**Functional Review of Public Financial Management**

**of the Health Sector of Iraq**

Sabhi Saleh

Akmal Minallah

**Functional Review of Public Financial Management of the Health Sector of Iraq**

**PREFACE**

This Final Report (FRe) is a guide for decision makers and meant to provide support in the essential analytical work involved in planning, budgeting and in the assessment of Public Financial Management’s (PFM’s) functioning. This Final Report (FRe) is one of the many Functional Reviews of Public Financial Management of the Health Sector in Iraq (PFMHSI) and is mainly concerned with the optimum use of public funds and resources that are made available to the health sector by improved PFM functioning so as to make potential savings in costs or reduce costs but able to provide the best health care to all.

This Final Report is to help all those involved in bringing all around economy, efficiency and effectiveness in the health sector via improved PFM functioning and precisely to help Ministry of Health (MOH) / Inspector General of Iraq(IGOI) and each of their unit/establishment at different levels in particular and assist the World Health Organization’s Country Office in Iraq (WHO-COI) in general in conducting further analysis and follow proper planning/budgeting processes and show different types of cost implications in each initiative or various initiatives if undertaken on the recommendations of this functional review by way of a reform process for and of the Ministry of Health of Iraq (MHI) and for the much needed improvement in PFM’s working/functioning in its health sector.

This FINAL REPORT is based on Functional Review (FR) of the existing PFMHSI and presents a list of major recommendations at the end of the findings for targeting activities to be initiated for improving and strengthening the weak links/ areas through a proper reform process. This Final Report does not provide an action plan or road map for how recommendations should be implemented and/or to be carried out. Nevertheless, this Final Report surely serves a basis for the reform of the health sector and for developing a proper strategy for an improved PFM (Public Financial Management) functioning in Iraq to achieve desired goal / results.

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(i)

**Functional Review of Public Financial Management of the Health Sector of Iraq:**

**FINAL REPORT**

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We would like to extend our sincere thanks to all of those staff of the WHO Country Office of Iraq and Ministry of Health and their associated public bodies, local government officials and representatives of Iraq who assisted in providing information, documents, files, analysis reports and notes which were necessary to consider for this functional review. With some we could meet personally and interacted but with some we could not, however, we were able to share views and exchanged ideas electronically. Also thanks to Mr. Faisal Omar for making arrangements for our stay in Iraq and Jordan and visits to various places/institutions in connection of this given tasks.

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(ii)

**Functional Review of Public Financial Management Of the Health Sector of Iraq:**

**FINAL REPORT**

**TABLE OF CONTENTS**

|  |  |  |
| --- | --- | --- |
| The Cover Page of the FINAL REPORT |  | Page Number |
| Preface | (i) |  |
| Acknowledgement | (ii) |  |
| Table of Contents | (iii) |  |
| * Introduction   1.1 Scope, Objectives and the process of FR of PFM  1.2 Conducting of Functional Review of PFM  1.3 The PFM Reform Process |  |  |
| 2. The Methodology for the Functional Review  2. 1 Functional Review – PFM Systems |  |  |
| * Overall Planning, Budgeting And Public Financial Management Related to the Health Sector:   3.1 National Health Accounts  3.1.1 Assessing Health Care Financing  3.1.2 Sources Of Funds  3.1.3 Health Care Expenditure  3.1.4 Budget Allocation  3.2 Expenditure Review and Trend Analysis  3.2.1 Major Classification of Expenditure  3.2.2 Equity Funding in Primary Health Care |  |  |
| * Resource Allocation Links With Policies And Plans * Policy, Plans and Funding * Interface Between MOF & MOP and MOH * Recurrent Budget & Investment Budget of MOH   4.1.4 Budget Tracking System & Chart of Accounts |  |  |
| * Efficiency Analysis (EA) * EA in relation to Health Outcomes   5.1.2 Steps to Improve Efficiency  5.1.3 Case Study and Operational Efficiency  5.1.4 Financing Issues  5.1.5 Financing Options for Improving Efficiency  5.1.6 Effects of Centralized Financial Management and  weak Linkage Between Budgeting and Planning  5.1.7 Lessons Learnt |  |  |
| * Level and Structure of Health Care Financing   6.1 Policy Options for Health Care Financing |  |  |
| * Summary and Conclusion |  |  |
| * Recommendations |  |  |
| * Acronyms |  |  |

(iii)

**1. INTRODUCTION:**

This Report is one of the many Functional Reviews of Public Financial Management of the health sector in Iraq and is mainly concerned with the optimum use of resources that are made available to the health care sector for improved service delivery. This Report will help all those involved in bringing all around efficiency in the health sector via PFM. It will also assist the World Health Organization’s Country Office in Iraq in conducting further analysis of the planning/budgeting process and show different types of cost implications in each initiative or various initiatives if undertaken on the recommendations of this functional review. This Report presents a summary of the findings and recommendations at the end. However, this Report does not provide an action plan or road map. Report serves as a basis for the reform of the health sector and for developing a proper strategy for an improved PFM (Public Financial Management) functioning to achieve desired goal / results.

Public Financial Management reforms are complex and depend on political environment, social behavior and other contextual realities. Iraq is a resource rich country but needs to improve its health outcomes. This means that the challenge is to use the resources in such a manner that improves the condition of the people. Therefore, objective of a financial management reform is to introduce economy, effectiveness, efficiency, transparency and equity in the system. The financial management system, like all service delivery systems suffered due to war, sanctions and insecurity. There have been achievements during the past years which have made the PFM systems more credible. These include introduction of Financial Management and Debt Limitation Law in 2005; implementation of GFS compliant Chart of Accounts; establishment of the office of Inspector General; approval of procurement rules and steps towards implementation of integrated financial information systems to capture the data for decision making. Despite these successes, much needs to be done in terms of imbedding these systems in the work environment of the government departments. The improved Public Financial Management system requires skilled workforce. There is a greater need for training and capacity building.

