Budget Analysis of Administrative Institutions and Sector Policies in the Health Sector

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About CReDO

CReDO is a democracy and human rights nongovernmental organization that provides lobby and consultancy in the implementation of the democratic reform oriented policies. It provides knowledge and solutions in the framework of policy evaluation and assessment, policy management and implementation, developing relevant policy capacities needed to govern efficiently and effectively.

Specifically CReDO consultants provide:

- Cost-benefit analysis,
- Analysis of current policies,
- Analysis of public policy processes,
- Budgetary analyis,
- Institutional Analysis,
- Legislative analysis, regulatory impact analysis,
- Functional Analysis.

Among CReDO beneficaries are international institutions, Moldovan Government and various beneficiary groups.

Executive Summary

The goal of the report is to make a budgetary analysis of social policies. The Report is developed with UNICEF assistance and is addressed to the ministries from the envisaged areas. The results of the analysis will inform the reader on the efficiency in the use of public expenditures by public administrative institutions within the social sector areas and will foster a clear understanding of the priorities of social budgetary policies in relation to the main beneficiary groups.

The social sector includes the social, health, and education areas. The budget analysis has 2 aspects: 1) analysis of administrative budgets of central public institutions from the sector and 2) analysis of budget policies regarding the main funding mechanisms and main beneficiary groups of social policies.

The report is structured in several chapters. The integral structure of budgets in each area is analyzed in the first chapter. The second chapter contains the analysis of administrative budgets of central executive institutions in the envisaged fields. The main budget mechanisms and main priorities of budget expenditures in the envisaged areas are analyzed in the third chapter. The Report contains inter-sector comparison.

The conclusions of the report are grouped in 3 categories: conclusions on the efficiency of administrative budget use, conclusions on the identification of priorities in budget fund appropriation, and conclusions on the effectiveness of budget funds use. The Report recommends making efficient use of budget expenditures for administrative needs by enhancing productivity within subordinated agencies responsible for policy management. Nowadays the outdated technologies used for administration of policies reveal a high cost and artificial maintenance of a great number of public employees in the subordinated institutions. Another recommendation that results from the analysis of administrative budgets is the mandatory use of procedures for public procurements of services and goods. This category accounts for about 30% of all funds spent. The Report contains well-defined findings regarding the budget priorities for different beneficiary groups. The amounts paid with money or services are identified.

Contents:

1. Introduction

The budget policies or treasury policies are important in order to understand who and how much receives or benefits from the public funds. The budget analysis is necessary to ensure the transparency and accessibility for citizen to get to know the governance priorities.

The Report uses financial data from 2006-2007 and only in some cases uses expenditures planned for 2008. The information basis of the reports is the public and institutional reports, including financial data, in addition to the statistical data collected during the discussions and interviews with the accountable persons from the social sector.

The Report does not analyze social policies in the aggregate as it would need to include the tax policies in the Report, together with the main beneficiary groups. At the same time, the Report does not review the efficiency and impact of budget policies on the beneficiary groups because this requires a separate mission. The analysis of budget policies' impact claims the availability of statistical data with breakdown on main beneficiary groups before the consumption of budget policy benefits and their effect after their receipt. Although, the assessment exercise of social budget policy impact is difficult to separate from the social policies as a whole.

Abbreviations:

MSPFC – Ministry of Social Protection, Family and Child
NSIH – National Social Insurance House
RCMVE – Republican Council for Medical Vitality Expertise
MoH – Ministry of Health
SMC – Sanitary Management Center
NHIC – National Health Insurance Company
NCHEA – National Council of Health Evaluation and Accreditation
SPCPM - Scientific Practical Center of Preventive Medicine (CPM)
MA – Medicine Agency
SB – State Budget
SIB – Social Insurance Budget
MTEF – Middle Term Expenditure Framework
NDS – National Development Strategy
MEY – Ministry of Education and Youth
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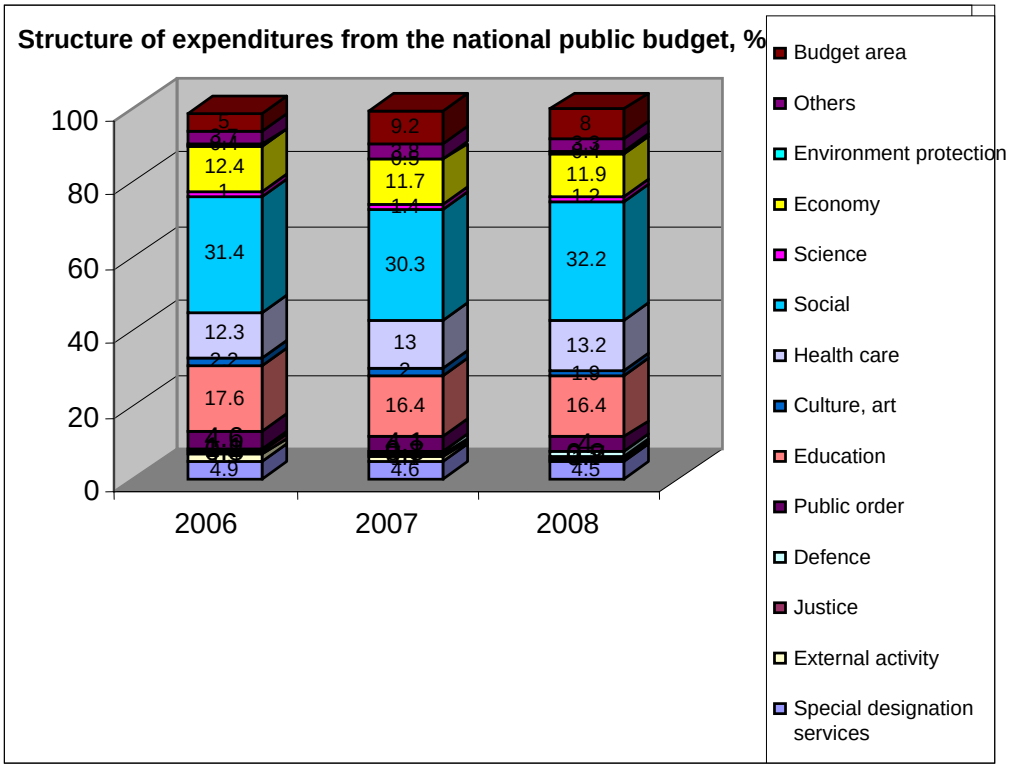
2. Budget Policies in the Social Sector

This Chapter analyzes the social sector budget macro-structure from a comparative perspective and from retrospective. The following 3 sections will present the analysis of budget structure and priorities from each area.

2.1 Sector Budget Policies

The social policies are a priority of public expenditures. The expenditures for social needs have a constant share of over 30% in the national public budget. The expenditures for health care account for 13%, and those for education – for 16% of the national public budget. The total value of social expenditures accounts for over 60% of the national public budget. This figure maintains its share over the last 3 years.

Figure 2.1

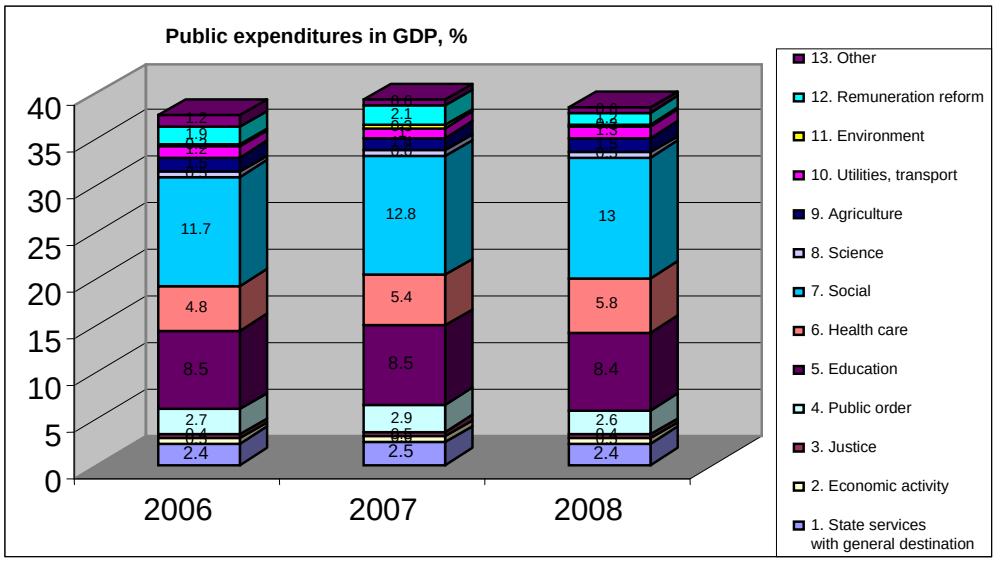


Source: MTEF 2008-10, 2009-11

The analysis of social expenditures structure in terms of Gross Domestic Product (GDP) reveals a similar situation. The expenditures for social sector account for 13%, for health care – almost 6%,

and for education – a little over 8%. Totally, the social expenditures account for a little less than 30% of GDP.

