

THE HEALTH FINANCING

# PROGRESS MATRIX

COUNTRY ASSESSMENT GUIDE



HEALTH FINANCING GUIDANCE NO 9

# **THE HEALTH FINANCING PROGRESS MATRIX: COUNTRY ASSESSMENT GUIDE**

**i** *This Guide should be read in conjunction with version 2.0 of the Health Financing Progress Matrix assessment, detailed in WHO Health Financing Guidance Paper #8; all documents released in December 2020 are available on the WHO website.*

*Feedback and suggestions in relation to any aspect of this document or the Health Financing Progress Matrix should be submitted using the dedicated [feedback form](#).*

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The health financing progress matrix: country assessment guide

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<https://apps.who.int/iris/bitstream/handle/10665/337906/9789240017825-eng.pdf>

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## List of abbreviations

CBHI	Community based health insurance
CIF	Cost, insurance, and freight
CHE	Current Health Expenditure
DFID UK	Department for International Development of the United Kingdom of Great Britain and Northern Island
DRG	Diagnosis Related Groups
FMIS	Financial Management Information System
FS	Financing Schemes
GDP	Gross Domestic Product
GGE	General Government Expenditure
GGHE-D	Domestic General Government Health Expenditure
GHED	Global Health Expenditure Database
HF	Health Financing
HFPM	Health Financing Progress Matrix
HTA	Health Technology Assessment
IHR	International Health Regulations
ITP	Illicit Trade Protocol (tobacco products)
IMF	International Monetary Fund
JEE	Joint External Evaluation
MCH	Maternal and Child Health
MTEF	Medium-Term Expenditure Framework
NCD	Non-communicable diseases
NHA	National Health Accounts
OOPs	Out-of-pocket payments
PBF	Performance-Based Financing
PEFA	Public Expenditure and Financial Accountability
PEMFAR	Public Expenditure Management and Financial Accountability Reviews
PER	Public Expenditure Reviews
PFM	Public Financial Management
PHC	Primary Health Care
PI	Principal Investigator
P4P	Pay for Performance
RBF	Results-Based Financing
RMNCH	Reproductive Maternal, Newborn and Child Health
SHI	Social health insurance
SPAR	State Parties Self-Assessment Annual Reporting
SSBs	Sugar-sweetened beverages
UHC	Universal Health Coverage
VAT	Value added tax
VHI	Voluntary health insurance
WHO	World Health Organization



## Using this document

This Guide has been developed primarily to support Principal Investigators charged with conducting country assessments the Health Financing Progress Matrix (Version 2.0), in response to feedback during the proof-of-concept testing in twenty countries . Background and a full explanation of the Health Financing Progress Matrix is provided in the Guidance Paper (1).

This Guide accompanies and should be used together with the Data Collection Template. All documents were released in late 2020 and are available from WHO's [webpage](#) dedicated to the Health Financing Progress Matrix.

# 1. Background

## 1.1. About the Health Financing Progress Matrix assessment

The Health Financing Progress Matrix (HFPM) is the World Health Organization's standardized qualitative approach to assessing country health financing systems, in terms of both the development and implementation of health financing policy. Together with estimates of revenues and expenditures provided through the [Global Health Expenditure Database](#), and measures of [service coverage](#) and [financial protection](#), the HFPM assesses health financing arrangements in a country at a point in time against a set of benchmarks, expressed in the form of nineteen desirable attributes. While comprehensive in scope, assessments capture only the critical elements of the health financing system, drawing on readily available information and analyses. The HFPM hence complements existing work, pulling together diverse policy and technical documents into a single framework.

Background to the Health Financing Progress Matrix (HFPM) is provided in the Guidance Paper (1) which lays out the desirable attributes of health financing systems. These effectively summarize thinking on what matters in health financing, based on theory and evidence, in order to make progress towards UHC. Not only do HFPM assessments show where a country's health financing system currently stands relative to these benchmarks, it does so in a way which provides guidance on future directions. The HFPM also allows country progress to be systematically tracked over time, capturing the dynamic shifts in the policy development process, not only changes in outputs and outcomes.

## 1.2. Who are Health Financing Progress Matrix assessments for?

Country assessments are produced first and foremost for those engaged in developing, implementing, or overseeing health financing policy. While the first time an assessment is conducted i.e. a baseline assessment, takes an estimated 1-2 months, subsequent assessments can be completed more rapidly, focusing on marginal changes in the intervening period.

By focusing on the critical elements only, assessments are relatively short, and as a result can be conducted regularly to provide frequent feedback to policy makers as part of the annual cycle of policy development, implementation, review, adjustment and improvement. In summary, the goal of HFPM country assessments is to provide regular, timely and clear policy-relevant information, based on an objective assessment of a country's health financing system relative to a set of evidence-based benchmarks, with identified policy priorities.

By assembling a variety of policy documents, and analytical work, often conducted by different agencies, into a single coherent assessment, the HFPM can provide a common reference for the stakeholders engaged in health financing policy. Country assessments can also form the basis of dialogue domestically, for example between different agencies, and be used as the basis for reporting to governing bodies; similarly, assessments can be used for reporting to external funding agencies where relevant. Finally, the attributes, questions, and progress levels can be used for capacity building purposes, and as a focus for technical debate and discussion.

## 1.3. Recommended approach to implementing the HFPM

There may be several entry points for the implementation of a HFPM country assessment but in all cases this will be agreed between the WHO Country Office and the Ministry of Health. In most cases, a Principal Investigator should be hired to complete or lead the completion of the assessment, and should be recognized health financing expert with a deep knowledge of the country's health system, and widely respected. In some cases, additional Investigators may be required. Conducting a country assessments involves reviewing and

summarising secondary information sources with very limited, if any, primary analysis to be conducted. There may, in some cases, be insufficient information to assess certain questions, but this itself is important information, and provides an agenda for discussions on future priorities for analytical and technical work.

Principal Investigators will liaise closely with the Ministry of Health nominated focal-person and with relevant fora such as a Health Financing Technical Working Group. There is flexibility in the process followed by the Principal Investigator at the country level, but in all cases they will be supported by a backup team selected from WHO Regional Offices and the WHO health financing team in Geneva. This backup team will provide advice where useful, and feedback on draft responses, ensuring the quality of the assessment prior to formal review.

Once fully drafted, the assessment is subject to a two-stage review process to strengthen both the quality and objectivity of the assessment. The first review is conducted by two experts who not have been closely involved in the assessment, but ideally have some knowledge of the country and its health financing system. Each expert independently reviews the assessment, including any preliminary scoring provided, and then jointly agree a consensus score for each question. Review and further discussion is then held with the Principal Investigator to finalize scores and key messages.

The objective of the second-stage review is to verify the interpretation of a country's performance relative to the progress levels for each question, to ensure consistency across countries. This ensures credibility in the assessment process and the quality of information in the global database of HFPM country assessments onto which finalized assessments are uploaded.