* **Scope, Objectives and the Process of the Functional Review of PFM:**

**The scope** of the Functional Review is:

* To strengthen PFM administration for efficiency and effectiveness
* To support World Health Organization (WHO) country office of Iraq and Ministry of Health to review the existing PFM processes and their linkage with Ministry of Finance and Ministry of Planning and suggest improvements.

**The objective** of the functional review of PFM of the health sector of Iraq is to get maximum ideas for strengthening PFM’s functional aspects, ideas to improve each of its functions by discussions, sharing experience of good practice and by revealing ideas with those who are also involved in preparing this kind of Functional Review either jointly or independently.

**The process** of Functional Review is given below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Addressing different types of questions**  →  ↓  **having dimensions to**  **i. Institutional**  **areas and aspects**  **ii. Organizational areas and aspects**  **iii. Individual level and aspects** | **Functional Review of PFM of the Health Sector of**  **Iraq**    ↓  **Evaluate the existing**  **PFM and its**  **Functioning** →  **Via FUNCTIONAL REVIEW- PFM System** | **Makes a list of areas that needs to be strengthened or weak areas and deficiencies observed is noted**  ↓  **Prepare Recommendations**  **for better use of available public funds & resources for better** →  **performance by a suitable reform process** | **Prepare**  ↓    **FINAL REPORT** |

**1.2 Conducting of Functional Review of PFM:**

This Functional Review is being conducted as part of the Iraq Public Sector Modernization (I-PSM). The I-PSM is a four year United Nations (UN) inter-agency comprehensive program funded by the United Nations Development Group Iraq Trust Fund (UNDG ITF) totaling around US$ 55 Million to support the Government of Iraq in its efforts to modernize its public sector with the ultimate goal of improving governance and quality and delivery of services at all levels, including at governorate and district levels. In line with the Millennium Development Goals (MDGs) and the need to link the modernization process to improved services delivery, three sectors have been selected to serve as pilots given the readiness and the work that has been done by the line ministries involved in these sectors. These are health, education , water and sanitation.

**2. THE METHODOLOGY FOR THE FUNCTIONAL REVIEW:**

This was done by looking at how different functions are being performed presently in PFM and how these are administered, regulated and controlled via a Case Study and knowing about existing economy, efficiency and effectiveness in the functioning of PFM.

**2.1 FUNTIONAL REVIEW – PFM SYSTEM:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Function** | **MoH** | **Region (MOH)** | **Governorate (DOH)** | **Hospital** | **IG** | **BSA** | **MOF** | **MOP** | **Other** |
| **1. *Budget Policy Linkage*** |  |  |  |  |  |  |  |  |  |
| Health Policy | **√** | **√** |  |  |  |  |  |  |  |
| Cost Sector Strategies | **√** | **√** |  |  |  |  |  |  |  |
| Medium Term Fiscal Framework |  |  |  |  |  |  | **√** |  |  |
| Sector Ceilings |  |  |  |  |  |  | **√** |  |  |
| Demands for Investment projects | **√** | **√** | **√** |  |  |  |  |  |  |
| Finalize Investment Budget | **√** | **√** |  |  |  |  |  | **√** |  |
| Issue Budget Call Circular |  |  |  |  |  |  | **√** |  |  |
| Finalize Recurrent Budget |  |  |  |  |  |  | **√** |  |  |
| Approve Budget |  |  |  |  |  |  |  |  | Council of Ministers and Parliament |
| **2. Budget Execution** |  |  |  |  |  |  |  |  |  |
| Procurement of Medicine | **√** |  |  |  |  |  |  |  |  |
| Salary of Staff | **√** | **√** |  | **√** |  |  |  |  |  |
| Maintenance Budget | **√** | **√** |  |  |  |  |  |  |  |
| Pre Audit of Payment | **√** | **√** |  |  |  |  |  |  |  |
| Internal Audit |  |  |  |  | **√** |  | **√** |  |  |
| Execution of Development Budget | **√** | **√** |  |  |  |  |  | **√** |  |
| 3. Auditing and Reporting |  |  |  |  |  |  |  |  |  |
| Budget Execution Reports | **√** | **√** |  |  |  |  | **√** |  |  |
| Annual Financial Statements | **√** | **√** |  |  |  |  | **√** |  |  |
| Audit of the Financial Statements |  |  |  |  |  | **√** |  |  |  |

**3. OVERALL PLANNING , BUDGETING IN PFM RELATED TO HEALTH SECTOR:**

Iraq inherits a centralised PFM architecture. Fiscal Management and Debt Limitation Law provides legal framework for the PFM system in Iraq. Departments send recurrent budget demands to Ministry of Finance and investment budget demands to Ministry of Planning. Provincial Directorates of Health sends the budget proposals to the central office. MOH budget is divided into two main categories which are recurrent and investment. The recurrent budged is divided in following categories;

* Employee Compensation
* Goods
* Services
* Maintenance
* Other expenditures
* Non monitory expenditures

Improved Chart of Account is adopted by the government. This Chart of Account is compliant to General Financial Statistics (GFS). Chart of Account is the basis of a transparent financial management system that supports decision making. A comprehensive Chart of Account is important not only for budgeting and accounting but also for costing, planning and management reporting. The new chart of account is multi dimensional. It has the capacity to help end users analyse all dimensions of a transaction. For example ***who*** incurred the cost eg organisational unit like central department, hospital or a primary healthcare facility; ***what*** was the cost incurred on eg salary, operations etc; ***why*** was the cost incurred (functional classification) eg improve primary healthcare, tertiary health care or education etc; ***How*** the transaction will be spent eg from recurrent budget, capital budget, pension fund and classification to identify ***where*** the money is to be spent. These are critical information requirements that help better decision making, budgeting, planning and costing.

Annual Financial Statements are prepared and audited by the Supreme Audit Institution (BSA). Financial Management and Debt Limitation Law describe the check and balances in the system that ensures accountability of all departments to the elected body. Commission of Integrity receives cases of fraud and embezzlement.

