiscal space for health and its empirical application to LMICs from 2000 to 2017 (Barroy et al., 2016; Barroy et al., 2018c). A second step consisted of developing and testing a measure for gauging the contribution of overall public expenditures and the health’s budget share to budgetary space for health from 2000 to 2017 (Barroy et al., 2016; Barroy et al., 2018c). A second step consisted of developing and testing a measure for gauging the contribution of overall public expenditures and the health’s budget share to budgetary space for health from 2000 to 2017 (Barroy et al., 2016; Barroy et al., 2018c).
around fiscal space and its links with public finance frameworks (WHO, 2019).

**Results**

**Connecting macro-fiscal environment, budget priority and PFM**

Budgetary space for health can be defined as the potential resources budgeted and used for health through the PFM system. Within this definition, budgetary space for health depends on three main components: (i) the overall expenditure envelope; (ii) budget allocation decisions, including the share allocated to health; and (iii) laws, rules and systems for budget use, or PFM. The proposed shift in terminology from fiscal space for health to budgetary space for health reflects the need to embrace both revenue and expenditure policies (‘the two sides of the same coin’). The budget for the health sector stems from the overall fiscal space available due to macro-fiscal considerations, over which health authorities have limited control, and from budgetary decisions and practices, over which health authorities have greater control.

This definition is the outcome of a growing understanding among academia and policy-makers that resources available in the health sector depend not only on the level of funding but also on how funds are allocated, formulated within health budgets and managed through the PFM system. The added PFM component is particularly relevant considering the growing evidence that PFM weaknesses can alter the availability of resources within the health sector (WHO, 2016; Barroy et al., 2019). Historical budget under-execution in health is estimated to limit budgetary space by 20–40% in sub-Saharan African countries (Barroy et al., 2019; Piatti et al., 2021).

**Component 1: annual public expenditure envelope**

The first component that determines budgetary space for health is the annual public expenditure envelope which is determined by the overall fiscal space (see Figure 1, Component 1). The IMF recently updated its list of interconnected factors that influence overall fiscal space to include economic growth, revenue, fiscal policies, debt, the size of contingent liabilities, access to capital financing, deficit rules and monetary policies (IMF, 2016; 2018). The function of the annual public expenditure envelope as a primary driver of budgetary space for health is another noticeable shift that separates the budgetary space for health approach from the initial framework of fiscal space for health, in which economic growth played a more direct role. In our approach, economic growth is included as one of the drivers of the overall fiscal space, in line with the updated IMF definition. Economic growth has an indirect role on health spending, due to evolved revenues and budgeted expenditures.

Overall fiscal space is dynamic. Public expenditure policies can influence overall fiscal space (see Figure 1). For example, an extension in a health benefit package could improve fiscal space through growth effects.

**Component 2: share of the public expenditure envelope dedicated to health**

The second component that determines budgetary space for health is the share of the public expenditure envelope that is allocated to the health sector (see Figure 1, Component 2). This share depends upon budget allocation decisions by the legislature and competitive budget negotiations between the ministry of finance and sector ministries. Political considerations and imbalances in power among different sectors may influence the share of the budget allocated to health. The share may also depend on whether the budget proposal, formulation, costing and linkages to a results framework are well-developed. Effective sector’s engagement in budget planning will affect budgetary allocation decisions.

**Component 3: effective and flexible PFM**

Once the share of the budget allocated to the health sector is defined, a key factor in determining budgetary space for health is the effectiveness and flexibility of the PFM systems (see Figure 1, Component 3). This is essentially where PFM and the rules and practices of budget use come into play, including how budgeted funds are allocated to priorities and implemented through the health system. If funds are poorly allocated and used ineffectively by service providers, this may reduce the existing budgetary space for the sector. The inclusion of this third component in the budgetary space for health approach is critical to a comprehensive understanding of budgetary space that reflects the realities of the public finance processes in place. Further details are provided in the next section.

The final element of note is the influence PFM may have on future budget allocations for health (see Figure 1). If the sector executes its budget fully or demonstrates an effective and efficient use of
Health more flexible or elastic (see Figure 2). Rigid budget structures
interventions can free up resources and make budgetary space for
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Stage 1: budget formulation
During Stage 1 of the budget cycle, budget formulation, some PFM
interventions can free up resources and make budgetary space for
health more flexible or elastic (see Figure 2). Rigid budget structures
defined by line items often limit reallocations, resulting in low health
spending (Chakraborty et al., 2010; Barroy et al., 2018a). Using
more flexible approaches to formulate health budgets, such as pro-
gramme- or output-oriented approaches (Cashin et al., 2017; Barroy
et al., 2021), is likely to enhance flexibility in the use of funds and
the potential for more and better spending in health.

Stage 2: budget negotiation and approval
PFM interventions during Stage 2 of the budget cycle, the negoti-
ation and approval stage, can enlarge the future budgetary space for
health. While politics and power matter, a budget’s share for health
will be determined by the technical preparation done in advance of
budget negotiations, the robustness of the results framework and the
alignment of the health budget proposal with the overall budgetary
process and calendar (Rakner et al., 2004). A proactive and results-
based approach from health authorities to budget negotiations and
approvals is likely to have a direct impact on the level of budget
share allocated to the sector.