## 2. Stage 1 of the HFPM assessment

**i** *STAGE 1 OF THE HFPM ASSESSMENT IS A LANDSCAPING OF THE MAJOR HEALTH COVERAGE ARRANGEMENTS (SCHEMES AND PROGRAMMES) IN THE COUNTRY, OUTLINING THE OBJECTIVE AND KEY DESIGN FEATURES OF EACH; STAGE 1 PROVIDES A PICTURE OF THE EXTENT TO WHICH THERE IS STRUCTURAL FRAGMENTATION WITHIN THE HEALTH SYSTEM, PROVIDING USEFUL BACKGROUND FOR STAGE 2. INFORMATION FOR STAGE 1 SHOULD COME PRIMARILY FROM SECONDARY SOURCES WHICH SHOULD BE REFERENCED.*

### 2.1. Deciding which schemes and health programmes to include

Prior to completing Stage 1 a decision needs to be made with respect to which schemes or programmes to include; the Principal Investigator should discuss with the WHO health financing team. Note that schemes are not referred to here in the same way as in National Health Accounts (NHA). The objective in this assessment is to describe the key features of *important* or *relevant* financing arrangements (schemes or programmes) in the country's health system; important in the sense that a scheme should be included if it is relevant to discussions on future health financing reforms and policy directions. The aim is not to capture every single scheme or programme as in a NHA study, although these should be cross-referenced. In general, Stage 1 includes schemes or programmes which exhibit some of the following characteristics:

- represents a large amount of health expenditures, especially public expenditure; hence we include here the government health budget which may not typically be thought of as a programme or scheme.
- covers a significant part of the population e.g. a health insurance scheme
- is a distinct pool of funds managed separately
- is managed with separate governance arrangements from the main health system e.g. a vertical health programme
- represents a high-profile initiative taking new approaches e.g. for provider payment, even if not (yet) covering a large population group or representing a significant amount of expenditure

In terms of the private sector, private insurance should be included, ideally as one scheme or sector; while there is often great variation within this sector, this should be summarized for the purpose of Stage 1, focusing on the role played by private health insurance within the health system in relation to publicly funded benefits. Out-of-pocket payments (OOPs) should not be included as a separate scheme or category; the Sankey Diagram (see next section) shows the extent of OOPs in the health system, but these do not represent a scheme in terms of the criterion of a separate pool of funds managed for a specific purpose. Discussion should include:

- Principal Investigator
- WHO Country Office Responsible Officer
- Point of contact person in the Ministry of Health
- WHO Regional Office Advisor
- WHO Geneva designated staff

## 2.2. Describing each scheme or programme

**i** STAGE 1 DESCRIBES THE WAY EACH SCHEME OR PROGRAMME IS DESIGNED IN TERMS OF A NUMBER OF CRITERIA INCLUDING THE MAIN HEALTH FINANCING FUNCTIONS. FURTHER DETAILS ARE PROVIDED IN THE TABLE BELOW, REPLICATED IN THE DATA COLLECTION TEMPLATE PROVIDED SEPARATELY.

	ASSESSMENT AREA	GUIDANCE NOTES
A	<b>FOCUS OF THE SCHEME</b>	Once the scope of schemes has been agreed, describe each in terms of its focus; this may be all citizens in the case of general budget funding for health facilities, an insurance scheme for public sector employees, community-based insurance, free-care programmes, vertical disease programmes etc. In addition to adding a short description please code using the drop-down list.
B	<b>TARGET POPULATION</b>	Please add here the best estimate of the number of people entitled to receive services or other benefits under this scheme. This provides a denominator for various equity related calculations.
C	<b>POPULATION COVERED</b>	Please add data or estimates about the numbers covered relative to the target population. This figure provides numerator information and, in some cases, will be the same as the denominator e.g. where the basis for coverage (next question) is automatic. In other schemes such as those targeting informal sector/non-salaried workers, the figure of actual enrolees may be significantly lower.
D	<b>BASIS FOR ENTITLEMENT / COVERAGE</b>	What is the legal basis for coverage or entitlement? Is it a) mandatory, i.e. where entitlement to service benefits depends on a contribution made by or on behalf of individuals that is required by law (e.g. payroll-deductions under a social health insurance scheme); b) automatic, i.e. where the basis for entitlement is “non-contributory” (e.g. citizenship, residence, income/poverty status); or c) is participation and hence the basis for entitlement voluntary, i.e. not required by government even if it may be required by an employer?
E	<b>BENEFIT ENTITLEMENTS</b>	Under the scheme, is a specific set of services, medicines etc. listed explicitly as being covered (positive list)? Are all services covered with, for example, some exclusions (a negative list)? Please add a description and code using the drop-down list.
F	<b>CO-PAYMENTS (USER FEES)</b>	Do users have to make a co-payment (user fee)? If so, please give further details of what services these are applied to, and whether to certain subgroups. Are there exemptions, based either on individual (e.g. income/poverty status, age, sex, disease) geographic (e.g. rural vs urban), or facility type (e.g. health centre vs hospital)? Finally, please describe how the co-payment is structured e.g. a single fixed amount, a series of fixed amounts, a percentage of the bill; if the latter, is there a ceiling on total payments over a period of time?

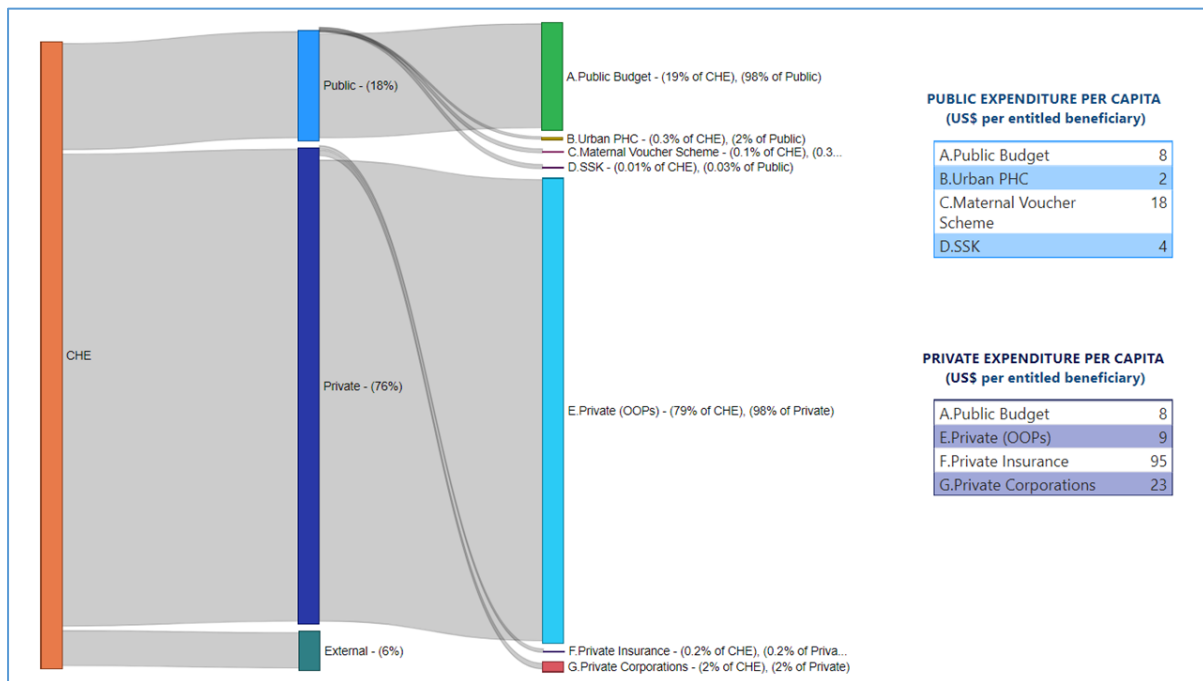
	ASSESSMENT AREA	GUIDANCE NOTES
G	OTHER CONDITIONS OF ACCESS	In addition to any co-payments which users may have to pay, there may be other conditions which must be met in order to access services. For example, patients may have to follow a referral system, or be limited to public health facilities or a preferred provider network. Other conditions may be that only generic medicines are provided, or there are limits on the treatment intervention provided; for example, in the early years of the Universal Coverage Scheme in Thailand, haemodialysis was only publicly funded as treatment for renal failure if peritoneal dialysis (the first line of treatment), was not effective.
H	REVENUE SOURCES	Where does funding for the scheme or programme come from? Funds may come from the health budget, for example as direct funding to health facilities, allocations to a targeted scheme e.g. under 5s, or transfers to a health insurance scheme on behalf of the poor. Other examples are pre-paid contributions linked specifically with coverage as in insurance schemes. Finally, indicate any funding from external sources.
I	POOLING	Are revenues for the scheme held at the national level, or allocated to subnational government authorities? Does the scheme pool its revenue in a single fund, or in multiple funds, for specific population groups or geographical areas?
J	GOVERNANCE ARRANGEMENTS	Briefly describe the management and governance arrangements of the different schemes or programmes where possible. There is some similarity with pooling arrangements so please add here information about the line Ministry which the scheme falls under (e.g. Ministry of Health, Ministry of Social Welfare), as well as information about governing boards etc. Please add references for more detailed information.
K	PROVIDER PAYMENT	Describe the way in which health service providers are paid under this scheme; there may be multiple approaches. Please code using the drop-down list.
L	SERVICE DELIVERY AND CONTRACTING	Which type of facilities provide services under the scheme? Think in terms of inpatient, outpatient, primary, secondary or tertiary, and also whether publicly owned, private-for-profit, or private-non-profit? Is there an accreditation scheme, or a preferred provider network? Are contracts or service performance agreements used?