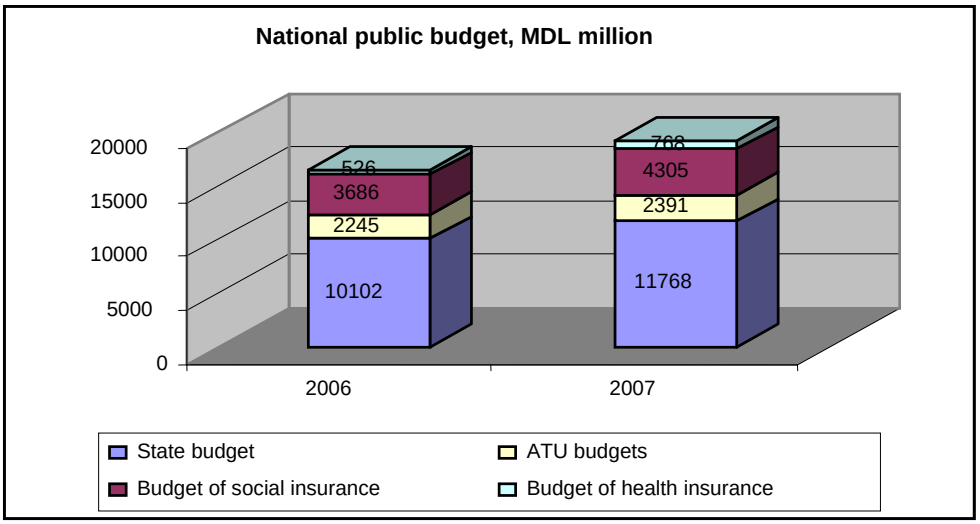
Figure 2.2



Source: MTEF 2008-10, 2009-11

The national public budget consists of 4 main budgets: state Budget (revenues from taxes and fees), budget of local public authorities (ATU), social insurance budget, and health insurance budget. The relative share of budgets is obvious.

Figure 2.3



Source: MTEF 2008-10, 2009-11

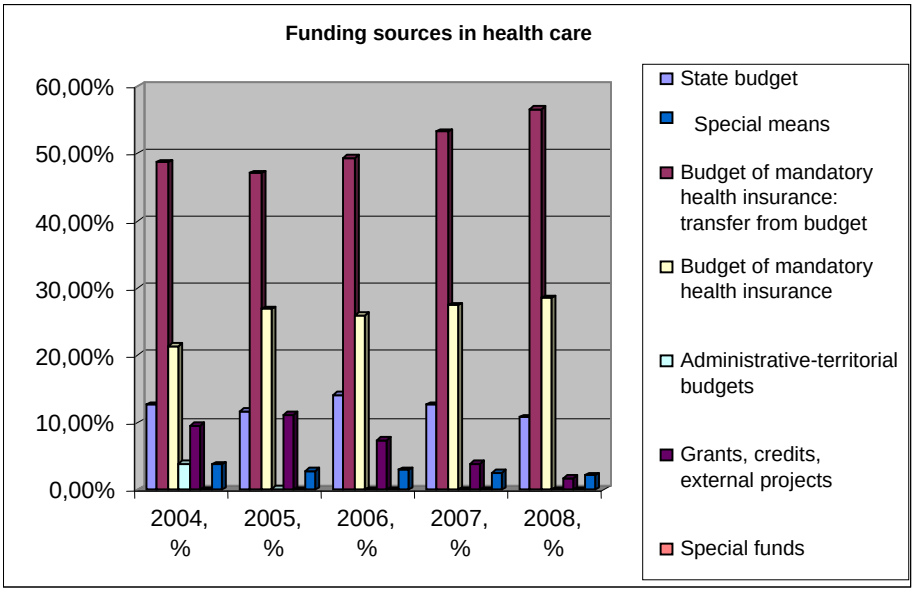
2.2 Budget of Health Care Policies

There are 3 main sources in the health care area: the State Budget (SB) and the health insurance budget (HIB) that form the expenditures for medical service provision, the state budget through health care programs and budgets of local public authorities. The share of state budget through contributions to HIB and health care programs is over 70%. The weight of HIB is continuously increasing.

The analysis of budget expenditures in health care area shall be performed through the analysis of public health care programs, analysis of relative expenses for health care spheres (primary, emergency, outpatient, investigation, and hospital health care) and for different beneficiary categories.

The Figure below shows that HIB (28%) and transfers from the state budget for insurance (55%) form the greatest expenditure budget in health care – over 80%. The Government public health care programs funded from state budget resources account for over 10% of health care expenditures; the rest belongs to the budgets of local authorities and grants.

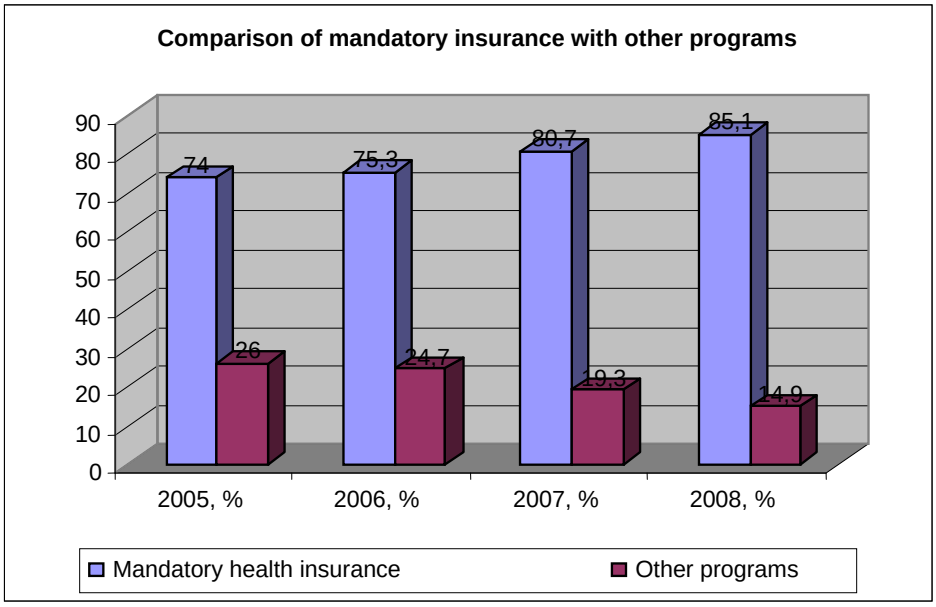
Figure 2.11



Source: Annual Budget 2006, 07, MTEF 2008-10, NHIC Report 2006 07, author's calculations

In the Figure below, HIB is compared with other expenditures in health care sector. So, the detailed analysis of HIB is extremely necessary.