Baghdad has a well developed auditing system. Supreme Audit Institution (BSA) was established in 1927. It is the member of International Organisation of Supreme Audit Institutions (INTOSAI) and invests in training of staff and research in international best practices. Pre-audit of transactions is done by the departments. According to Financial Management and Debt Limitation Law, it is the responsibility of the budget executors to establish arrangements for accounting and internal control in spending units and sub units under their jurisdiction. Recent development is establishment of Inspector General Office. This office is modelled on that of USA.

**3.1 National Health Accounts:**

**3.1.1 Assessing Health care Finance**: National Health Accounts were prepared in April 2011. This is an important step in assessing healthcare financing in Iraq and in improving the overall health system performance in order to achieve the health system goals of improving health, reducing health inequalities, securing equity in financing and being responsive to the population needs and expectations.

There were some data limitations regarding the preparation of National Health Accounts. The Household-level expenditure captured by IHSES 2007 was available only by broad expenditure categories, which did not allow the disaggregation of data according to specific types of providers or functions; there were variation between NHA data requirement and Chart of Classification; it was impossible to disaggregate spending by different ministries. In addition, data by in kind donor funding and funding through NGOs was not available. Security situation also constrained data gathering. However, these limitations do not have substantial impact on findings of NHA.

According to the findings of NHA; Iraq spends more than what it was estimated by previous studies. It is estimated that in 2008, 3.3% of GDP and per capita spending of USD 136 were directed to health services; public funding accounted for 74% of health spending, donor support represents 1% and private spending amounts to 25%. The majority of health care spending is for public health programmes and primary care. Significant funding is on pharmaceuticals (36.8%) and administration (22.3%).

**3.1.2 Sources of Funding:**

Total funding on Health Sector during 2008 was ID 5.138 billion. Out of the amount, ID 3.773 billion were spent through budgetary sources, this is 73.4% of the total. International donors account for 1.2 percent and private sources 25.3%.

Ministry of Health is the biggest financing agent of Health Sector Expenditure as it accounts for 73.1% followed by other ministries which are less than 1%. Out of pocket expenses by citizens account for 25.6%, the proportion of government expenditure out of total health expenditure is relatively high, and is even higher than its equivalent in other middle-income countries in the East Mediterranean Region. This represents the important role played by the government and its ministries in providing **health care coverage** to entire Iraqi population and in securing universal social health protection.

Ministry of Health resources are financed by the government budget and are spent on government healthcare entities. Donors transfer the resources to government budget and citizens transfer out of pocket expenses directly to the private sector health provider. Private insurance market is still negligible in Iraq.

**3.1.3 Health care expenditure:**

In terms of health care expenditure the biggest share goes to pharmacies of Ministry of Health which is ID 1,365,298 million or 26.6% of total health care expenditure. This is followed by public sector Primary Healthcare expenditure amounting to ID 1,294,037 million or 25.2% of the total expenditure. 22% expenditure is spent on administration, 14.6% on general hospitals and 10.3 % is incurred at private pharmacies. In General, Iraq health funds are primarily spent on curative care (more than 37%). A good share of 36.8% goes towards Pharmaceuticals dispensed on outpatient care and 22% are spent on Administration cost and salaries.

As per IHSES 2007, overall, 18% of the Out of Pocket (OOP) direct spending is the share of the MOH hospital facilities with around 34% for private Physicians and 39% for Pharmaceuticals. Transportation absorbs 9% of OOP health spending.

**3.1.4 Budget allocation**

Government of Iraq puts high priority to health sector. Since 2003, health care expenditure has increased from US $ 23.75 to US $ 125 in 2009. In 2008, MOH allocated 23% for outpatient care including primary health services versus 11% for Inpatient secondary curative care. Drugs and Medical supplies accounted for 36% of total MOH budget. The MOH Administration and operating cost absorb 30% which mostly goes towards personnel cost. The Ministry supplies essential medicines through its central warehouse and health care dispensaries to public. A minor user fee is in place which covers less than 1% of the cost per prescription. On the other side, there is a growing private sector in Iraq. It consists of a network of main pharmacies. Their number has increased in the last few years. This has a direct impact on availability of medicines, but not necessarily on accessibility and affordability. Private spending on pharmaceuticals or household out-of-pocket expenditures on pharmaceuticals amounted to USD 412 million, which is 28% of the spending on pharmaceuticals (1,892,415 million) with an average of USD 12.8 per capita. Public spending on pharmaceutical remains the largest part and accounts to USD 13 per capita.

It is clear that at 36 percent of total health expenditures, pharmaceutical is a major area of the health sector that needs to be better managed and regulated if health care costs are to be controlled and contained. The rapid growth in the pharmaceutical sector, the near complete reliance on brand name medicines, and imports to meet demand make rationalizing expenditures on pharmaceuticals a key area for policy reform.

* **Expenditure Review and Trend Analysis:**

**3.2.1 Major Classification of Expenditure:**

The budget of Ministry of Health is divided in six major classes. These are: Employee Compensation; that includes Salary, allowances and pension payment

* Commodity; that relates to procurement of goods, major part of this budget relates to procurement of medicine
* Services; is payment against services rendered. This is an important component that ensures better operations and service delivery
* Maintenance is an important element of health sector budget. The buildings and machinery should be in a good running condition for improved service delivery
* Other expenditure includes miscellaneous items that does not fit into any of the above category and non monitory transaction does not have a direct impact on budget expenditure
* Investment budget relates to construction of new buildings

For better service delivery and achievement of health outcomes, each item of expenditure is necessary. During the last five years, the allocations of health sector has increased, which is in line with the national policy. However this increase is in specific items of expenditure. For example payroll has substantially increased as compared to other items. In 2007, employee compensation cost was almost half of the commodity cost. Due to revision in salaries and induction of more staff, by 2009, employee compensation became the biggest expenditure item. It has been observed in many post conflict countries, that government jobs become a good source of social protection. Employee compensation cost is generally a rigid cost. In 2010, government announced a budget cut of 4%. The cut did not apply to employee compensation and purchase of medicine, as a result, the Ministry of Health was forced to delay some of its procurements, which were critical for service delivery.