For several sections drop down coding lists have also been developed which should be used wherever possible.

### 2.3. Mapping health expenditures

**i** THE HFPM PROVIDES A COMPLEMENTARY ASSESSMENT TO NATIONAL HEALTH ACCOUNTS. EXPENDITURE DATA FROM HEALTH ACCOUNTS STUDIES CAN BE MAPPED AGAINST THE SCHEMES AND PROGRAMMES DEFINED IN STAGE 1 TO COMPLEMENT QUALITATIVE INFORMATION AND PROVIDE AN INSIGHT INTO THEIR RELATIVE IMPORTANCE FINANCIALLY.

Once the schemes or programmes to be included in the Stage 1 assessment have been agreed, health expenditure data is mapped against each; a draft example using data from Bangladesh is shown below using a Sankey Diagram. Mapping health expenditure data against the schemes also allows estimates of per capita spending for each scheme or programme to be made, providing useful background information for the subsequent Stage 2 assessment. The best data source for this will be a recent country-specific NHA in which the names of the different “schemes” will be identified as “financing agents”. Such diagrams can be developed with the support of the WHO health financing team.



## 3. Stage 2 of the HFPM assessment

### 3.1. Assessment areas and desirable attributes

**i** *THE HFPM ASSESSMENT IS ORGANIZED IN TERMS OF SEVEN ASSESSMENT AREAS OR DOMAINS BASED ON THE FOUR HEALTH FINANCING FUNCTIONS TOGETHER WITH THREE ADDITIONAL ASSESSMENT AREAS.*

Seven assessment areas are identified in the current version of the HFPM which follow the health financing framework based on core functions, with a new module included for this Version 2.0 addressing issues related to public health functions, health programmes, and health security. These are:

<b>1) Health Financing Policy, Process and Governance</b>	3 attributes
<b>2) Revenue Raising</b>	4 attributes
<b>3) Pooling Resources</b>	2 attributes
<b>4) Purchasing and Provider Payment</b>	3 attributes
<b>5) Benefits and Conditions of Access</b>	5 attributes
<b>6) Public Financial Management</b>	2 attributes
<b>7) Public Health Functions and Programmes</b>	(no unique attributes; draws on others)

Desirable attributes, previously referred to as guiding principles, have been developed for each assessment area; they describe a positive situation or state of affairs, in relation to each assessment area. These ideal, or desirable attributes are based on a theory of change, empirical evidence, and a results chain, and the assumption that movement towards these attributes is expected to improve health system performance, and progress towards UHC.

The number of unique attributes for each assessment area are listed above; however, many of these are cross-cutting, for example two of the attributes in the Revenue Raising assessment area are equally relevant to Public Financial Management (PFM). Similarly, while the assessment area Public Health Functions and Programmes has no unique attributes, it relies on five attributes drawn from other assessment areas. Given the cross-cutting nature of many elements of the assessment, multiple crosswalks are built into the accompanying database, allowing responses from country assessments to be viewed from a number of different perspectives (see details in the WHO Guidance Paper (1)).

### 3.2. Assessment questions

**i** *THE HFPM ASSESSMENT (VERSION 2.0) COMPRISES THIRTY-THREE QUESTIONS, INCLUDES FOUR NEW QUESTIONS NOT INCLUDED IN VERSION 1; THESE ADDRESS HEALTH FINANCING AND HEALTH SECURITY, AND THE FINANCING OF HEALTH PROGRAMMES AND PUBLIC HEALTH FUNCTIONS, ALSO REFERRED TO AS COMMON GOODS FOR HEALTH.*

Each assessment area comprises several questions each building on a desirable attribute, as detailed in the document WHO Health Financing Guidance #8, and listed at the beginning of each section of this document.



Desirable attributes reflect a desirable or ideal situation with respect to one of the health financing functions, while each question digs deeper into specific elements of this attribute. As more countries use the HFPM to assess their health financing system, these questions will be reviewed, revised and improved. In this version, released in December 2020, there are thirty-three questions distributed as follows:

- |  |             |
|--|-------------|
| 1) Health Financing Policy, Process and Governance | 3 questions |
| 2) Revenue Raising                                 | 5 questions |
| 3) Pooling Resources                               | 5 questions |
| 4) Purchasing and Provider Payment                 | 5 questions |
| 5) Benefits and Conditions of Access               | 5 questions |
| 6) Public Financial Management                     | 6 questions |
| 7) Public Health Functions and Programmes          | 4 questions |

A full list of questions is provided below:

ASSESSMENT AREA	#	QUESTION TEXT
<b>1) Health Financing Policy, Process and Governance</b>	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
<b>2) Revenue Raising</b>	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
<b>3) Pooling Revenues</b>	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
<b>4) Purchasing and Provider Payment</b>	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

ASSESSMENT AREA	#	QUESTION TEXT
<b>5) Benefits and Conditions of Access</b>	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
<b>6) Public Financial Management</b>	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
<b>7) Public Health Functions and Programmes</b>	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

### 3.3. What matters and what does progress look like?

**i** EACH QUESTION CAPTURES ONE OR MORE DESIRABLE ATTRIBUTE. FOR EACH QUESTION, FOUR PROGRESS LEVELS ARE DEFINED, EACH DESCRIBING THE SITUATION AND STATE OF AFFAIRS AS THE SITUATION IMPROVES; THIS CONSTITUTES THE RUBRIC FOR COUNTRY ASSESSMENTS.

Each assessment area comprises several questions and for each question background information is provided outlining why the question is important and why it matters in order to make progress towards UHC. Four progress levels are articulated for each question to illustrate what progress looks like. The core of the Progress Matrix is the belief that there are better and worse ways of designing and implementing health financing reforms, reflected in the desirable attributes. These in turn are based on accumulated global evidence as well as “common sense” thinking from the perspective of UHC assessed at the “whole system, whole population” level.

For each progress level, further information reflections and are provided to guide the Principal Investigator in their assessment. This focuses on characteristics that reflect increasing levels of “progress” in terms of the features of systems that are associated (and ideally have a causal effect) on health system performance goals and intermediate objectives, again from a system-wide perspective. The progress levels, labels and generic characteristics are presented below; note that some questions focus only on a) policy development, while others also address b) implementation.

PROGRESS LEVEL		GENERIC FEATURES OR CHARACTERISTICS
1	<b>EMERGING</b>	a) There is no clear or approved policy statement, and ongoing. Ongoing strategies do not reflect global evidence or use local evidence. b) Funding is not linked to policies, or to mechanisms which drive implementation.
2	<b>PROGRESSING</b>	a) Policies under development but only partially reflect global evidence and local assessments of performance. Formal discussions conducted with stakeholders, b) Some aspects of policy are being implemented, or policy is being pilot tested.
3	<b>ESTABLISHED</b>	a) Policy document formally approved; largely reflects global evidence and local assessments of performance problems. b) Widespread implementation with some assessment taking place, feeding into policy and implementation adjustments.
4	<b>ADVANCED</b>	a) Approved policy document consistent with global evidence, local assessments of performance problems, disseminated to a wide range of stakeholders. b) Effective implementation taking place nationally with systematic monitoring and evaluation of performance to inform policy design improvements.