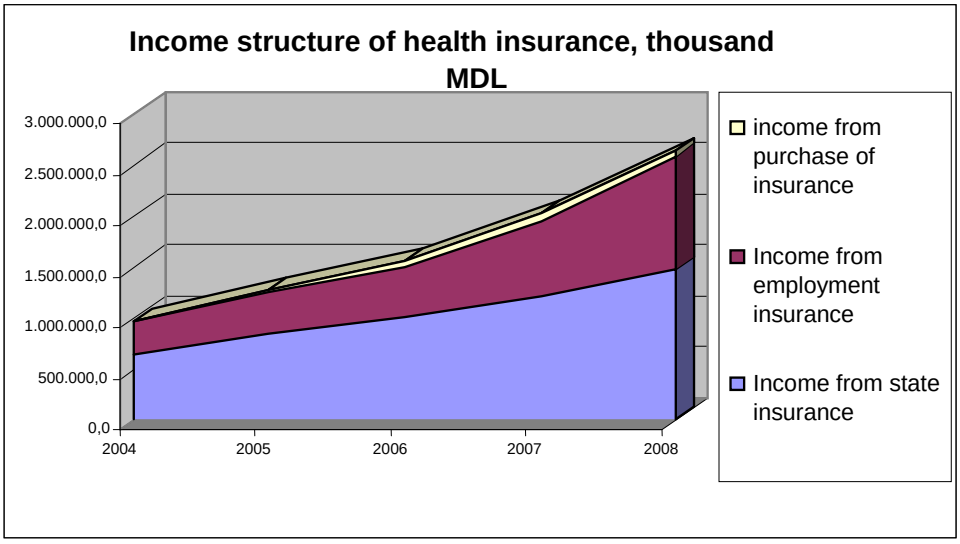
Figure 2.12



Source: Annual Budget 2006, 07, MTEF 2008-10, NHIC Report 2006 07, author's calculations

The analysis of health insurance budget (HIB) is represented in the diagram below. We can notice a slight increase in the weight of insured employees' contributions.

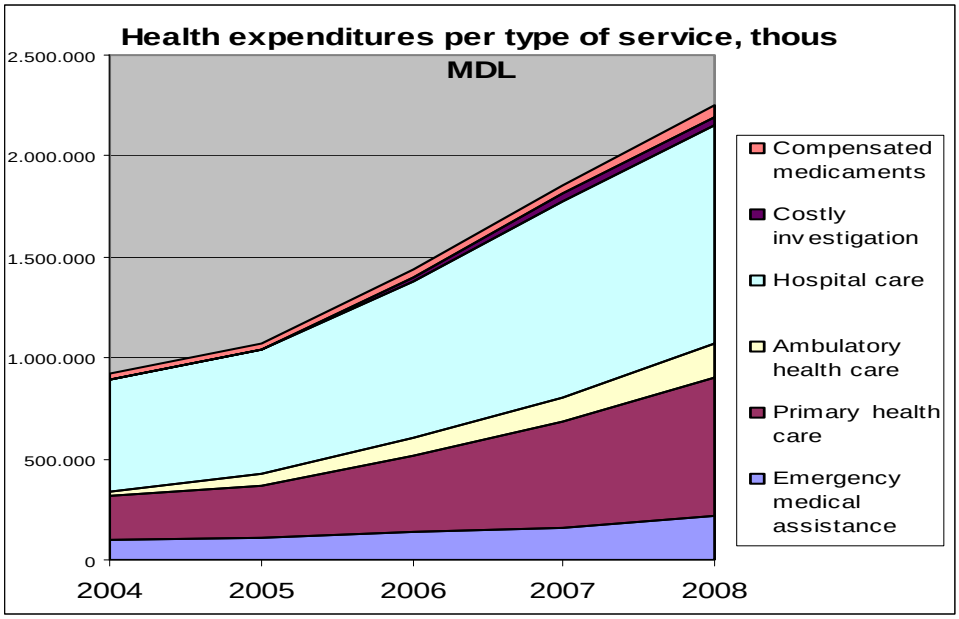
Figure 2.13



Source: MTEF 2008-10, NHIC Report 2006, 07, author's calculations

The figure below demonstrates how the HIB sources are spent among the spheres of health insurance system. We can see that hospital services are the main priority with over 60% of expenditures. The primary health care shows an insignificantly increasing allotment, but it is limited to 35% of expenditures. The emergency and outpatient services are limited to 5-6%, the expensive investigations and compensated medicines account for less than 1-2% of the expenditures of the health insurance system.

Figure 2.14



Source: MTEF 2008-10, NHIC Report 2006, 07, author's calculations

Conclusions of the section on analysis of budget policies in the health care area:

- the main beneficiary groups, except for the person insured through employment, are the retired persons, disabled people, and persons insured individually,
- the main national programs aim at investing in the material and technical basis or enhancing the medical treatments at the level of hospital services,
- the public health care and prevention programs are at an incipient level.

3. Analysis of Central Public Institutions' Budgets

The administrative budget expenditures shall be analyzed in this chapter. This analysis will take into account the administrative costs of central executive public institutions. The significance of this analysis is the relative distribution of budget appropriations within the executive institutions. The economic analysis of distribution of expenditures for human resources, current expenditures or capital investments offers information and conclusions regarding the efficiency of budget funds use, identifies the main cost centres by economic budget lines.

3.1 Health Care Sector

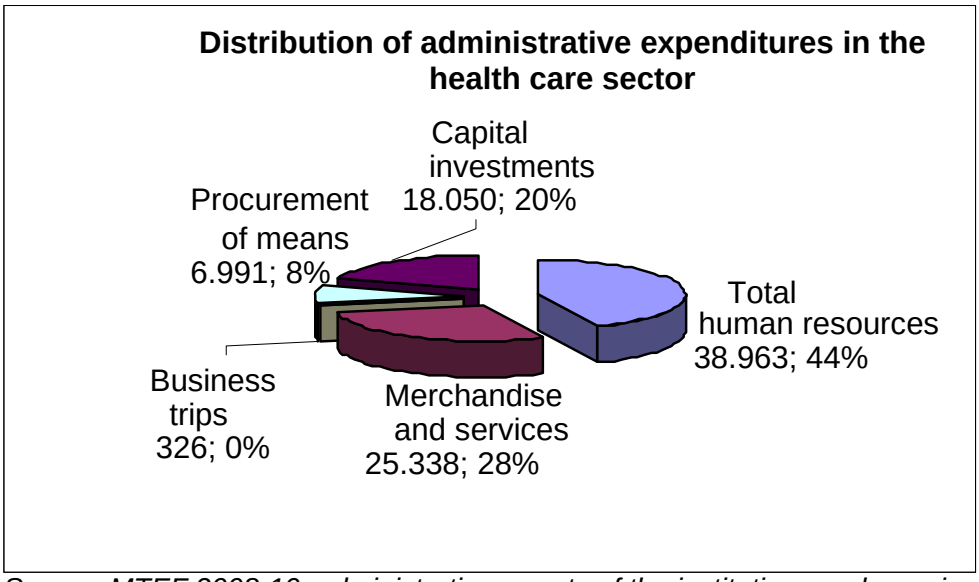
The health care sector consists of several central executive institutions:

- MoH – responsible for the development and coordination of policy implementation,
- SMC – responsible for systematizing data and information from health care area,
- NHIC (with regional representation offices) - responsible for the funding of providers of medical services through insurance,
- MA – responsible for accreditation, homologation of medicines and inspection of pharmaceutical product quality,
- NCHEA – responsible for the accreditation and quality monitoring of health care service provision,
- PMC (with rayon representation offices) – responsible for implementation of the conditions for compliance with the standards on public health care production and promotion.

The health care area has a stronger institutional development than the social area. The administrative expenditures of health care institutions amount to almost MDL 40 million a year. The amount of expenditures in this area is comparable with that from the social area.

Almost 45% of administrative expenditures are designated for human resources, i.e. almost MDL 40 million, 28% belong to goods and services, or over MDL 25 million, and 28% rest with capital investments and procurements, or almost MDL 25 million.

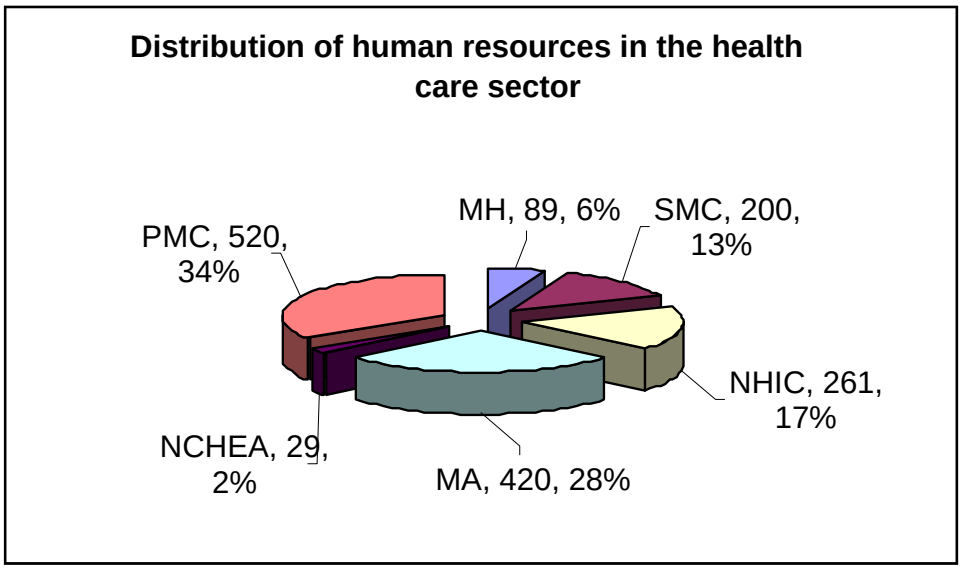
Figure 3.6



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

Total number of persons employed in the activity of administrative institutions from the health care area exceeds 1500, of which Ministry of Health has the least weight of human resources.