Stage 3: budget execution
The execution of health expenditure creates budgetary space for
health. PFM improvements during budget execution, Stage 3 of the
budget cycle, can maximize the existing envelope. Overall revenue
shortfalls may impact the level of available resources across sectors.
However, policy actions such as credible revenue forecasts, multi-
year plans, realistic cost estimates, and flexible budget formulation
can improve budget execution upstream. Aligned cash plans, effect-
ive procurement management, provider autonomy and a tailored
control and accountability system can improve execution down-
stream (Barroy et al., 2019; Piatti et al., 2021). When implemented
effectively, these interventions that signify a collaborative approach
between finance and sector stakeholders can reduce the gap between
the adopted or theoretical budgetary space for health and actual
budgetary space for health.

Stage 4: budget monitoring and evaluation
Effective budget monitoring and evaluation can enlarge budgetary
space for health when the process is used to inform future budget
allocations. The use of budget performance information to secure
higher allocations has been proven to work successfully in several
countries. Countries with a long experience of spending reviews have
demonstrated that such reviews help governments focus on improving
expenditure prioritization and finding budgetary space for new
spending priorities (OECD, 2017). Improving the quality and consis-
tency of financial data would create a better foundation upon which
to build stronger arguments for an increase in budget
allocations.

The scope of PFM improvements defined above, and the impact
on freed-up resources for the sector, will be limited if national health
insurance funds cover the majority of health expenditures through separate budgetary processes. Still, improving and tailoring PFM
frameworks constitutes an effective pathway to a sustainable in-
crease in public resources for the sector in contexts where insurance-
Based contributions are not a suitable option (Yazbeck et al., 2020).

Discussion
Mainstreaming PFM in budgetary space analysis and
dialogue
Country assessments of budgetary space for health must be compre-
hsensive and include PFM-related issues. Any assessment that focuses
solely on revenues will not provide a comprehensive picture of the existing or potential budgetary space for health. Incorporating PFM
into the approach will provide a broader understanding of the budgetary space available and realistic ways to expand it. Three
aspects should be considered during the assessment. First, use exist-
ing guidance to identify key weaknesses, primarily in budget for-
ulation and execution, which hinder the effective programming and
use of budgeted resources (WHO, 2017; UNICEF, 2019; World
Bank Group, 2021). Second, identify corrective actions to eliminate
or reduce these weaknesses and enhance budgetary space for health.
Third, provide complementary information on the scope of potential
gains that could be generated through targeted PFM improvements.
For example, quantify the degree to which budgetary space would
be enhanced if health budget execution were improved.

Budgetary space for health assessments must also be aligned
with the budgeting process. If the assessment is not a routine
practice within the budgetary system, a careful sequencing will be
helpful in linking analysis with the multi-year budget calendar (see
Figure 3). During the budget development phase (Year 0), sector
engagement in the budget dialogue is critical. A budgetary space for health assessment should be conducted, with a view to influencing the multi-year allocation plan. Budget ceilings are then updated every year. Therefore, health sector engagement is also crucial before the ceilings are determined, at the beginning of the annual budget calendar, to influence any adjustments to the sector’s annual envelope. The ministry of health should then update the budgetary space for health assessment at the end of the 3-year cycle (Year 3), to support the development of the next cycle (Years 4–6) (see Figure 3).

The same comprehensive approach should apply to budgetary dialogue. PFM must be mainstreamed in budgetary space for health discussions between finance and health authorities. Health policymakers are encouraged to broaden their discussions beyond revenues and include PFM, with special attention on strengthening PFM processes to expand budgetary space for health. This is especially important in the context of COVID-19 as countries seek to increase health sector allocations to fight the pandemic and sustain progress towards UHC. Moving forward, countries should prioritize dialogue on PFM-related interventions that can enhance budgetary space for health including: (i) exploring flexible budget structures to free-up unnecessary spending, (ii) using a results-based approach in budget negotiation to influence budget allocation decisions, (iii) working towards full budget execution to reduce unused revenues; and (iv) using budget performance information to shape and enlarge future allocations.

**Conclusion**

The introduction of the fiscal space framework in the early 2000s led to important contributions. The framework has helped health authorities to better understand macro-fiscal realities and place health reforms within a broader context. With the current focus on domestic public resources, it is time to provide additional support for countries, to help them align their budgets with the financing requirements for UHC and fighting COVID-19. The notion of budgetary space for health introduced in this paper is an attempt to meet these goals and link available resources for health to the current realities of public finance.

The budgetary space for health notion helps countries understand both the revenue and expenditure sides of health resources and provides a practical approach that helps health and finance authorities understand how their actions can impact available budgetary space. By expanding the focus beyond revenue to include budget allocation decisions and the rules and practice of budget use, health authorities can engage in a more comprehensive and effective budgetary dialogue with finance authorities. This approach would strategically position the health sector in budget allocations and the use of resources rather than focusing on revenue generation, which is more closely linked to finance authorities. We also encourage ministries of health to reconsider their approach to budgetary space assessments in the context of multi-year budget plans. A deeper integration of PFM dimensions into assessment and dialogue will likely be the most effective way to enhance budgetary space for health in most LMICs. With strong country leadership and supportive global development partners, this may prove the most practical way to finance progress towards UHC and the COVID-19 response.

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