Within the context of the HFPM, these terms should be viewed as labels rather than having some intrinsic meaning. In addition, and while defined as four distinct categories for ease of exposition and communication, it is best to think of the progress assessment for any question as a continuous rather than a discrete variable. To support the Principal Investigator with the assessment, progress levels are in most cases described in terms of a number of criteria, with “for examples” also included.

### 3.4. Background quantitative indicators

**i** *IN SUPPORT OF THE COUNTRY ASSESSMENT PROCESS, RELEVANT PUBLICLY AVAILABLE QUANTITATIVE INDICATORS HAVE BEEN COMPILED INTO A DASHBOARD, WHICH WILL EVOLVE OVER TIME AS MORE INFORMATION AND INDICATORS ARE IDENTIFIED.*

As part of the assessment process, relevant quantitative data needs to be obtained and organized to make a well-considered assessment, as well as to strengthen objectivity. Relevant indicators published on the Global Health Expenditure Database (GHED), and selected other databases, have been compiled into a dashboard specifically developed and tailored to support those conducting HFPM country assessments. The dashboard can be found via the [WHO website](#).

Country-specific health accounts analysis should be used in addition to those indicators published on GHED. However, data which is only available in-country will be equally, if not more important for the assessment. In many cases this information will provide greater detail than that available from published databases.

### 3.5. Issues to consider during assessments

**i** FOR MANY QUESTIONS THE PRINCIPAL INVESTIGATOR WILL NEED TO REACH OUT TO LOCAL SOURCES FOR ADDITIONAL INFORMATION AND FOR VALIDATION PURPOSES. NOTE, HOWEVER, THAT HFPM ASSESSMENTS PRIMARILY INVOLVE PULLING TOGETHER EXISTING INFORMATION RATHER THAN CONDUCTING NEW ANALYSIS.

While some collection of data will be necessary, Principal Investigators (PI) are not expected to conduct any significant new analysis; indeed, an important part of the assessment is to identify areas where little information exists, and which are a potential priority for future work. Certain issues are likely to arise during the assessment, which should be discussed with the back-up team, some of which are discussed below:

- The aim of the assessment is to assess how well-aligned health financing arrangements in a country are with progress towards UHC. The key thing is to look at how the entire health system is performing, not simply one or two individual schemes. After considering how individual schemes are organized and perform, look at how coherently these fit together to make up the health system in its entirety. The PI should also consider any potential positive or negative spill-over effects from individual schemes or programmes for the wide health system and for the population not covered by the scheme (see for example Q3.5 (whispill)).
- WHO uses the concept of health financing functions, for example revenue raising, pooling, purchasing, to allow a common assessment of health financing systems across countries organized in different ways, often labelled as “tax-financed” or “social health insurance”. The language in the assessment follows the functional language, not the language of “labels” so the Principal Investigate needs to translate from what is seen in the country health system into the different functions and assessment areas.
- Much of the assessment focuses on “fragmentation” which is often the cause of performance problems in health systems. Fragmentation can arise from multiple coverage schemes in the same country e.g. an insurance scheme for civil servants, another for salaried workers in the private sector, and CBHI for informal sector workers. Stage 1 of the assessment maps out these schemes. In many countries such schemes do not exist, particularly where a traditional budget funded approach dominates; even in these systems, however, fragmentation can arise when separate health programmes e.g. for TB, or HIV, establish their own systems of benefits, provider payment etc. While it is highly unlikely, if there is no fragmentation in the health system in question, this should be indicated in your responses and it may not be necessary to answer some of the questions.
- A key aspect of the assessment is to capture the dynamic of policy development and implementation, not simply to provide a static picture of the current situation. In practice, this means looking at what discussions and, for example, analytical work is taking place, and how policy is evolving, and in which directions, even if under development or in draft form. This allows assessments and feedback to be provided on a more regular basis.

## 4. Health financing policy, process and governance

**i** THIS ASSESSMENT AREA LOOKS FOR HEALTH FINANCING STRATEGIES WHICH TAKE A SYSTEM-WIDE PERSPECTIVE, ARE DRIVEN BY UHC GOALS, AND ARE BASED ON AN EVIDENCE OF THE UNDERLYING CAUSES OF SUB-OPTIMAL PERFORMANCE. ALSO LOOKED AT IN THIS SECTION IS THE PRESENCE OF EFFECTIVE GOVERNANCE OVER THE HEALTH FINANCING SYSTEM, THROUGH CLEAR ROLES AND PROCESSES FOR THOSE BODIES AND MECHANISMS CHARGED WITH HOLDING IMPLEMENTING AGENCIES TO ACCOUNT, AS WELL TRANSPARENCY AS TRANSPARENCY IN BOTH FINANCIAL AND NON-FINANCIAL PERFORMANCE.

DESIRABLE ATTRIBUTES IN HF POLICY, PROCESS AND GOVERNANCE*		QUESTIONS
<b>GV1</b>	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services.	hfstrat (1.1) govacntbl (1.2) bdgtprcss (6.3) prgalgnplcy (7.1) prgpoolalgn (7.2) scrtyprep (7.3) scrtyresp (7.4)
<b>GV2</b>	There is transparent, financial and non-financial accountability, in relation to public spending on health.	govacntbl (1.2) expinfmon (6.5)
<b>GV3</b>	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments.	data4gov (1.3) pfmdiag (6.1)

\* Desirable attributes articulate ideal situations relevant to each assessment area.

### Question 1.1 (hfstrat):

Is there an up-to-date health financing policy statement guided by goals and based on evidence?

#### **i BACKGROUND TO THE QUESTION**

This question looks at whether there is a clear policy statement with respect to health financing strategy, which is relatively recent and relevant to the current situation in the country. Many countries have developed stand-alone national health financing strategy documents, but those that have not may still have a clear policy statement, for example within a broader health policy document, or a health system strengthening strategy document.

What is important, is that there is some level of detail in terms of strategic directions for the key areas of health financing policy, that this is based on some evaluation studies which look at the main performance challenges; these can be thought of in terms of UHC i.e. use of services according to need, and financial protection for patients. This is a crucial consideration when assessing on this question i.e. whether and how the country's health system performance has been assessed, and whether/how determinants of weak performance are identified.

Policies which are simply adopted or copied from other countries are unlikely to be effective; in contrast, policies which directly address the specific problems identified in the country's health system, and which will plausibly have a positive impact on performance. Assessments may have been conducted by the government or by local specialists, or a development partner or international agency; the main question here is whether such evaluations exist and if so whether used to inform policy, and whether implementation mechanisms are in place to translate policy into action.

Note that later questions in the assessment ask a similar question for specific areas of health financing policy, so look at this question at a broad level. Interpret "up-to-date" as within the last 3-4 years, although more important is that the current policy remains relevant to the current situation. Also note that question 7.1 asks specifically about policy alignment between the vertical programmes detailed in Stage 1 and broader health financing policy, so that issue does not need to be addressed in detail here.

#### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

In summary a good health financing policy development process involves the following:

- An up-to-date/recent health financing policy statement exists
- The policy is guided by clear goals, in particular those related to UHC and health security
- The policy considers global evidence on what works in terms of health financing policy and UHC
- Proposed reforms and strategies address the underlying causes of performance problems in the health system, based on relevant diagnostic, situation analysis, or evaluation studies specific to the country's health system.
- Is based on a process which engaged the relevant stakeholders
- Is aligned with and reinforces a broader health system strategy, especially with respect to service delivery.