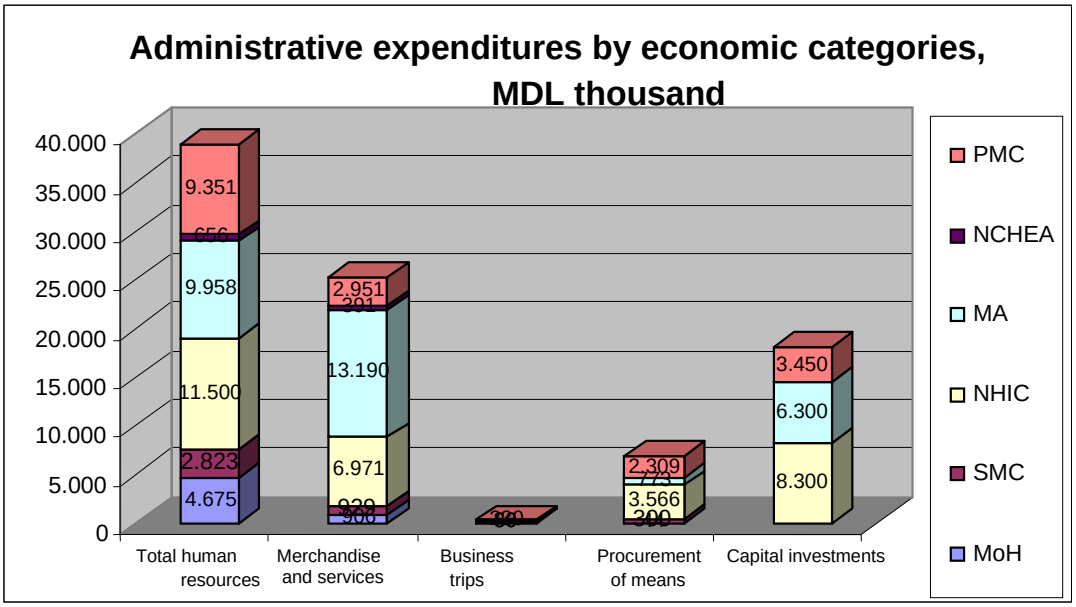
Figure 3.7



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

The expenditures for human resources of the administrative institutions account for the greatest part of the budget.

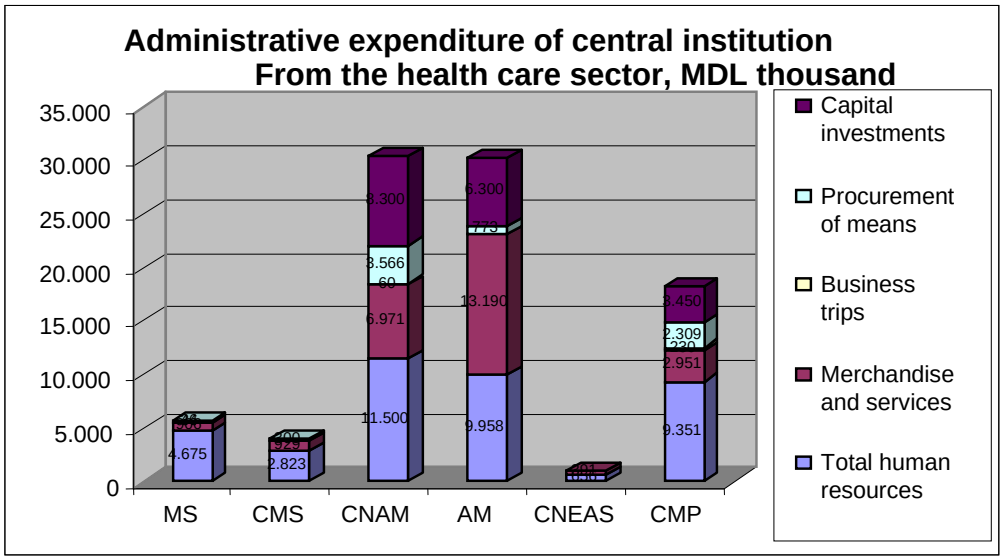
Figure 3.8



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

In the Figure below we analyze the administrative budgets of the institutions from this sector. NHIC, MA, and subsequently PMC, have the most important budgets and the highest number of employees in the health care area. They are followed by MoH and SMC with a great disparity, accounting for only 25% of the budget of the aforementioned institutions.

Figure 3.9



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

Conclusions of the section on analysis of administrative budgets of health care institutions:

- efficiency and propriety of the use of money appropriated for equipment purchase and payment of goods and services within NHIC, MA, and PMC,
- examination of the opportunity to re-distribute the human resources of NHIC, MA, and PMC to the MoH, including the funding of working places,

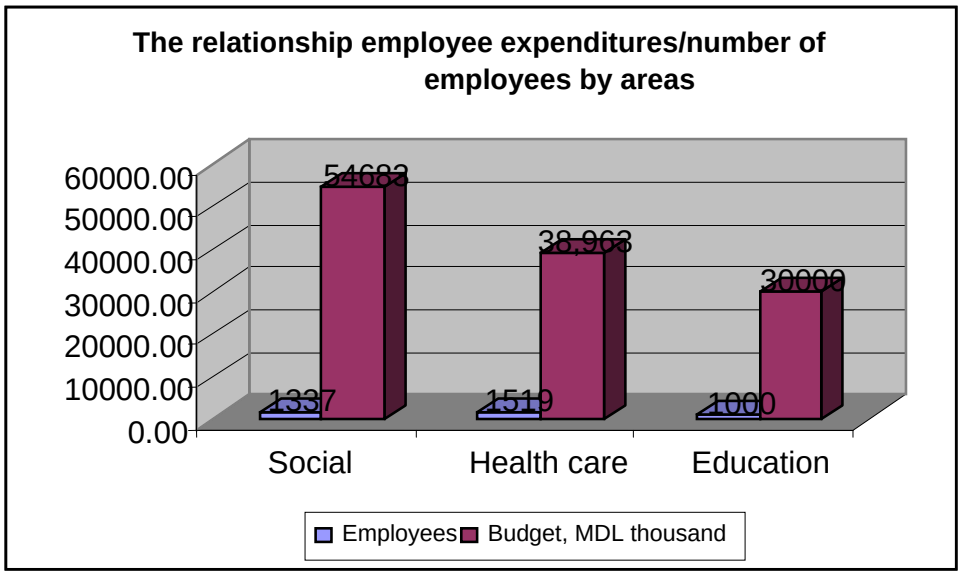
- increasing the productivity within MA, PMC through the automatization of processes relevant to the regulatory activity,
- introduction of the mandatory procedure of MoH notification about the administrative expenditures of the institutions from the health care area.

3.2 Comparative Analysis

In this section we will perform some comparative analyses of administrative budgets from the envisaged areas.

From the figure below we determine that the number of administrative employees is the greatest within the social area (NSIH has the greatest share), and health care area comes next. The budget amounts have a similar relationship. From the ratio between budget amounts and the number of employees results that the salaries in the social area are higher, the absolute relationship being MDL 41 thousand a year for an employee in the social area and MDL 31 thousand a year for an employee in the health care area.

