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## BRAZIL

# Raising the Quality of Public Spending and Resource Management in the Health Sector

Bernard Couttolenc, Gerard La Forgia and Yasuhiko Matsuda

### Introduction

*Brazil has made significant progress in human development over the last decade, thanks to a series of policy innovations, and equity of access has increased considerably.* In health, consolidation of government health financing, the organization of the sector into a country-wide system (Unified Health System, or SUS) and an increased emphasis on primary care have been critical for these improvements.

*Significant challenges relating to inefficiencies and the low quality of services remain.* Given high public debt and tax burden, system affordability and sustainability may be increasingly threatened, while equity gains obtained in recent years may be difficult to sustain. Financial authorities are increasingly concerned about rising health care costs, which already represent about 11 percent of public expenditures. At current levels of health system inefficiency, total health spending could increase from 8 to 12 percent of GDP by 2025, while household spending on health as a share of income could rise from 5 to 11 percent. Increasing the efficiency and effective use of health resources to contain rising costs is perhaps the greatest challenge facing the Brazilian health system.

*Many of the challenges facing the health sector are linked to governance failures,* notably the lack of incentives and accountabilities that ensure that services are affordable and of acceptable quality. Public spending constitutes a powerful instrument to influence performance in publicly-funded providers. The structure and management of funding flows to these providers strongly influences the incentives they face. In health, governance also refers

to the means by which a provider organization (such as a hospital), its managers and staff are held accountable for their behaviors (such as resource management, planning, service monitoring, financial management, etc). Accountability is a key concept that captures the responsibilities of actors and the consequences they face based on performance. That means that poor performance is sanctioned and good performance rewarded to promote quality and impact. Where there is no accountability those that excel and those that under-perform are treated equally; a system that is unfair, and compromises quality and impact. In short, governance impacts the quality of public spending, the effectiveness of resource management, and ultimately, the efficiency and quality of service delivery.

This report referenced in this note<sup>1</sup> assesses resource allocation and management, planning and budgeting functions, and budget execution at different levels of government for public expenditures on health services. The emphasis is on understanding the incentives generated for service providers, and the overall soundness of the accountabilities established in the public health services expenditure system. The analysis seeks to identify weaknesses of accountabilities for service provision that stem from the structure and process of intergovernmental and provider funding flows and related managerial practices.

### The Unified Health System

The publicly financed Unified Health System (SUS) nominally covers the entire Brazilian population with a complete range of services free of charge. In practice it is the only health service for over half of the population,

<sup>1</sup> Extracted from "Brazil: Governance in Brazil's Unified Health System (SUS): Raising the Quality of Public Spending and Resource Management", World Bank Report No 36601-BR, February 14 2007

and is the main provider of care for the poor.

Brazil's federal structure and the decentralized nature of the SUS make the financial flows difficult to track and monitor, which in turn makes accountabilities diffuse and difficult. Despite continuous upgrading, existing information systems do not permit accurate identification of how resources are allocated within the context of SUS, nor how expenditures are executed and services provided at the health unit level. Information is lacking regarding how much SUS as a whole (including the federal, state and municipal governments) spends on hospital and primary care. The levels of efficiency in health service provision are not systematically documented.

The report assesses how the processes of allocation, transfer and utilization of resources are conducted at the different levels of the system. The study provides valuable information regarding the reality of the executing units of the system and how these relate to the central levels. It also seeks to identify problems related to financial flows, analyze how resources are used at the local level, and estimate their impact on the efficiency and quality of health services in general. In this respect, the study provides a basis for improving the entire cycle of public resource management processes (i.e., planning, budgeting, budget execution, input management, and health service production) in the health sector, which together help to bolster good governance in health care delivery.

Specifically, the study seeks to survey and describe how public expenditure is allocated for each type of health unit, program or health program; assess the extent to which the resources transferred to states and municipalities are used for the purposes for which they are intended; collect evidence of delays and slippages in budget execution by state and municipal secretariats and service provider units and how these problems affect service delivery; and offer a set of policy recommendations to improve efficiency in resource management and the quality of care in the SUS.

## Planning and Budgeting

The planning and budgeting process in SUS – similar to that of Brazilian government institutions in general – is well structured but overly formalized. Its complexity and bureaucratic formalism limit its usefulness as an effective management tool and as a basis for holding public entities accountable.