**LEVEL 1: EMERGING**

*There is no clear policy statement with respect to health financing and no legal document that supports implementation is available.*

No diagnosis/assessment has been conducted recently e.g. past 3-4 years. No evidence of applied policy research studies on health financing have been undertaken. Impromptu evaluation studies for specific health financing functions may exist but do not address underlying causes of performance. Policy statements might have been developed based on evidence from other countries but are not based on a recent situation analysis which take into consideration the specific country context. Elements of these health financing policy statements might be reflected in the national health strategy but do not provide explicit links and alignment within the broader health system and UHC goals.

**LEVEL 2: PROGRESSING**

*A policy statement is in place but little action to translate this into system change.*

A policy statement based on global evidence has been developed but not recently. An assessment driven by external agencies might have been developed and tries to address the root cause of underlying problems but has not been considered to inform policy decisions. The policy statement has not been well aligned within national health policy objectives and is still at a consultation stage due to lack of consensus and weak evidence. Some of the proposed changes are not feasible within the country context.

**LEVEL 3: ESTABLISHED**

*An up-to-date policy statement based on a recent diagnosis of the current situation exists .*

A health financing policy statement exists and has been translated into legal government order documents. A recent assessment/diagnosis within the past 3-4 years might have been commissioned by a development partner to examine the impact on only financial protection for example. Changes to be implemented are only focused on specific aspects of health financing and do not take a holistic approach. Not all the relevant stakeholders are involved in the process and there is no clear evaluation and monitoring plan in place.

**LEVEL 4: ADVANCED**

*A clear policy statement based on a diagnosis of the current situation exists, and has been developed in collaboration with other sectors and participation of relevant stakeholders.*

A health financing policy statement has been developed based on a diagnosis of the country's health systems performance, identifying the underlying causes of the problems with performance. The process has been driven by the government. Health system goals are defined explicitly, including UHC (equity in service use, quality, financial protection), broader goals (health, responsiveness, considering equity dimensions for each), and possibly health security (e.g. preparedness and response capacities). Goals are contextualized to the country context rather than used in a generic way. Changes to be implemented are clearly set out in order to address underlying performance problems. Recommended changes can feasibly be implemented in the country context and have been translated into laws/regulations through a consensus and participatory process involving all stakeholders.

## Question 1.2 (govacntbl):

Are health financing agencies held accountable through appropriate governance arrangements and processes?

### **i** BACKGROUND TO THE QUESTION

Accountability in the health financing system is required i) to ensure that a coherent sector-wide vision and strategy is in place, and ii) to ensure that those agencies responsible for implementing health financing schemes and programmes discharge their duties effectively. Accountability is not led by any one agency but a range of entities, agencies, and institutions. For example, ensuring accountability for the use of public resources may involve national health coordination committees, supervisory boards for social health insurance agencies, overarching supreme high councils for health insurance, the Ministry of Finance, parliamentary committees, Parliament itself, some form of public committee, and monitoring by civil society groups and the media. The Ministry of Health will most likely play an oversight role for certain schemes or programmes

This question looks at the country's institutional arrangements and processes to govern the health financing system; this includes holding individual programmes to account, as well ensuring coherence at the system level i.e. across health financing programmes. When oversight of individual schemes is ineffective, for example when the distribution of roles and responsibilities across schemes is unclear, performance problems are likely to emerge, such as the inefficient use of resources, and misalignment of implementation with strategic objectives. A second example is when the objectives of programmes are not well aligned with each other, resulting in uncertainty over roles and responsibilities; as a result, benefit entitlements may overlap across schemes, or providers may be paid more than once for the same service. In countries with a semi-autonomous purchasing agency, the separation of roles with the Ministry of Health is often unclear, especially when the purchasing agency reports to a different ministry e.g. labour or social affairs. For example, while usually focused on implementation of policy, the purchasing agency may become more actively engaged in policy development.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Start by reviewing the schemes in Stage 1 and the oversight bodies documented there. Assess how clearly-defined their roles and lines of responsibility are. Second, list any higher-level oversight bodies tasked with ensuring coherence across schemes; think of a jigsaw, each piece representing an individual programme which, when complete, fit perfectly together. Look for legal and reporting frameworks, procedures, and actions which improve the coherence of policy and strategy and help to hold implementing organizations accountable. Assess the extent to which representation in governance processes is skewed towards particular groups (e.g. labour unions, employers, civil servants) rather than reflecting the population more generally, particularly where informal employment is high. Finally, how transparent is financial and non-financing reporting i.e. what was achieved for the money and are reports publicly available. If the standing agenda of governing bodies is available, look at whether detailed performance information is reported and reviewed.

#### **LEVEL 1: EMERGING**

*Roles and responsibilities are not clearly defined across governing bodies for health financing, accountability is weak, and there is poor coordination across schemes.*

Oversight of health financing is weak and ineffective, with no clear documentation of the mandate, role and responsibilities of governing institutions either in relation to the programme(s) they oversee, or in relation to each other. Governance is organized by scheme or programme only, rather than at the level of the wider system.



As a result, there are gaps and or unnecessarily duplications across schemes, for example benefit entitlements overlap, and providers receive more than one payment for the same service. Agencies and individual managers are not held accountable for how funds are spent, or progress made towards strategic priorities. There is little formal communication among key government institutions such as Ministry of Health, Ministry of Finance and where relevant purchasing/insurance agency(ies). There is very little or no public information on how funds are used or on the activities of health financing agencies.

#### **LEVEL 2: PROGRESSING**

*Some roles and responsibilities are defined and divided across governing bodies for health financing, but duplication and poor coordination remains. Some accountability mechanisms are in place but remain weak.*

Official documents, in some cases legislation, have been developed outlining the mandate, role and responsibilities of the various governing bodies; however there remains a lack of clarity regarding how each relates to the other with areas of uncertainty, gaps and or duplication (still a lack of clear system-wide governance of financing). A purchasing agency may exist, but is not empowered to act strategically, with unclear reporting and accountability lines. The Ministry of Finance, Ministry of Health, and national purchasing / insurance agency have some communication, but not in a very effective way, for example the purchasing agency's budget is approved directly by Ministry of Finance and or Parliament without effective Ministry of Health engagement or oversight to align the agency's mechanisms with health system performance goals. At certain points of the health financing policy cycle, policy analysts, health providers and other stakeholders are engaged.

#### **LEVEL 3: ESTABLISHED**

*Most health financing schemes have clear reporting lines to oversight bodies, and collectively roles and responsibilities are clearly defined and divided, although better coordination still required. Accountability mechanisms function relatively well.*

Ministry of Health sets overall health system priorities and strategies and plays a leading role in developing health financing policy and budgets. A purchasing agency(ies) operates with autonomy to define contracts, payment rates and mechanisms, guided to some extent by wider policy directions provided by its governing Board and or the Ministry of Health. A Governing Board exists for the purchaser, although its legal framework is in parts unclear, e.g. while the Board approves the budget it has a passive role in holding the agency to account for non-financial performance. Oversight agencies and processes have strengthened the accountability of health financing agencies, with some action being taken on poor performance, but room exists for improvements; performance reports are made public but not annually.

#### **LEVEL 4: ADVANCED**

*Governing institutions roles are clearly defined both for individual schemes and the health financing system overall. Both government and non-government stakeholders are systematically involved, with implementing agencies held publicly to account for performance.*

Ministry of Health has clear leadership role for the development of health financing policies, and oversight of implementing agencies across schemes and programmes, including any semi-autonomous purchasing agency(ies). Programmes and schemes have clear oversight arrangements and reporting lines, and higher-level institutions ensure coherence across health financing agencies. Ministry of Finance, Ministry of Health, the national purchasing agency(ies) are systematically engaged in health financing policy development, with clarity on roles and responsibilities (e.g. policy versus execution). Adjustments to health financing policy are made transparently, and the general public as well as related public and private stakeholders participate at key points. Explicit mechanisms and institutional arrangements are in place to hold health financing institutions and individual managers to account, with regular public reporting on financial and non-financial performance, and oversight from the public, including civil society, to address poor performance.