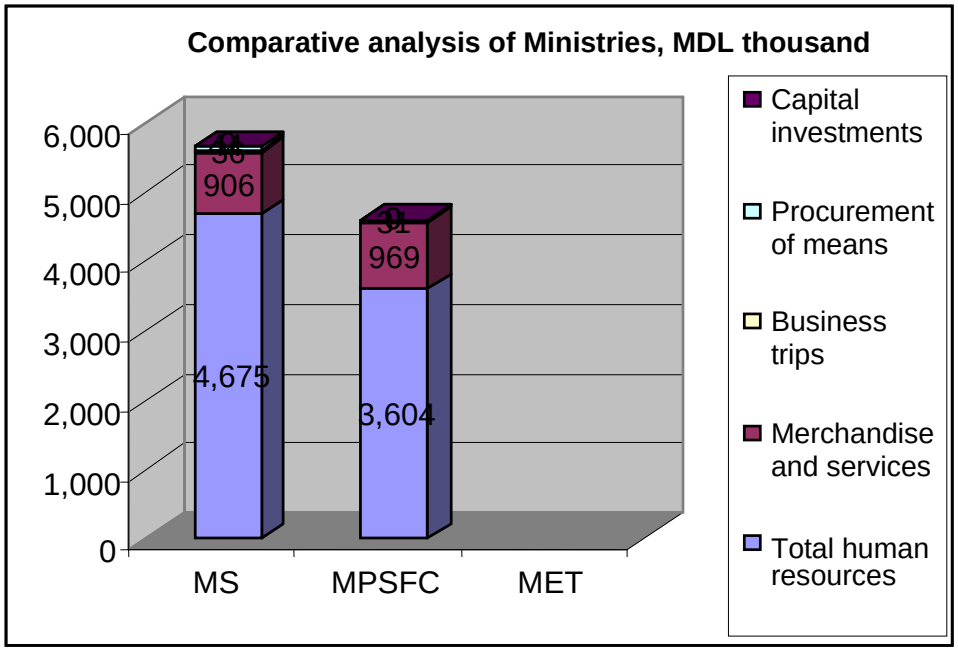
Figure 3.14



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

The comparative analysis of the situation per economic and financial lines within ministries reveals no major difference.

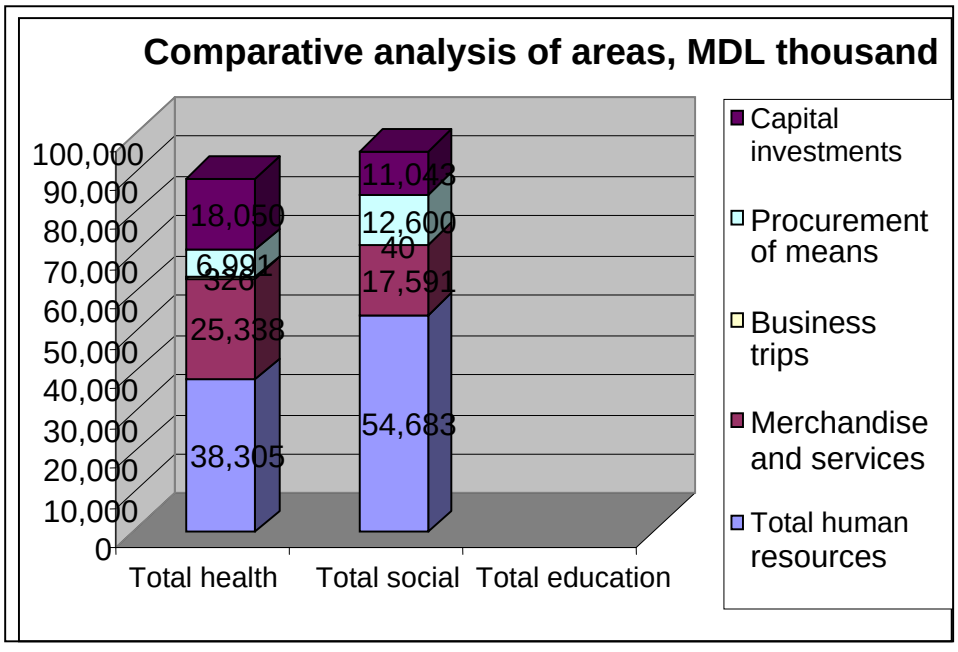
Figure 3.15



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

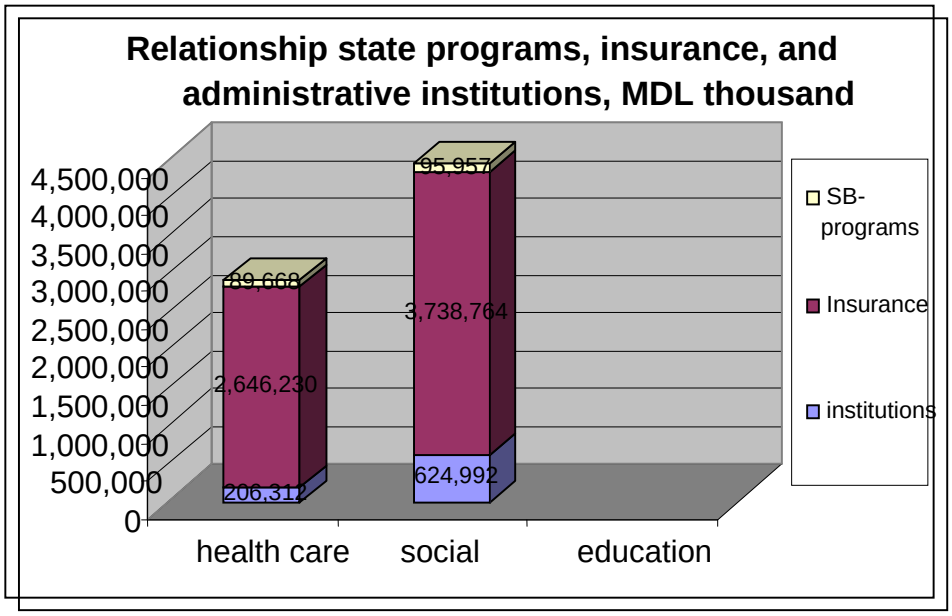
The analysis of economic and financial budgets in these areas reveals a comparable situation. The greatest administrative budget expenditures are recorded in the social area, the health care area comes next.

Figure 3.16



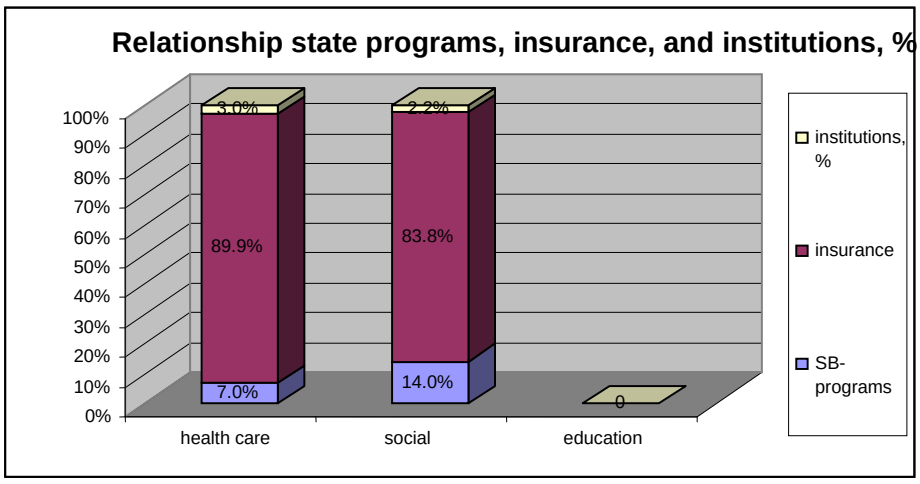
A useful comparison is offered by the relation and proportion of total expenditures per sector and the weight of administrative expenditures. The administrative expenditures account for 3% in the health care area and 2.2% in the social sector.

Figure 3.17



The health and social insurance systems account for the greatest portion of expenditures, i.e. over 80%. The direct expenditures through state programs are much lower.

Figure 3.18



The analysis of the information submitted reveals greater administrative costs in the social sector. The amounts paid for human resources are also higher in this sector.