- Legally mandated deadlines for the process of planning and budget preparation and delivery are usually met with few delays but the use of data and analysis to identify priority problems in a given locality and as a basis for planning is rare.
- States and municipalities suffer from a serious lack of capacity to develop evidence-based plans to guide their health policies and interventions.
- The plans present objectives and targets, but almost never define articulated strategies and actions to meet them. In many cases, the plans constitute declarations of intentions rather than maps of how to arrive at desired outcomes.
- Participation of the various actors involved, including the expected accountability structures, such as the Health Councils, is insufficient, largely ineffective and potentially counter-productive.
- Planning and budgeting are disconnected, especially at the local level.
- Strategic and financial data needed to develop plans and budgets are often centralized in the Finance or Planning Secretariat and not often made available to the Health Secretariat and or unit managers.
- Managers of most public facilities (primary, diagnostic or hospitals) have limited or no authority to plan service provision, define their budgets, reallocate resources or manage inputs.

## Budget Execution

The weaknesses in planning and budget formulation is further evidenced by the widespread practice observed at sub-national levels of significantly modifying allocations during the budget execution phase often ignoring priorities specified in the planning process.

- Significant changes between the initial budgetary allocation and the amount actually available limit the benefits of planning and financial forecasting. The frequent delays observed in the release of budgeted funds results in their suboptimal use by managers. For example, some of the “frozen” funds can be released only at the end of the year, leaving little time for purchases. Municipalities have little capacity for robust budgetary execution due to a lack of qualified personnel and limited autonomy and decision-making authority of line secretariats and health facilities.
- Most of the states and many municipalities do not comply with the constitutionally-mandated minimum percentage of their funding to be spent on health, even though some spend considerably more. Fed-

eral transfers do not compensate for this inequality in spending.

- At the level of the state and municipal secretariats, the system for budget monitoring, control and reporting is well structured, but focuses on compliance with legal standards and financial control, with little concern for assessing results.
- A multitude of parallel reporting exists associated with programs having restricted funding and/or specific payment mechanisms.
- Availability of disaggregated data on budget execution is limited

### Management of Supplies and Medicines

In the health sector, management of supplies (e.g., from acquisition to use) consumes a substantial portion of financial resources (about 20 percent of the total) and can be a major cause for inefficiency and loss. The current norms governing the process of government purchases are effective in limiting (but not eliminating) the likelihood of misappropriation of resources, but at the same time, their strictness and lack of flexibility create significant distortions.

### Management of Equipment and Installations

Acquisition and maintenance of equipment and physical plant is among the most costly elements of any health system. Inefficiency in this area can therefore be a significant source of cost escalation. In recent years, the Ministry of Health (MOH) and state and municipal health secretariats have attempted to achieve more rational planning of equipment purchases and distribution. The report finds that most units still encounter serious difficulties in maintaining installations and equipment, with significantly negative consequences for the quality and efficiency of treatment; but to date facilities have not been held accountable for the management of equipment and installations.

### Management of Personnel

The rigid legislation governing human resources in the health sector makes management of human resources difficult and burdensome. However, the problems identified in personnel management in the health secretariats and units – principally those of the public sector – are not solely due to limitations and distortions imposed by legislation. Many problems are related to management practices that result in inefficient use of resources, and in some cases, an absence of management. More fundamentally they are grounded in a complete absence of manager

accountability.

### Management of Production and Quality

Service and quality management is in its infancy. Few health secretariats or units regularly collect data on productivity, efficiency, or quality. In some cases, the classic indicators of productivity (average hospital-stay, turnover of beds, occupation rate) and quality (mortality, hospital infections) are monitored, but rarely used for decision-making, which contributes to the inability to hold providers accountable for their performance.

The data gathered through the survey show, for example, that doctors work fewer hours than the number of hours contracted, while still producing the same number of consultations. This situation is typical of public facilities where “real” working hours are negotiated between doctors and managers, and have little relation to “contracted” hours. The reduced time spent with patients may also compromise quality of care. In addition, 40 percent of the cancellations of scheduled surgeries reported in the survey are attributed to internal management problems and inefficient use of resources, such as the absence of medical or support staff, lack of materials, the failure to sterilize the equipment, etc.