### Question 1.3 (data4gov):

Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?

#### **i** BACKGROUND TO THE QUESTION

The generation and use of relevant and reliable health financing information and evidence, is essential to the development of comprehensive health financing policy and its effective implementation (Question 1.1), and also for effective governance and accountability in health financing (Question 1.2). Note that there are two subsequent questions which also look at the issue of information; Question 3.3 includes consideration of the availability of a common or unified health information system across purchasing agencies as one measure to mitigate the problems arising from fragmentation, and Question 4.5 addresses how and to what extent information from provider payment databases are used to inform purchasing decisions.

It is important to distinguish between monitoring information which assesses whether progress is or isn't being made on key areas of health financing, such as financial protection, and knowledge from evaluation studies which analyse the underlying causes of, for example, worsening financial protection. Both are important for this question. Countries vary in terms of how regularly they collect health expenditure data, for example through National Health Accounts studies, which provides essential information for monitoring. Ideally, data collection is guided by a system-wide monitoring and evaluation framework which extends from health financing policies and related strategies. Where several monitoring and evaluation frameworks exist, focused for example on each of the schemes and programmes detailed in Stage 1, or around individual external grants, these need to be coherent with and feed into the system-wide framework.

In support of the governance function, health financing data need to be combined with information such as service utilization, and provider activity, to make informative decisions. The ease with which such data can be combined depends on the system of data architecture; health financing data are often developed in silos, as mentioned above, and may not easily align patient, facility and health worker registries, management information systems for clinical management e.g. patient records, or procurement. Hence, the development and consolidation of health financing and related data, combined with similar improvements in the capacity to analyse and use the data, are important elements of progress towards stronger governance of health financing.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

In this question, the issues that matter are the following:

- a) whether relevant health financing data are produced regularly, national health accounts studies, are considered reliable and used to inform national policy assessment and dialogue.
- b) whether a system-wide framework to monitor and evaluate the implementation of national health financing policies and strategies exists, and is used for governance purposes
- c) related to (b), whether evidence on health financing is organized in a way which allows a system-wide assessment of progress towards UHC
- d) whether health financing data are combined with activity and performance data to support the governance function
- e) whether deeper evaluations and applied policy research are conducted, and made publicly available

**LEVEL 1: EMERGING**

*Information for monitoring is not routinely produced, and few evaluations are conducted, apart from certain programmes. No common data collection format across the health system exists, and little use is made of household survey data for governance purposes.*

National health accounts have not been produced, or not recently, and financial protection has not been analysed in recent years; there are few if any in-depth evaluations of weak performance in health financing. Information linking expenditures to performance is available for some schemes or programmes, in particular those which are externally funded, but these are disconnected from other data systems in the health sector. Where there is automation of data collection, this is limited, and there may be no standard codes for health facilities, patient characteristics, diagnosis, procedures, etc. For example, one health facility may be registered certified by the Ministry of Health or a related agency, and another as an authorized business by the Ministry of Finance, making integration of data and production of relevant knowledge for governance very difficult.

**LEVEL 2: PROGRESSING**

*Monitoring mechanisms exist but are not routinely implemented and depend heavily on external agencies; use of household surveys has increased, but integration with other data is challenging. Governance remains weak.*

NHA study conducted within the last two years, and some evaluation studies have been undertaken, but on an irregular basis, and driven by external funders. There is little evidence of expenditure information and the results of evaluation studies being used to inform policy decisions by oversight bodies. Triangulation of health financing and expenditure data with other sources has started e.g. household surveys, provider activity data. Integrating health financing data with the emerging eHealth architecture e.g. establishment of common terminologies, is being discussed; standard codes are in use for government health facilities but not the private sector.

**LEVEL 3: ESTABLISHED**

*A monitoring and evaluation framework exists, with NHA, financial protection, and evaluation studies produced more regularly.*

Those charged with governance have a regular flow of quality information, but further disaggregation is required to allow, for example, an assessment of distributional equity across schemes i.e. at the system level. Evaluation studies go beyond description and look at underlying causality based on explicit hypotheses regarding the intended effects of reforms and policies. Applied policy research is undertaken by a variety of actors, with some evidence of uptake by governance bodies. Health financing data systems are better integrated into the e-health architecture, with some common identifiers in place.

**LEVEL 4: ADVANCED**

*A well-designed monitoring and evaluation system for health financing exists, and high-quality data are systematically available and used to inform oversight of health financing, and report to the public on progress.*

Quality health financing data on health expenditures (annual) and financial protection (every 5 years) are in place and analysed jointly with performance data to allow a system-wide assessment by governance bodies, who use these analyses for policy adjustments and to hold implementing agencies to account for agreed priorities and strategies. Most data are provided through government routine data statistics, with parallel systems not required. Health financing data systems are fully integrated into the e-health architecture, and the broader e-government framework. Evaluation studies are used to inform decision-making for revisions to health financing strategies, and for wider health policy. Comprehensive data privacy and data protection arrangements are in place. Reports to the public take place for example in Parliament, or through publicly available annual reports.

## 5. Revenue raising

**i** THIS ASSESSMENT AREA LOOKS FOR THE PRESENCE OF A CLEAR POLICY STATEMENT REFLECTING GLOBAL EVIDENCE, BOTH IN RESPECT TO THE LEVEL OF FUNDS RAISED FOR HEALTH AND THE MIX OF REVENUE SOURCES. THE BUDGET EXECUTION RATE IS ALSO ASSESSED, AS IS THE USE OF DIRECT FISCAL MEASURES TO INFLUENCE HEALTH. SEVERAL OF THESE ATTRIBUTES ARE DIRECTLY RELEVANT TO THE SECTION ON PUBLIC FINANCIAL MANAGEMENT.

DESIRABLE ATTRIBUTES IN REVENUE RAISING*		QUESTIONS
RR1	Health expenditure is based predominantly on public/compulsory funding sources.	revpol (2.1) prgrsv (2.4) bdgtcntrl (6.4)
RR2	The level of public (and external) funding is predictable over a period of years.	predict (2.2) bdgtprcss (6.3)
RR3	The flow of public (and external) funds is stable and budget execution is high.	stable (2.3) pfmalloprty (6.2) bdgtprcss (6.3) bdgtcntrl (6.4)
RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms.	hlthtax (2.5)

\* Desirable attributes articulate ideal situations relevant to each assessment area.

## Question 2.1 (revpol):

**Does your country's strategy for domestic resource mobilization reflect international experience and evidence?**

### **i BACKGROUND TO THE QUESTION**

This question deals specifically with the country's policy, strategy and or vision for revenue raising for health. There are two main elements to revenue raising policy, first the level of funding, and secondly the mix of revenue sources. As countries become richer, a greater% of the government's budget tends to be allocated for the health sector, and public spending increasingly dominates overall health spending. Evidence also shows that the more public financing dominates, the better health systems perform in terms of UHC; for example, out-of-pocket spending at the point of service tends to reduce in importance, with access and financial protection improving. Public revenues refer to those that are mandatory (or compulsory), pre-paid, and pooled. In health systems which rely heavily on private financing, patients are charged according to their health needs and given the high cost of many services this leads to high unmet need and is a significant barrier to UHC.

In terms of the level of funding, a number of targets exist, based on priority to health, per capita levels of public spending, and allocations to PHC; while there is no magic number or right level of spending (evidence shows that performance varies widely at any given level of spending), little progress towards UHC will be made at very low levels of public spending.

With respect to the mix of revenue sources, it is more useful to think of public versus private as mandatory or voluntary; voluntary schemes which are non-profit, for example community-based health insurance schemes, have very limited impact in terms of scale, and suffer the same problems of adverse selection faced by for-profit insurance. Furthermore, mandatory insurance schemes based on payroll (labour) taxes will be limited in scope where informal employment dominates and may lead to widening inequities in access to services. Health insurance initiatives should recognize the need to fund heavily through general budget allocations.

### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

Look for policy statements with the objective of increasing and moving towards a predominant reliance on public spending, and or which aim to boost levels of real per capita public spending where these are low e.g. relative to other countries; check whether these statements are backed up by actual increases. Look for policy statements or initiatives about initiatives to increase revenues; assess initiatives such insurance schemes, and whether these will depend on general revenues for funding (preferential), payroll taxes (less preferable where informal employment is high), or voluntary contributions (less preferable given limitations in scaling-up and problems of adverse selection). Beyond policy statements, look at the relevant indicators and trends over time.

#### **LEVEL 1: EMERGING**

*Policy/strategy for domestic resource mobilization reflects poor understanding of lessons from global experience.*

Public, mandatory funding sources are minimal in total health spending (e.g. over 60% comes from out-of-pocket payments), with health consistently a low priority in budget allocation decisions (e.g. under 8% of public spending). Stated policy assumes that significant revenues can be mobilized through voluntary contributions or that it is easy to transform OOPS into prepayment through insurance schemes.

**LEVEL 2: PROGRESSING**

*Policy/strategy shows some limited understanding regarding the importance of public funding, but policy is not realistic or there is no clear plan for implementation.*

The recommendation that health systems rely mainly on “compulsory sources” is meant to imply they are funded mainly from some form of taxation, not that everyone is required, for example, to make a financial contribution to join a health insurance scheme to expand coverage. Unrealistic spending targets may be still used without clear implementation plans. Data shows that most revenues come from a combination of external (donor) sources and private sources (mainly out-of-pocket payment but also voluntary health insurance), and health remains low priority for public spending relative to countries of similar income, despite some recent increase.

**LEVEL 3: ESTABLISHED**

*Policy/strategy reflects clear understanding of main lessons on importance of increasing public funding but still has problematic aspects.*

Policy direction reflects greater realism in the use of spending targets, and or a recognition that expanding voluntary health insurance is not desirable; questions are raised regarding the use of tax subsidies to encourage uptake. While most revenues are from public/compulsory sources (e.g. government budget revenues and mandatory social health insurance contributions combined), private sources play a significant role (e.g. 30% or more). The share of the health sector in public spending has been stable or increasing.

**LEVEL 4: ADVANCED**

*Policy/strategy recognizes need to maintain a predominant reliance on public funding in a fiscally realistic manner and see explicit complementary role for private financing within an overall policy framework.*

Most of health financing relies on public/compulsory funding sources, with private sources playing a minimal (e.g. less than 20%) but clearly defined role in total financing, which reflects the limitations of voluntary contributions. Health is given a medium-high priority as a share of overall public spending, and inequitable subsidies for private health spending are minimal or avoided completely.

** QUANTITATIVE INDICATORS**

Several indicators useful for this question are discussed below with the latest data for each available in your country in the accompanying dashboard; please review this data and where possible obtain information locally for the most recent years. GGE%GDP provides an idea of overall government fiscal capacity; this is important as even if a high priority is given to the health sector in budget allocations, indicated by GGHE-D%GGE, the amount government spends per person (GGHE-D per capita) may remain low. This raises a broader question of public finances, which while not the primary role of Ministries of Health, is nevertheless of great importance and hence concern. The indicator GGHE-D%GDP is a composite indicator combining government fiscal capacity with the priority given to health. The split between public, private, and external funding provides a picture of the extent to which public funds dominate, versus private (particularly out-of-pocket) funding, with data on external funding indicating reliance on, and the potential influence of, external agencies.

## Question 2.2 (predict):

How predictable is public funding for health in your country over a number of years?

### **i** BACKGROUND TO THE QUESTION

This question is concerned with the predictability of public funding for the health sector, critical for the effective planning and delivery of health services to avoid disruptions in services. A Medium Expenditure Framework (MTEF) helps to make revenues more predictable, as would moving any external funding on-budget i.e. flowing through domestic public systems, rather than through parallel budgeting and reporting channels. Consider both domestic public funds, as well as external funds flowing through domestic public systems when answering this question.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

This question looks for the existence of a multi-year budgetary process in the country based on the MTEF (or similar tool) as being the accepted mechanism to plan and forecast future funding. The question also looks at whether the MTEF is being implemented effectively, and to what extent annual budget allocations for Ministry of Health align with MTEF forecasts.

#### **LEVEL 1: EMERGING**

*There is little or no forward budgeting, and there are large or significant year-to-year fluctuations in public funding for health (and where relevant, external funding).*

No systematic forward budgetary planning exists in terms of a multi-year budgetary process through the development of an MTEF; as a result, the resource envelope for health is unclear and unpredictable. There is no multi-year revenue scenario for government or expenditure framework for the sector, and no longer-term plans for external funding, etc.

#### **LEVEL 2: PROGRESSING**

*Although revenue and expenditure scenarios exist, predictability of the level of public funding for the health sector remains poor.*

There are frequent in-year budget adjustments, external aid flows are off-budget. An MTEF exists but is of poor quality, with over-estimation of revenues and poor predictability in future available funds. There is no link between the MTEF and the annual budget process, public revenue scenarios are inaccurate, and central government is unable to influence the planning and budgeting processes of devolved levels of government.

#### **LEVEL 3: ESTABLISHED**

*The level of public funding for the health sector is relatively predictable due to well-functioning budgetary processes.*

For example, there is reliable revenue forecasting, a clear budget formulation process, as well as links between medium-term plans and annual budget processes, regular engagement with subnational governments on planning and budgeting, but some problems remain especially in relation to failures to consider aid fungibility etc.

**LEVEL 4: ADVANCED**

*The level of public funding for health is highly predictable.*

Under this scenario there is, for example, accurate revenue forecasting and information on sector-specific budget ceilings. A good quality MTEF exists, with dialogue between health and finance jointly defining a health-specific used for rolling 3-year budgets. A health-specific MTEF has been introduced and is a good predictor of annual budget allocations to Ministry of Health. The MTEF has clear links to annual budget formulation processes, close engagement between central and subnational governments in planning and budgeting, external aid flows which are “on budget”, and the potential for offsetting declines in domestic funding incorporated into negotiations and planning.

**i QUANTITATIVE INDICATORS**

Taken from the Public Expenditure and Financial Accountability (PEFA) database, indicator PI-21: Predictability of in-year resource allocation assesses the extent to which the central Ministry of Finance has the capacity to forecast commitment and cash requirements and provide reliable information on the availability of funds to budgetary units for service delivery. Countries for which data are available are given a score from A (high) to D (low). Note that this indicator refers to public expenditure overall and is not specific to public spending on health.

Other contextual information can be gained from trend or time-series information on indicators such as GGHE% GGE, and GGHE pc available on the supporting indicators dashboard.



## Question 2.3 (stable):

How stable is the flow of public funds to health providers?

### **i** BACKGROUND TO THE QUESTION

This question looks beyond budgets approvals and is concerned with how well those budgets are executed. Low budget execution is a significant problem in many countries and is often used as a counterargument to efforts to increase budget allocations to health. Think about the underlying reasons for this, such as over-estimated revenues, a disconnect between planning and budgeting, the lack of a formal budget preparation process, delays in operationalizing PFM reforms, or unrealistic plans with poor data. Other reasons may include late or misaligned disbursement or release of funds, limited Ministry of Health capacity to plan expenditures, and procurement delays; all of this affects how stable the flow of funds is to health providers. Unstable fund flow can lead to delays in salary payments, and stock-outs of essential supplies, and in turn the effectiveness of other interventions, such as strategic purchasing, can be undermined.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Progress on this issue is captured in measures which can mitigate low budget execution and disruptions in the flow of funds to health providers. Criteria include:

- quality of expenditure forecasting
- counter-cyclical measures to smooth expenditures
- timely release of funds
- transparent cash-management systems
- subnational units have flexibility to reallocate expenditures
- short turn around for claims processing and payments (for insurance funds)

#### **LEVEL 1: EMERGING**

*Health budgets at central and subnational levels, and SHI agencies where relevant, are rarely executed as planned.*

Health budget frequently fails to comply with basic budget discipline. Reasons may include poor revenue forecasts leading to insufficient or unpredictable revenue streams, late and or irregular release of funds, changes in mid-year prioritization, rigid line item controls, and widely differing capacities of subnational units. Cash budgeting in place putting sector at risks of funds shortage. As a result under-execution of budgets is a significant problem.