4. Budget Priorities

In this Chapter we analyze the situation regarding the policy priorities in the areas under discussion. The budget priorities are viewed, on one hand, as the totality of budget expenditure programs for beneficiary categories and groups, and on the other hand, as the prioritizing of budget expenditures for certain categories of beneficiaries. This approach is in compliance with the policies on groups of beneficiaries and reflects the fundamentals of policy analysis with respect to the planned objectives. At the same time, the analysis we perform in this chapter is limited only to budget policies, i.e. treasury instruments of policies[1].

This chapter aims at determining the budget expenditures for different beneficiary groups, carrying out a total assessment of the public value for each type of budget appropriation. A firm conclusion on the efficiency of budget policies can not be drawn on the basis of the study goal and the methodology used.

4.1 Priorities of National Programs

Under this section we shall analyze the budget priorities by health programs and actual budgets spent for different beneficiary categories. There are 2 funding tools within the health care system: national programs and the insurance system. The insurance system creates direct services for beneficiary groups and the amounts that belong to these groups can be estimated. The national programs are classified according to their objectives; some national programs suppliment directly the health care services.

Budget priorities for national programs

The national programs can be classified according to the objectives planned:

- system consolidation programs,
- treatment programs,
- prevention programs,
-
- programs for health risk mitigation[2]

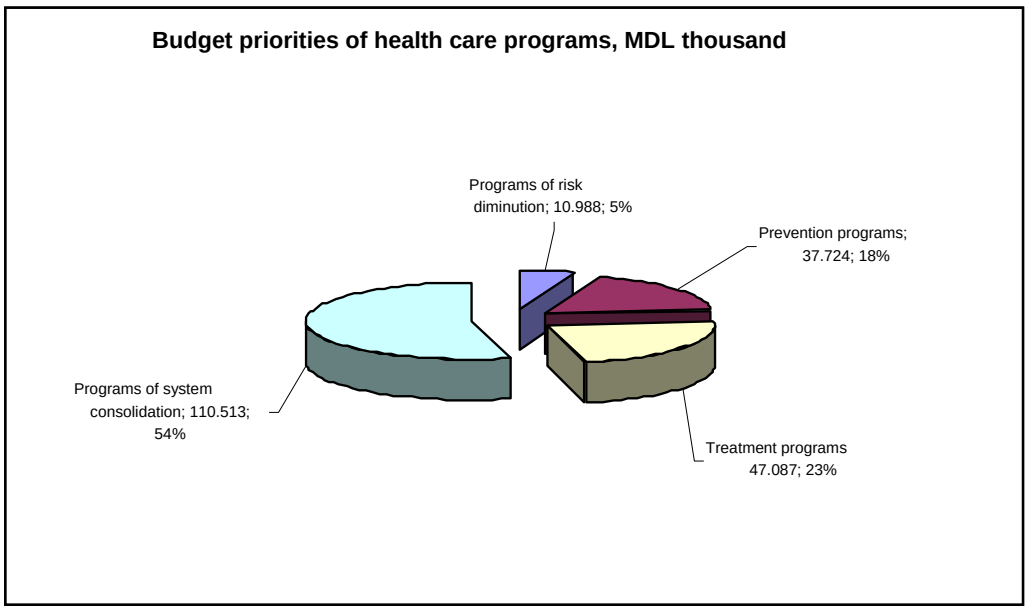
The analysis of budget expenditures by program reveals that the expenditures of the system consolidation programs are the greatest, accounting for 54% of the total budget expenditures or MDL 110 million a year. The programs that strengthen and supplement the existent treatment services funded from insurance sources come next and account for 23% or MDL 47 million. The prevention programs account for only 18% or MDL 38 million and the health risk mitigation programs account for 5% or MDL 11 million a year.

[1] Usually, the budget analysis should be supplimented with analysis of tax and information policies, institution functioning, and relevant information flow. Finally, there should be measured the impact of these policies on the groups of beneficiaries in terms of planned results.

[2] The scientific programs managed via the Academy of Sciences of Moldova were not analyzed in this section. Their implementation is the responsibility of PMC. The amount of budget expenditures is lower than MDL 15 million per year.

The national programs mechanism is managed through the MoH and the implementation of programs is the responsibility of the public institution that operate in the health care area.

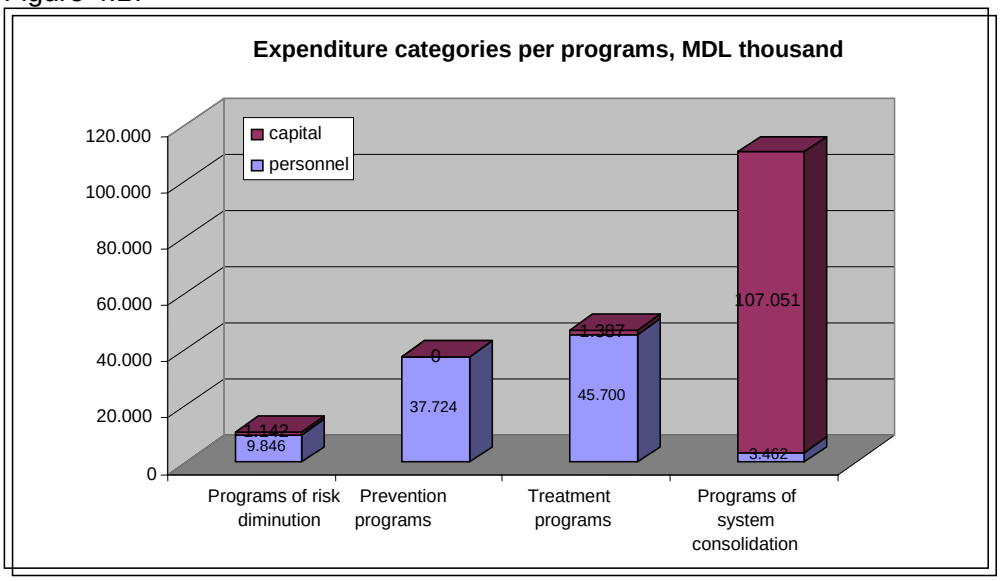
Figure 4.16



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

The analysis of economic and financial expenditures of the programs, displayed in the figure below, shows that, except for the system consolidation program, 95% of programs' expenditures are directed to human resources. Within system consolidation program, the situation is reversed, so that 95% of expenditures are directed to capital investments.

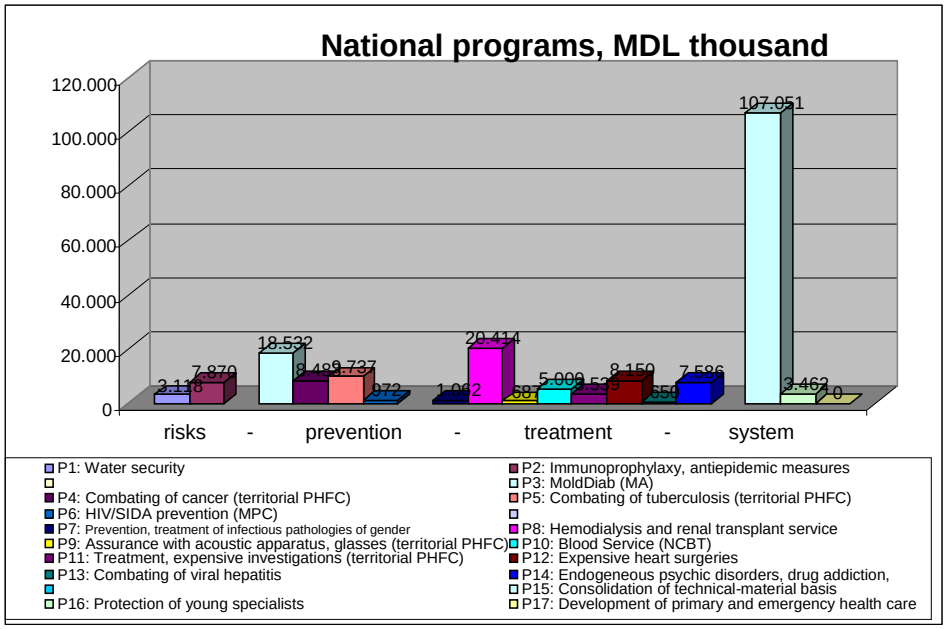
Figure 4.17



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

A more detailed and comparative view on the programs is presented in the figure below. The program for technical-material basis consolidation is prominent, amounting to MDL 100 million. The other programs amount to MDL 3-5 million or up to MDL 10 million, except for the MoldDiab program, which amounts to MDL 18 million and the program for hemodialysis and renal transplant services that amounts to MDL 20 million.