The second category is Commodity cost. In 2007, Commodity cost comprised the biggest portion of Ministry of Health budget, but gradually due to more rapid increase in employee compensation cost and investment cost, the proportion of Commodity cost is decreasing. This is demonstrated in the chart below;

The budget for commodities has increased during the past five years, but as a proportion of overall budget for Ministry of Health, its proportion has decreased. In 2007, commodity budget was more than 40% of total budget which in 2011 is reduced to almost 30%. The increase in commodity budget is shown in nominal term. Inflation and population has significantly increased during the past five years, therefore in real terms the increase may not be significant. The result of this trend is that the government cannot keep up the demand of providing medicine to its population. As a result, governorates spend significant amount of funds on procurement of medicine. The health department of Dahouk has done a comprehensive study of health care expenditure and finances. In 2009, out of the total expenditure on medicine, Ministry of Health, MoH Baghdad contribution was 63.8% and in 2010 the contribution of MoH Baghdad reduced to only 26.7% of all expenditure incurred on procurement of medicine in Dahouk. There are additional pressures in Kurdistan Region. The KRG receives 17% of medicine procured by Ministry of Health. This is based on the share of population. However, due to insecurity in Iraq, approximately 350,000 internally displaced persons have settled in Kurdistan. This is an additional burden on KRG which is not reflected during budget preparation process.

The third main category is the investment budget. The investment budget as part of the total budget has progressively increased during the five years. During the five year term, the investment budget has doubled, eg from 450 billion to more than one trillion. It is still around 20% of the total budget. The government targets to increase investment budget until such time that it is 40 -50% of total budget. This will be a big challenge. As seen in the graph above, increase in investment budget and salary is already eating up much of the fiscal space. This increase is at the cost of critical service delivery expenses like purchase of medicine, maintenance of hospitals etc. the increase in cost of investment demands increase in salary, maintenance and services etc. because when we construct a new hospital we also raise a demand for hiring new staff, maintenance of building, payment of utilities etc. The most insignificant item of expenditure in terms of its share of total budget is maintenance and services. This is the most critical item in term of ensuring the quality of service delivery. These items ensure that utility bills are paid, machinery is in a running condition, ambulances are doing productive work and doctors are working in a conducive environment.

Analysis of the budget distribution to governorate shows that the budget is still centralized. As shown in the graph below, the Ministry of Finance in Baghad retains 38% of the budget. Most of the governorates receive 2% to 3% of the budget.

**3.2.2 Equity Funding in Primary Health Care – Costing of Basic Health Care Model**

In February 2010, the Ministry of Health developed a comprehensive “Basic Health Services Package” (BHSP). Since the Primary health care is considered by the Government as the corner stone for health in Iraq, much of the data used were derived from the PHC units currently operating. The data was collected from 162 cost facilities at each level of PHC service delivery etc District Hospitals, Health Main Centers and Health Sub Centers.

Following are the findings of costing exercise;

* The total Health Expenditures of 162 facilities amounted to ID 166 billion in 2008 fiscal year, with an average of ID 9.6 billion spent by each of the 17 Health departments at the governorates. The average health facility spending was 1 billion per year.
* 97% funding was provided by the Finance Ministry and only 1% is out of pocket. The biggest portion of resource pool is absorbed by Salary which is 50%, followed by Drugs and Pharmaceuticals which is 26%.
* The highest share of direct cost is absorbed by services of curative care and emergency. Whereas preventive care got less funding.
* As seen from the graph above, funds are concentrated in major hospitals like District Hospitals and that too in curative side. This distortion leads to inequitable allocation of resources. As compared to District Hospitals, it appears that Sub Centers are starved of resources. The health care system in Iraq has been based on a hospital oriented and capital-intensive model that has limited efficiency and does not ensure equitable access.

**4. RESOURCE ALLOCATION LINKS WITH POLICIES AND PLANS:**

**4.1.1 Policy, Plans and Funding**: Predictable policy and predictable funding are the key elements that ensure service delivery. Without predictable policy, the spending becomes ad-hoc and erratic and without predictable funding, the policy becomes a wish list. Therefore, it is important that systems are in place to ensure that policies are prepared in a participative manner and has strong ownership of all stakeholders and that these are prepared within the realities of fiscal constraints so that resource allocation to the policies and priorities remains predictable. The policies and priorities of the government of Iraq are given in National Development Plan 2010 to 2014. It aims at increasing the GDP at 9.8% per year; creating 3.5 to 4 million new jobs, diversifying the Iraqi economy through improved participation by other sectors; reducing poverty rates by 30% of 2007 level; establishing a spatial development trend by promoting fair distribution of infrastructure among all federating units; establishing sustainable development and strengthening the role of local government. The total cost of development plan is estimated at $ 186 billion. $ 100 billion will be invested through Federal Budget and remaining $ 86 billion will be generated through domestic and foreign investors. The vision for health sector as provided is,

***“Healthcare system that adopts primary healthcare as a foundation including health services to satisfy individuals needs according to the international health standards to the extent possible”.***

The National Development Plan provides ambitious targets for achievement of the vision. These include: improving the ratio of health care providers to citizens; reducing infant death rates from 35 to 32 per live new born ; reducing maternal death rate from 82 to 78 per 100,000 new births and increasing percentage coverage of immunization of pregnant mothers from 80 percent to 90 percent. These targets can only be achieved if required funds are available for activities that will achieve these results. This highlights the importance of budget policy linkage. As will be explained in next session, during the past five years there has been steady increase in resources allocated to the health sector in Iraq.

**4.1.2 Share of health sector out of the total Budget of Iraq at a glance from 2006 to 2010:**

Health Sector increased its share from less than five percent in 2006 to more than 12 percent in 2010. Allocation in investment budget is more impressive. In 2006 Iraq allocated only 0.44% of its budget to investments in Health Sector and in 2010 this share increased to 4.58%. Similarly the share of recurrent budget increased from 3.95% to 7.64% of overall budget. This demonstrates that despite competing resources like security, defence and oil, the health sector expenditure has progressively increased as per the policy of the Government of Iraq.

The sources of funding and their distribution are important aspect of Iraqi PFM system. More than 95% of the resources come from Oil export. There is a lot of volatility in this sector due to international price fluctuation.