The survey inquired about the principal problems affecting the service offered and its quality. The principal problems as identified by state, municipal and facility managers include: shortage of medical drugs, lack of personnel, limited installed capacity to deal with demand in outpatient units, and lack of medical supplies. These are all related to shortcomings in resource management practices detailed in this study. Hospitals managers also report poorly qualified personnel and low quality hygiene practices (e.g., raising the risk of hospital-acquired infections) while outpatient managers cited the lack of or unavailability of diagnostic and therapeutic equipment.

## MAIN CHALLENGES AND RECOMMENDATIONS

The various problems identified in the analysis, and their associated recommendations, can be grouped into four categories.

### Fragmentation of the planning and budgeting process

*Synchronize and align the processes of planning, budgeting, execution, and information, and orient them toward performance.* Planning should be the basis for defining

performance targets. Plans should contain a limited set of easily measurable performance goals. Measurement of activity costs would be an important complement. As such, the MOH should support the installation of cost accounting systems at the facility level, particularly in hospitals.

**Consolidate the transfer of funding resource-by-resource and link growth in financing to growth in performance, thereby rewarding good performance and penalizing low performance.** The existing transfers can be streamlined based on broad functional/programmatic categories that are already well-accepted in the sector (e.g., Primary Care, Hospital Treatment of Medium and High Complexity, etc.). The states and municipalities could then allocate the funds received through these block transfers to specific programs, based on their own plan and budget. The formula for determining the distribution of the transfers should be guided by explicit policy criteria such as (i) attenuation of inter-regional/jurisdictional inequality in health outcomes and access to services, or (ii) performance enhancement at the unit level (i.e., greater efficiency and better quality, as measured by specific, results-oriented indicators).

### **Inflexibility and complexity in budget execution**

**Develop and introduce organizational arrangements that give the management units increasing levels of the freedom of action and authority to make decision on the management of resources.** The pace of granting such autonomy must be calibrated with each unit's demonstrated capacity, however, and the capacity of the central agency (e.g., health secretariat) to monitor and control its performance. On a pilot basis, some of the large hospitals (e.g., referral units), and possibly regional health districts, can be granted full autonomy to manage its finance and human and material resources. It would be best to start with hospitals that already are official budgetary units and therefore have some experience with autonomous input management. For smaller units with more limited administrative capacity, specific aspects of decision-making authorities could be delegated. Some could become budgetary units, whereas others may need to be given less autonomy. For each case, a preparatory study should be conducted to determine the exact level of decision-making each of the authorities is to be delegated.

### **Lack of managerial autonomy, incentives and capacity**

**Strengthen and professionalize management capacity.**

The Ministry could promote adoption of modern management techniques by the secretariats and health units. Such techniques would include management of decentralized personnel; management of purchases and stocks that facilitates estimation of needs, programming of purchases and better control of stocks; management of equipment and installations that enables monitoring of the state of the equipment and its permanent maintenance; evaluation of activity costs and efficiency; evaluation of results in terms of coverage and performance indicators on effectiveness and quality of services. It would be necessary to revamp human resource policies (e.g., better structuring of health care and management careers, systematic training policy) to make careers in the public health sector more attractive.

**Apply mechanisms to strengthen accountability, such as management contracts that make the administrators focus on specific goals and measurable results.** This instrument could serve as a basic mechanism for planning, monitoring, and evaluation. Greater autonomy granted to specific facilities should be balanced with clear performance expectations (targets) and ex-post accountability. In using management contracts as a tool of accountability, a mechanistic application of "reward and punishment" should be avoided. Instead, the performance targets should be used as references around which the secretariat and the unit can develop on-going reviews, dialogue, and appropriate corrective measures to enhance the unit's performance.

### **Inadequate management information.**

**Establish strong monitoring systems that aim to improve organizational performance.** These systems should supply useful and clear information for internal management, including data on program/unit performance that permit comparisons with targets as well as among the units themselves.

#### **More Information**

Obtain the report and further information of the work of the World Bank in the Health Sector at <http://www.worldbank.org/lachealth>

#### **About the Authors**

Bernard Couttolenc is a Consultant), Gerard La Forgia is a Lead Health Specialist (LCSHH) in the Latin America and the Caribbean of the World Bank., and Yasuhiko Matsuda is a Senior Public Sector Specialist in the East Asia and Pacific Region (EASPR)