Figure 4.18



Source: MTEF 2008-10, administrative reports of the institutions under review, author's calculations

The funding of health care programs accounting for over MDL 200 million a year and their management needs a developed management system for programs and projects. The management cycle of a program or project requires professional skills within MoH. Assessment of program implementation results should be referred to health care promotion objectives and correlated with the health care services provided via the insurance system. Another aspect of national program functioning is the high role they play in health risk prevention.

4.2. Budget Priorities within Insurance

Budget priorities by beneficiary category

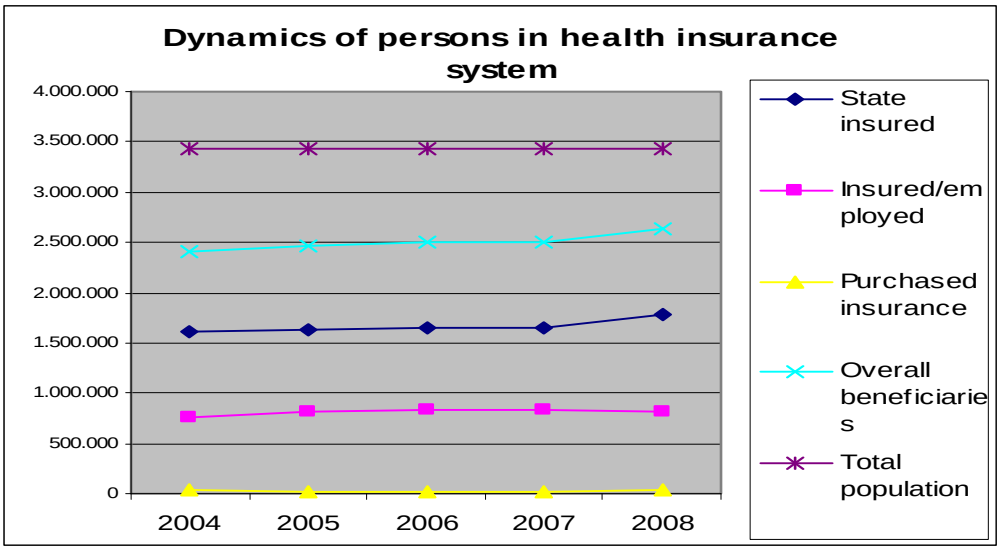
Under this section, we shall analyze the budget expenditures for health care that go to the following beneficiary groups:

- retired persons,
- disabled persons,
- preschool-aged children,
- school-aged children and young learning people,
- pregnant women,
- employed and unemployed persons.

These groups benefit of health insurance from state budget sources in the health insurance system. 30% (in the diagram below) of the beneficiaries of health care services through insurance are the persons insured through employment. Their disaggregated profile could not be obtained from the existent data.

The total number of insurance system beneficiaries (including those insured by the State) is a little more than 2.5 million. Almost 1.0 million persons, mostly farmers and people from rural regions, hold no health insurance.

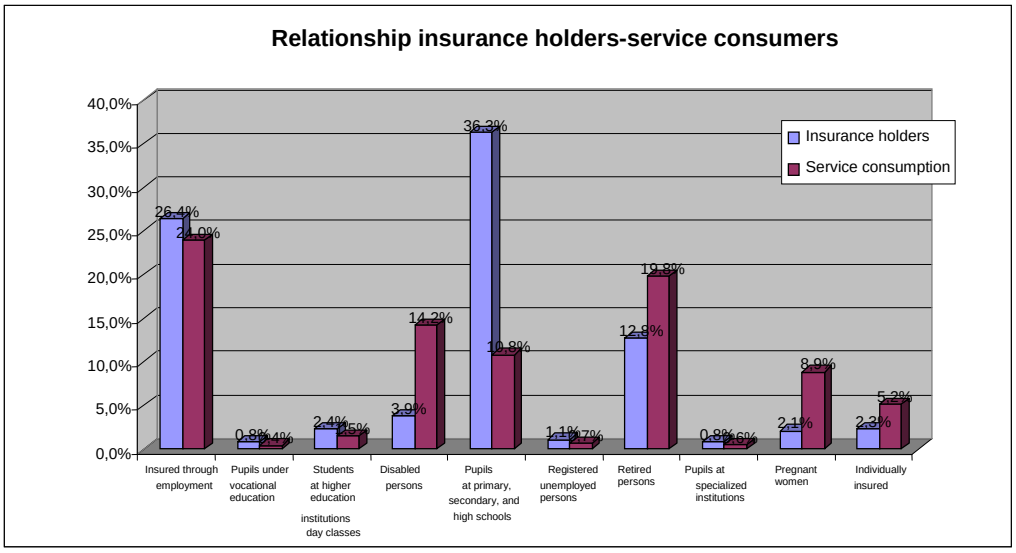
Figure 4.19



The detailed analysis of insurance card holders displayed below is important in order to understand who and to what extent benefits of financial resources from health insurance. At the same time, the possession of insurance cards speaks only of the right to access the health insurance system, while the actual accessing and consumption of health care services depends on the frequency and consistency of accessing health care services.

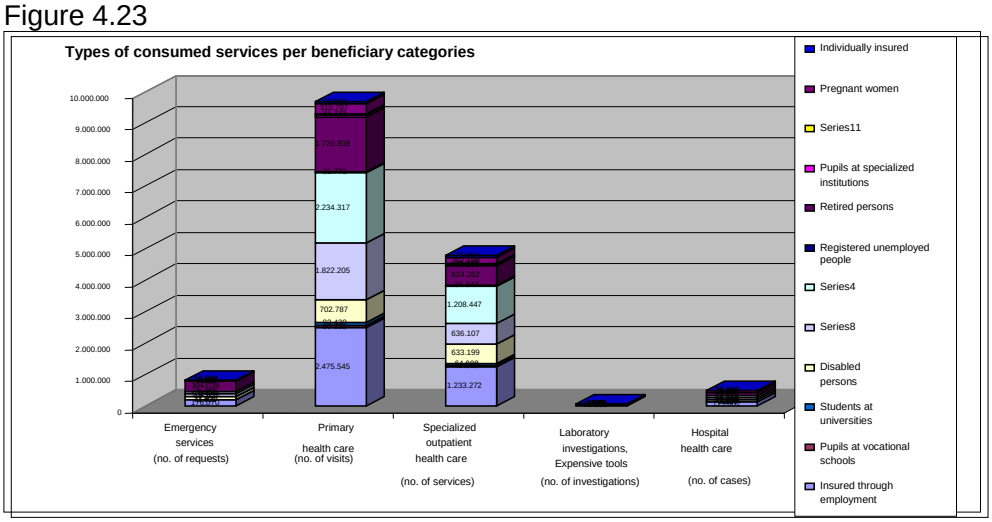
The following figure shows information about the relative share of health insurance system beneficiaries and the frequency of health care service use, and, consequently, shows the amount of financial appropriations for each beneficiary group. The information analysis reveals some groups of persons that use more actively and frequently the health care services thus, consuming more funds, and it also reveals the groups that under use health care services. For example, the persons insured through employment contracts account for 26.4% of total number of persons in the system, but they consume only 24% of health care services; the disabled persons account for 3% of total number of persons in the system, but they consume 14.2% of financial resources; the retired persons account for 12.8% of total number of persons in this system, but they consume 19.8% of health care services; and the pregnant women account for 2.1% of the total number of persons in the system, but the consume 8% of health care services.