Medium Term Budget is an excellent tool that provides basis for translating plans into medium term budget. Earlier only the MOF used to prepare MTFF but this activity did not translate into three years sector ceilings. For the next budget year which is 2012; for the first time; Ministry of Finance has issued instructions for preparation of three years budget. This is an important development because plans and policies are prepared in medium to long term time frame. It is difficult to implement plans through one year budget based on incremental allocations. The three year budget will help departments improve their efficiency with more funds be allocated to it by prioritising their activities and as per sector strategies and National Development Plan.

**4.1.3 Interface between Ministry of Finance and Ministry of Planning and Absorptive**

**Capacity of Ministry of Health:**

The budget of Iraq is divided in two parts; recurrent and capital budget. Recurrent budget deals with the operations of a department and includes Personnel Compensation Cost, Goods, Services, Maintenance and Other costs. Capital Budget deals with additions of infrastructure. Both the elements of budget are critical for achieving the sector outcomes and goals. For example, the maternal mortality rate can be improved through trained healthcare workers providing round the clock service. The funding for their salary comes from recurrent budget. Similarly MMR also improves when we increase the outreach by constructing new clinics through capital budget. There is a very close linkage between the two. Ignoring this linkage will have negative effect on service delivery. Construction of new facilities through capital budget has future recurrent budget implications. For example, construction of a tertiary care facility will require funds for salary, repairs, goods and services as the hospital starts operating.

**4.1.4 The Recurrent Budget and Investment Budget of Ministry of Health at a Glance**

**from 2006 to 2010:**

In Ministry of Health, there has been a sharp increase in percentage of investment budget as compared to total budget. In 2005, the investment budget was only 3.1% of total budget. This increased to 11.5% in 2009 and 19 percent in 2010. However due to low absorption capacity, the funds have not utilized. This also highlights the issue of lack of integration between recurrent and investment budget. If these are not planned in coordinated manner than the effect of increased recurrent budget due to completion of investment projects is not reflected in the forward estimates for recurrent budget. For example building of hospital has impact on salary cost as healthcare workers are required to run the facility. In Iraq, the Recurrent and Capital Budget are prepared separately. For example recurrent budget is prepared by Ministry of Finance and Development Budget by Ministry of Planning. In addition there is lack of coordination with donor funding.

The Government of Iraq has improved the allocations for investment budget. This is impressive given the fact that health has to compete with other sectors like security and oil and gas. On the recurrent side the utilization rate remains more than 95%. The utilization rate for investment budget remains from 30% to 70%. The funds that are not utilized during a year carry forward to next year budget. There are many reasons for low utilization of capital budget. This includes limited capacity among the staff for preparing sector strategies, feasibility reports and appropriate project costing. Weaknesses in procurement and contracting also lead to delays. Unstable environment due to security situation is a major contributing factor.

Delays also occur due to delay in approval of capital budget by the parliament. In Kurdistan, the parliament did not approve the budget till April. During this time the MDAs are allowed to spend 1/12th of last year’s budget. However since the system is cash based, unless the parliament approves the budget, the work on development projects is not started.During the war of 2003 much of the data regarding inventory of physical assets was destroyed. There is a need for comprehensive inventory of the Government assets. Such a survey is also important because due to trade embargo and insecurity the maintenance of infrastructure has suffered. Absence of medium term budgeting has also contributed to this neglect. The government has issued instruction to the departments to prepare medium term budget for 2012. This will help the alignment of recurrent and development budget for ensuring better allocations for maintenance. However there will be a greater need for capacity building in these areas.

**4.1.5 Budget Tracking System and Chart of Accounts:**

Iraq inherits a centralised PFM architecture. Fiscal Management and Debt Limitation Law provides legal framework for the PFM system in Iraq. Departments send recurrent budget demands to Ministry of Finance and investment budget demands to Ministry of Planning. Provincial Directorates of Health sends the budget proposals to the central office. MOH budget is divided into two main categories which are recurrent and investment. The recurrent budged is divided in following categories;

* Personal Costs ii) Goods iii) Services

iv) Maintenance v) Other expenditures vi) Non monitory expenditures

Improved Chart of Account is adopted by the government. This Chart of Account is compliant to General Financial Statistics (GFS). Chart of Account is the basis of a transparent financial management system that supports decision making and tracking. A comprehensive Chart of Account is important not only for budgeting and accounting but also for costing, planning and management reporting. The new chart of account is multi dimensional. It has the capacity to help end users analyse all dimensions of a transaction. However, a multi dimensional Chart of Account needs an information system that is integrated and that can capture transaction data and display it in a **multidimensional** reporting system. The Government of Iraq has, with the help of USAID started working on an Integrated Financial Management System (IFMIS) but the outcomes are not achieved. Therefore data is not accessible at the level of transaction but only to the level of trial balance. The other issue is that there is no mapping between the legacy Chart of Account and the new GFS compliant Chart of Accounts. This results in confusion in application of new Chart of Account and in many areas the legacy Chart of Accounts is still used.

**5. EFFICIENCY ANALYSIS (EA) IN PFM AND STEPS TO IMPROVE:**

**5.1. 1. Efficiency Analysis in relation to Health outcomes and Health System Goal of equity in Finances:** The most important indicator of efficiency in relation to health outcomes and health system goal of equity in financing is allocative efficiency. This involves the efficient allocation of public expenditure in accordance with government priorities. Second most important indicator is operational efficiency. As discussed above, allocative efficiency can be improved through better alignment of government policies and plans with the budget allocation. The budget and expenditure pattern indicates that allocative efficiency is weak in PFM systems in Iraq. More funds are allocated to curative as compared to preventive. Although share of primary health care is reasonable, but with in primary health care more funds go to District Hospitals as compared to field units. The size of MoH budget has increased but the increase is not proportionate in all categories of expenditure. There is rapid increase in Salary and Capital Budget but relatively modest increase in operation expense like maintenance and services. The distortions in budgetary allocations lead to distortion in service delivery.

**5.1.2 Following steps can improve allocative efficiency**.

**I. Integrate recurrent and development budget:**

More harmonized budget preparation is required by eliminating separate budget preparation processes. This may require the preparation of recurrent and development budget under one roof both at the central government level by integrating the work of Ministry of Finance and Ministry of Planning but also at the level of Ministry of Health by better coordinating the activities of recurrent and development budget preparation.

**II. Prepare sector strategies with costing:**

Medium and Long term sector strategies in line with National Development Plan should be prepared and these should include cost of implementation. This will help integrating the plans with budgets.

**III. Implement Medium Term Budget:**

Plans are medium term and these plans should be supported through medium term budgets. The Government of Iraq has introduced Medium Term Budget for the next financial year e.g. 2012. Medium Term Budget requires expertise in preparing forward budget estimates and allocating fiscal space to priority areas. This requires a lot of training and capacity building

**IV. Improve Capacity in Health Economics for Better Planning:**

The officials in Ministry of Health are doing commendable job in bringing PFM reforms in health sector. During interaction with the Ministry of Health, it was noticed that there is a strong need for capacity development in health economics. It is recommended that with the help of WHO, training programmes in health economics may be arranged for deserving officials in Ministry of Health.

The second important aspect is operational efficiency. In order to highlight the issues pertaining to operation efficiency a case study is prepared **which** is given below.

**5.1.3 CASE STUDY – OPERATIONAL EFFICIENCY**

Rezgari Hospital is a 490 bedded hospital in the heart of Erbil. It was constructed through Iraqi fund by Marubeni Construction Company in 1983. It caters for a large catchment area. The hospital administration is keen to make improvements for better service delivery and efficiency. There are many issues which hampers the efforts of hospital administration to improve the service delivery. Some of these include;

* Budget making is highly centralized. The hospital has no information regarding the budget related to repairs and maintenance, goods and services and has little control over the salary budget
* Budget is prepared at the level of Director of Health, Erbil. He gets lump sum budget for many service delivery units and releases them according to the needs.
* Medicine is procured centrally. The medicine procured for the hospital is less than its need and therefore, administration has to procure additional medicine during the year. However, in one month the hospital is authorized to make purchases up-toUS $ 1600. The Director of Health is authorized to approve monthly purchases up-to US $ 10,000 and the ceiling for Director General is US $ 40,000.
* For the machinery and equipment, there is a maintenance contract with firms. These contracts are executed at the level of Director Health and not the hospital administration. However, if hospital administration is not satisfied with services of a vendor they can complain to the Director Health
* Hospital administration cannot prepare plans, because they don’t have information about resources.
* Repairs cannot be done in timely manner because approvals are required from outside organizations and it takes time.

**5.1.4 Financing:**

Hospital administration has introduced innovative measures for financing some of the hospital activities. Nominal fee is charged at hospital facilities. For example:patients are required to pay US $ 40 for an MRI, where as in private facilities the rate is US $ 200. Out of these receipts, 40% goes towards revenue of the hospitals, 30% towards staff incentive, 10% to Director Health and 20% is deposited as revenue to the Ministry of Finance.

**5.1.5 Improving Efficiency Through Better Financing Options:**

Rezgary hospital was facing efficiency issues in service delivery. The waiting time for patients is very long. In case of ENT, a patient has to wait for five to six months for a surgery by a junior doctor and one to two years for a surgery by a senior specialist. The long waiting time is due to short working hours which finish at 2 pm and lack of incentive to the staff to work beyond official hours. As a result the hospital was carrying idle capacity as its equipment and theatres were not in use during the evening hours. This has most profound effect on the poor patients. Because it is observed that in such circumstances, the patients who are referred from private facilities get priority in the waiting list and those who cannot afford private visits suffer.

The hospital administration decided to give incentive to the hospital staff that uses the hospital facilities during the evening hours. According to a notification approved by the Health Ministry, the hospital premises can be used for revenue generation during the evening hours. The rates for each category of operation are as follows;

|  |  |
| --- | --- |
| **Category** | **Rates in US $** |
| Minor operations | US $ 85 |
| Medium operations | US $ 170 |
| Major operations | US $ 420 |
| Specialised Operations | US $ 630 |

These rates are less than what is charged in the private sector. The revenue generated through

these operations is distributed in the following manner:

|  |  |
| --- | --- |
| **Category** | **Percentage of Revenue** |
| Development of the Hospital | 20% |
| Doctors Share | 40% |
| Share of support staff | 30% |
| Share of Anesthetist | 10% |
|  |  |

This is a win- win solution for all. It provides incentive to the doctors and the staff to work during the evening time. It improves the hospital efficiency by reducing the idle capacity and waiting time. It provides comfort to the poor patients by reducing the waiting list in the morning (poor patients cannot avail the evening facilities) and it provides additional resources to the hospital to make petty repairs without going through lengthy approval process.

**5.1.6 Effects of Centralized Financial Management and Weak Linkage Between**

**Budgeting and Planning:**

Better service delivery can be ensured through better budget and planning linkage. Budgeting and planning linkage can be effective if decision making is delegated to service delivery units. Rezgari hospital is a classical example of weak budget and planning linkage leading to weak service delivery due to highly centralized management structure. The flow chart of approval process for repairs and maintenance is given below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Ward Manager | Director Finance | Hospital Manager | Director Health | Purchase Committee | Director General |
| 1 | Payment made to vendor  3  2  Prepares a note  Request for repairs | Approves payment  4  No  Yes  Approves the note | 5  Notify purchase committee  No  Yes  Approves the note | 6  Verifies completion of work  Selects vendor and monitors work |  |

Hospital management cannot prepare effective plans because there is lack of information about resources and resources cannot be allocated to needed area because resource allocation is centralized at the level of Director Health and the Ministry. Rezgari hospital was built in 1983. The hospital does not have a budget for repairs and maintenance. Since 1983, no major repairs were done in the hospital. As a result the structure is damaged in many ways. If hospital has budget at its disposal than needed repairs can be done from time to time. Now the Ministry has approved US $ 1 million for the repairs and renovation of the hospital. The accounting and engineering section is enthusiastically carrying out this work. Two floors are already done and work is in progress in the remaining floors. Approval process for repairs and maintenance takes much time. The process follows is explained below (and the flow chart is shown above):