Figure 4.20



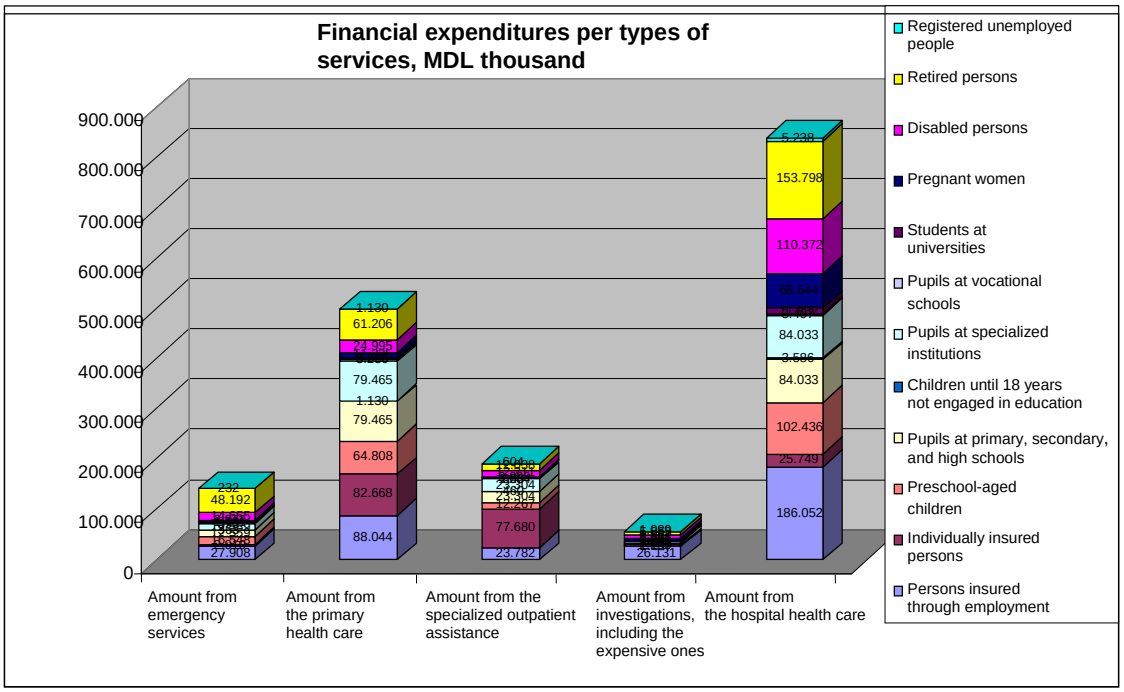
The children represent 36% of the persons in the system, but they consume only 10% of health care services. The following figure represents the structure of consumed health care services per category of people. We see that the primary and outpatient care services are most frequently used by almost all beneficiary groups. The hospital services are used much less by all beneficiary groups.

Figure 4.23



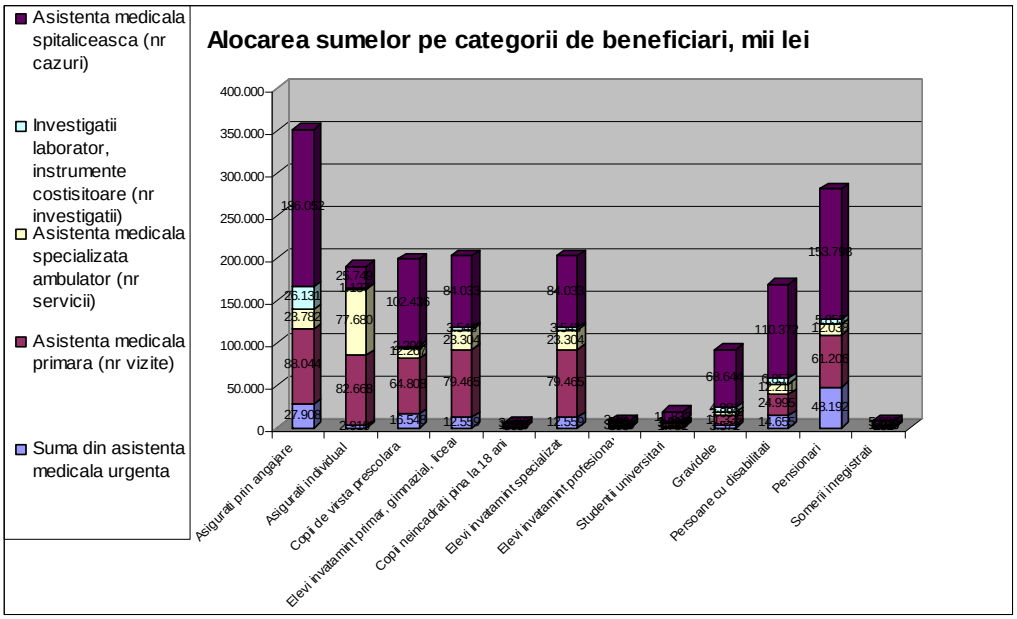
The frequency of accessing different types of health care services is represented in money terms in the diagram below. Thus, we can see how much belongs to each beneficiary group in money terms. The cost of hospital services is almost MDL 1 billion, though the number of services is 0.6 million. The greatest share in the consumption of hospital services, following the group of persons insured through employment, belongs to the retired persons – MDL 153 million, and to disabled persons – MDL 110 million.

Figure 4.24



In the end, the diagram below displays the amounts relevant to each beneficiary group from the insurance system. Following the biggest group of persons insured through employment, the retired persons rank on the second place, being insured by the State with over MDL 280 million with the following structure of prevailing consumption of hospital services – MDL 153 million, MDL 61 million - primary care, and MDL 48 million - emergency services. The disabled persons consume MDL 170 million, mainly hospital services – MDL 110 million; the pregnant women consume MDL 92 million, the hospital services amounting to MDL 69 million. The children and pupils consume altogether over MDL 200 million, of which the primary health care and hospital services are prevailing.

Figure 4.25



Conclusions on health care policies:

- the analysis determines the costs and expenditures for beneficiary groups,
- the main users of health care services, except for the persons insured through employment, are the retired and disabled persons, who use mostly hospital services,
- the persons insured individually consume the greatest amount of funds per beneficiary,
- the national programs are mostly oriented towards the consolidation of material basis and are indirectly oriented towards the provision of hospital services,
- programs for healthy life style promotion and prevention of health care risks are under-financed, the relative appropriations being much lower than the investments made in materials,

5. Conclusions and Recommendations

The information about budget expenditures related to the administrative institutions and policy expenditures is not directly available for the society. The given information needs identification, systematizing, and presentation in this format, where a significant effort is necessary. This way, the authorities should issue reports and make available more information for the public in order to create a better image of the budgets and the way they are used.

Conclusions of the section on analysis of budget policies in the health area:

- the main beneficiary groups, except for the persons insured through employment, are the retired persons, disabled people, and persons insured individually,
- the main national programs aim at investing in the material and technical basis or supplementing the medical treatment at the level of hospital services,
- the public health care and prevention programs are at an incipient stage.

Conclusions of the section on analysis of administrative budgets of institutions in the health care area:

- efficiency and propriety of the use of the money appropriated for equipment purchase and payment for goods and services within NHIC, MA, and PMC,
- examination of the opportunity to re-distribute the human resources of NHIC, MA, and PMC to MoH, including the funding of working places,
- increasing the productivity within MA, PMC by the automatization of processes relevant to the regulatory activity,
- introduction of the mandatory procedure of MoH notification about the administrative expenditures of the institutions from the health care area.

The analysis of the information submitted reveals greater administrative costs in the social sector. The amounts paid for human resources are also higher in this sector.

Conclusions on health care policies:

- the analysis determines the costs and expenditures for beneficiary groups,
- the main users of health care services, except for the persons insured through employment, are the retired and disabled persons, who use mostly hospital services,
- the persons insured individually consume the greatest amount of funds per beneficiary,
- the national programs are mostly oriented towards the consolidation of material basis and are indirectly oriented towards the provision of hospital services,
- programs for healthy life style promotion and prevention of health care risks are under-financed, the relative appropriations are much lower than the investments made in materials.

6. References

1. Report on the Assessment of Institutional Skills of MSPFC, May 2008, CICO-CReDO for UNICEF,
2. Report on the Assessment of Institutional Skills of MoH, May 2008, CICO-CReDO for UNICEF,
3. Report on the Assessment of Institutional Skills of MEY, May 2008, CICO-CReDO for UNICEF,
4. Annual Budget 2005, 06, 07, 08, the Government of the Republic of Moldova,
5. Social Insurance Budget 2005, 06, 07, NSIH,
6. MTEF 2008-10, 09-11, Ministry of Finance,
7. Annual Social Report, 2006, 07,
8. Annual Health Care Report, 2006, 07,
9. Institutional and Financial Reports: NSIH, MSPFC, 06, 07,
10. Institutional and Financial Reports: MoH, SPCPM, SMC, MA, NCHEA, 06, 07,
11. Institutional and Financial Reports: MEY, 06, 07,