* Ward manager complains of leakage from ducts in the roof of the ward
* Director Finance asks the engineering department to examine the fault and submit cost estimate
* Upon submission of report by Engineering Department he forwards a note for the approval of Hospital Manager
* Hospital manager examines the proposal. If the proposal is valid and cost is within the monthly limit of US $ 1600, he approves it, otherwise he refers the case to Director Health
* The Director Health reviews the demand. If he finds the demand valid and within his limit of US 10,000 he nominates a purchase committee which selects a vendor. If the amount is above his limit then he sends the demand to DG Health
* Purchase Committee selects vendor, certify the satisfactory completion of work and this is followed by approval of payment to the vendor

**5.1.7 Lessons learnt:**

There are many lessons that we can learn from this case study:

* At the time of construction of development projects**:** there should be co-ordination between Ministry of Finance, Ministry of Planning, Ministry of Health and Donors on the feasibility of the projects especially regarding the recurrent cost implications of development projects. In this case, it appears that the hospital was built through capital budget but sufficient budgetary provision for repairs and maintenance of the hospital was not appropriately addressed during the budget making process. As stated earlier, the share of maintenance budget is very low as compared to salary, investment budget and commodity budget.
* Hospitals should have resources and flexibility to use the resources for improvement of hospital infrastructure. In case of Rezgari Hospital no repairs were done since 1983.
* Service delivery units, especially tertiary care hospitals should have long term plans. In order to prepare a long term plan the service delivery unit should have information and predictability of financial resources. In case of Rezgari Hospital, Budget Allocation is made only against employee compensation and stationary etc. they have no control over purchase of drugs, repairs and maintenance and other goods and services.
* Service Delivery systems should not only be equitable but also sustainable. Tertiary hospitals should plan to raise their revenue and provide incentive to their staff. The multiple financing options adopted by Rezgari hospital is a good example to follow.
* Tertiary care hospitals can improve efficiency and reduce waiting time by introducing incentive packages for staff working during the evening time. This is a win win solution of all stakeholders of service delivery
* Segregation of duty is a good internal control procedure. Multiple approvals reduce the risk of fraud and misappropriation. However there should be a balance between internal controls and efficiency of service delivery. If multiple approval process becomes so complicated that it delays the delivery of service than a more effective and simpler process should be adopted.
* **Level and Structure of Healthcare Financing.**

Health care financing is an important function and building block of the health care system because it enhances other inputs and functions and leads to the achievement of health system goals including financial risk protection and equity in financing.

In most countries of the region including Iraq, data on health care financing are often limited and fragmented particularly in relation to health expenditures by households for services purchased in nongovernmental sector. Such data gap does not facilitate a good analysis of the various components of health care financing. The main findings of National Health Accounts are that in Iraq, 3.3% of GDP is spent on Health Sector. Per capita spending on Health is USD 136. Major share comes from the Public Sector which is 73.4 %, followed by 25.3 % out of pocket cost and donor funding of 1.2%. Out of the total 136 USD per capita, the Government spends 100 USD. This shows the important role that the government plays to ensure universal health coverage.

Private insurance market is not established in Iraq. In terms of Financing Agents, Ministry of Health is the biggest Financing Agent where as other ministries also contributing to a lesser extent.

Total expenditure on Health during the year 2008 was ID 5.138 trillion. Out of this amount 14% are used by General Hospitals, 25.2% by Ministry of Health for Primary Health Care, 26.6% by Ministry of Health Pharmacies and in addition 10% by private pharmacies. The administration of health got 22.3%. In general, health funds are primarily spent on curative care, which accounts for 37% of funding.

During 2008, the medical cost of private expenditure in Iraq is more than USD 1 billion. 18% of Out of Pocket cost went to Hospitals managed by Ministry of Health, 34% for private physicians and 39% for Pharmaceuticals. Transportation accounts for 9% of out of pocket expenditure.

The level of health care spending, as per capita and as share of GDP, remains less than the average of countries with similar income. However the structure of health care financing shows a fair degree of equity in view of the limited burden on households who share only one fourth of the total health bill.

The high percentage of government contribution in health care financing reflects the constitutional commitment of the state to secure health and social security to individuals and families. The healthcare financing in Iraq can be termed as high risk. The ambitions like providing universal primary coverage are high but resources are limited. Majority funding comes from the government and government resources are tied to international oil price. Therefore, there is a need for diversification in health care financing. It is recommended that the Government of Iraq,

**6.1. Policy Options for Health Care Financing:**

* **Continue with Universal Healthcare Model:**

Government of Iraq is committed to provide universal health coverage to all citizens. This is a noble objective but needs resources and sustained level of allocation. The resource basket of Iraq depends on international oil price. When the prices are good, Iraq can afford public sector health financing, but at the time of resource constraint, viable financing options have to be seen. For example during the 2003, hospitals were encouraged to self finance the service delivery.

* **Target the Poor Population and Let the Rich Segment Bear the Burden of the service delivery:**

The spirit of universal Health Coverage is that no one should be deprived of health facility just because he cannot afford. That is health is a right and it is the duty of the state to provide this right to all. However it does not stop a government to let the rich segment of the society pay for health care. This helps allocate more resources to the poor. This also improves efficiency. As discussed before, in Kurdistan some hospitals have started encouraging the doctors to use the hospital premises for private practice during the evening hour. This promotes efficiency in hospital operations and also helps the hospital generate resources to help the poor.

* **Encourage Public Private Partnership:**

Prepare policies that encourage Public Private Partnership in health sector. Give incentives to private sector firms for making joint investments with public sector. This can be done in many ways like procurement of expensive diagnostic equipment and installing that in public premises or providing government owned land for establishment of private or charity hospitals.

* **Forge Partnerships with Charity Institutions:**

Some charity institutions are doing good work. Red Cross has done commendable work in Iraq. In Kurdistan, the public sector hospitals requests individuals and institutions to provide cancer drugs for free treatment of needy patients. Such activities can be done at a bigger scale. The government can establish working relationship with private charitable institutions for mutually beneficial activities.

* **Initiate Feasibility Studies**

Health Insurance is non-existent in Health Sector in Iraq. Ministry of Health should initiate feasibility studies related to development of contributive systems of social and preventive health insurance with technical support from WHO, ILO and other development countries.

* **RECOMMENDATIONS :**
* **National Health Accounts**
* Prepare and update National Accounts at regular intervals. At least once in three years
* Develop capacity within the Ministry of Health through trainings and workshops
* Select a core team in Ministry of Health and train them to become Health Economists
* Kurdistan is an autonomous region, therefore merits a more detailed section in National Health Accounts
* **Rationalize expenditure**
* Create new appointments only on the basis of approved job description
* Identify redundant positions and curtail the salary expenditure
* Allocate realistic share of centrally procured medicines to hospitals to governorates. this share may also reflect the needs of internally displaced persons
* Regulate procurement of medicine in private sector
* Create a balance between employee compensation cost and operational expense like services and maintenance
* Maintain the enhanced share of investment budget in health sector and improve its allocation to governorates
* Create a balance between funds allocated to preventive medicine and curative medicine Recommendations
* Budget should be prepared on the basis of activities that contribute to achievement of outputs and outcomes, instead of incremental increases on the previous year budget
* The focus should be on the service delivery and not new recruitments to provide social safety nets
* Maintenance and Service Budget should be in proportion to existing infrastructure. The priority should be on restoring the existing infrastructure as compared to building new ones
* Referral system may be strengthened and Sub Centers and Main Centers may be provided more resources so that their quality of service delivery improves and people do not by pass Sub Centers.
* Resources provided to the primary level do not cater to the needs of the population in view of the constitutional right of universal health care.
* **Link policies and plans with Budget**
* Prepare costed sector strategies
* Reflect the strategic allocations in annual budget
* Prepare budget on Medium Term
* Intensive training of officials to help them prepare budget in Medium Term.
* Prepare easy to read guidelines on how to prepare forward budget estimates. Train master trainers.
* Establish a strategic planning unit in Ministry of Health. The Strategic Planning unit will ensure that budgets are prepared in accordance with sector strategies.
* **Integrate recurrent and development budget**
* Prepare better working environment and integration between Ministry of Planning and Ministry of Finance
* Prepare budget documents that contain both recurrent and development budget on a similar reporting format
* Ideally there should be one Ministry responsible for preparing budgets for both capital and recurrent budget
* Merge Directorate of Projects with Directorate of Planning and Budget. Bring economic analysis unit also under the same roof.
* **Improve absorption capacity**
* Officials should be trained in preparing financing plans for investment budget. The investment budget is prepared by the contribution from government revenue in addition to loans, grants, public private partnerships and on the basis of cost recovery. The department of health should have sufficient information of these resources and they should have the capacity to prepare the medium term investment plans with appropriate mix.
* Training material should be developed and detailed guidelines may be prepared for doing project feasibility studies, project appraisals and contracting and cost benefit analysis
* Project managers who prepare better project plans should be rewarded
* Project managers may be empowered by decentralizing functions and simplifying multiple approval process.
* **Better Expenditure Tracking**
* Prepare regular budget execution reports
* Map legacy chart of account with new chart of accounts
* Improve communications between budget and planning wing and administration wing.
* Capture transaction data through Integrated Financial Management System. Initiate piloting of the project
* Prepare simple to use training material on Chart of Account
* Display Budget Execution Reports on Web Site. This will promote transparency
* Improve internal and external audit
* Establish a separate inspectorate division**.** Appoint pharmaceutical inspectors, sanitary inspectors, inspectors for checking monthly invoice of MOH health institutions and other health institutions providing health care, and inspectors for verifying health insurance status in each of its institutions
* **Improve allocative efficiency through;**
* Aligning budgets with policies and rationalizing resource allocation to preventive care as compared to curative care.
* Rationalize expenditure to Primary Health Care as compared to Tertiary Health Care
* Implement Medium Term Budgetary Framework
* Conduct regular Public Expenditure Reviews of Health Sector
* Conduct performance audits and programme evaluations
* More resources in operational budget to replace Outdated machineries, tools, equipments in hospitals and in PHI (public health institutions) . These should be replaced with modern health equipments of international standard.
* There is a complex structure and poor infrastructure situation in hospitals which needs immediate attention to structure and redesign otherwise this will keep frustrating in carrying out efforts in giving proper health care.
* **Improve operational efficiency through**
* Decentralizing budget making to spending units
* Encouraging spending units to prepare business plans and allocate resources according to the plans
* Improve budget execution through better procurement procedures and staff trained in procurements and contracting
* Simplify multiple approval process
* **Implement intensive training and capacity building exercise**
* New systems require training and capacity building. Training Needs Assessment may be prepared and new staff may be deputed in new functional areas. There is a dearth of Health Economists and Financial Analysts. Training plan may be prepared to fill this gap. Due to capacity gaps there is lack of structured planning, costing and improved budgeting practices.
* **Improve Health Sector Financing**
* Strengthen PFM functions related to public health like broadening the health insurance via contribution basis.
* Health insurance coverage for all Iraqi people which shouldhave macroeconomic sustainability dimension should be designed and started.
* Outsourcing of standard laboratory analyses and devises some mechanism to involve private sector health institutions with public sector health institutions- a kind of partnership for better health care/facility in health institutions.
* Need to design carefully considered reform map setting out the sequence of tasks in chronological order to ensure the use of public finances and available resources in the best possible process.
* Strengthen communication and coordination. It is important to put a communication plan so that staff at all levels understand the reform concept in PFM- what it actually means and why there is/are changes in PFM. This way they know the ways that they will be expected to execute their duties.
* Ensure that a full set of PFM – planning, costing, budgeting, monitoring, management and administrative tools exists and training and guidance are available to staff of MOH and all its institutions working in the health sector from time to time and at regular interval to update their knowledge and to help them develop their skills.