#### **LEVEL 2: PROGRESSING**

*Health budgets are sometimes executed as planned.*

Health budget implementation complies with basic budget discipline, but with some shortfalls, underspending, and or exceptional procedures. Similar problems to Level 1 but not as severe; social health insurance (SHI) fund revenues (where relevant) flow irregularly with long delays between submitted claims and payments, unclear policies in place regarding reserves, timeliness of contribution and budget transfers, etc.

**LEVEL 3: ESTABLISHED**

*Health budgets (including SHI fund) are usually executed as planned.*

Similar but less severe problems in comparison with level 2, but neither government nor SHI has strong counter-cyclical mechanisms in place to smooth expenditures when revenues fall unexpectedly. There is limited underspending or over-spending on a yearly basis, but delays remain in fund releases e.g. quarterly.

**LEVEL 4: ADVANCED**

*Flow of public funds to the health sector is highly stable.*

Thanks to good revenue forecasting, budget formulation process, timely execution of approved budgets as planned, and reserves or other counter-cyclical allocation mechanisms in place to smooth financial flows during lower-than-expected revenue inflows. Transparent and reliable cash management system allows the timely release of funds to frontline service providers. Significant underexecution rarely happens.

** QUANTITATIVE INDICATORS**

Taken from the Public Expenditure and Financial Accountability (PEFA) database, indicator PI-1: Aggregate expenditure out-turn measures the extent to which aggregate budget expenditure outturn reflects the amount originally approved, as defined in government budget documentation and fiscal reports. This indicator assesses the credibility of the budget by calculating the extent to which actual aggregate expenditure deviates from the original budget for the last three years of available data (including expenditures financed externally by loans or grants reported in the budget, along with contingency vote and interest on debt). If expenditure consistently varies from the original budget, this points to issues with the quality of budget planning and or challenges in budget execution.

Countries for which data are available are provided a score from A (high) to D (low). Note that this indicator refers to public expenditure overall and is not specific to public spending on health. Details PEFA assessments can be found here:

[https://www.pefa.org/assessments?c\\_ids\[\]=95](https://www.pefa.org/assessments?c_ids[]=95)

Other useful contextual information can be gained from trend or time-series information on indicators such as GGHE-D per capita, and GGHE-D%GGE.

## Question 2.4 (prgrsv):

To what extent are the different revenue sources raised in a progressive way?

### **i** BACKGROUND TO THE QUESTION

This question is not concerned with *how much* money is raised or spent on health, but rather *how* the money is raised and where the burden falls. This question reflects the explicit objective of “equity in finance” in global resolutions<sup>1</sup>, and many national policy statements, giving importance to financing health systems in a “fair” manner. The extent to which the holds true varies across countries and within countries across time. Support for equitable financing translates into solidarity-based funding mechanisms for the sector i.e. public financing. A measure of the burden of financing i.e. how it is distributed relative to capacity, can then be categorized as *progressive, proportional, or regressive*. *Progressive* means the financial burden (% of income) is higher for wealthier than poorer individuals; *regressive* means the burden (% income) is higher for poorer individuals; *proportionate* means the burden is the same across income levels.

An assessment should be made about how progressive/regressive each revenue source is used to fund the health system is; following this, the relative share of each source in total health spending is needed to make an assessment about how progressive or regressive overall funding is. The structure of the different revenue sources for health for each country will differ, but global evidence suggests the following:

- General budget revenues include indirect taxes (e.g. excise, VAT) and direct taxes (e.g. income, corporate profits). Direct taxes are typically designed to be progressive, while indirect taxes tend to be somewhat regressive (unless exemptions exist for essentials such as food, and items consumed mainly by the poor).
- Social Health Insurance (mandatory) contributions are usually set proportional to earnings. They can become regressive where countries set ceilings on the maximum contribution amount (so those earning above that ceiling effectively pay a lower rate).
- Out-of-pocket payments (OOPs) tend to be regressive, but sometimes appear as progressive when that poorer individuals do not seek care or seek care much less, hence incurring less OOPs.
- Voluntary prepayment for health insurance include both for-profit or non-profit insurance schemes. Contributions may be progressive or regressive depending on who is buying the health insurance. Tax subsidies for the purchase of VHI are typically very regressive; the benefits of VHI also tend to be very regressive.

If possible, compile tax rates for the different revenue sources, look at how these vary across income bands, and look for significant exemptions; an economics department at a University, or possibly one of the development banks or the IMF, may have done such analysis i.e. of progressivity in government revenues.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

While there is no correct level of funding, either total or public, given the evidence movement towards an increasing reliance on public sources is desirable. Reduced reliance on OOPs at the point of service is also desirable, particularly where the expected correlation with UHC performance holds true. Ideally time-series is available for the information identified above, to give a sense of how the situation is evolving. While data will

<sup>1</sup> [WHA resolution: Sustainable health financing structures and universal coverage \(2011\) - WHA64.9; https://undocs.org/en/A/RES/74/2](https://undocs.org/en/A/RES/74/2)

drive the assessment overall, look for any serious discussion and effort to improve the situation e.g. proposals to improve tax collection or make it more progressive, even when challenging to implement.

#### **LEVEL 1: EMERGING**

*Most sources of revenues are highly regressive i.e., payment is not based on ability to pay due to, for e.g. low levels of public revenue leading to high reliance on OOPS.*

In this scenario OOPs dominate, typically greater than 50% of CHE (total health expenditures); furthermore, general revenues are largely regressive e.g. based on indirect taxes with few exemptions. Furthermore, there is little dialogue or move to increase reliance on progressive revenue sources.

#### **LEVEL 2: PROGRESSING**

*There is a greater reliance on public revenue sources which mitigates inequities in health payments to some extent, but significant inequities remain in policy design.*

For example, SHI contributions are a fixed amount, rather than percentage rates, there are low contribution ceilings which favour those with higher incomes, and tax subsidies exist for the uptake of voluntary private health insurance.

#### **LEVEL 3: ESTABLISHED**

*Collection of revenue is designed in favour of equity but faces barriers to effective implementation.*

For example, tax evasion, non-compliance of tax payment or insurance contributions. Still, overall, the system relies mainly on public/compulsory sources.

#### **LEVEL 4: ADVANCED**

*Most revenue sources are highly equitable, i.e., payment is primarily based on ability to pay.*

For example, no contribution ceilings on payroll tax for SHI, broadening of tax base from wages to all income, and with relatively low levels of total health spending coming from OOPS or VHI contributions (and with no tax subsidies for VHI).

### **i** **QUANTITATIVE INDICATORS**

- Look at trends in the public private mix of revenues using the Health Accounts FS classifications.
- Look for local analysis of government revenues e.g. mix between indirect and direct taxes. Some studies will calculate a Kakwani Index as a measure of progressivity.
- Look at the structure of direct and indirect taxes e.g. tax rate increases with income? Exemptions in VAT for essentials e.g. food?
- For health insurance/payroll taxes, look at whether contributions are fixed amounts or a%, and if the latter whether the% changes across income bands.

## Question 2.5 (hlthtax):

To what extent does government use taxes and subsidies as instruments to affect health behaviours?

### **i** BACKGROUND TO THE QUESTION

Governments can (and many do) use fiscal measures (taxes and subsidies) to address negative externalities arising from the consumption of harmful products, such as tobacco, alcohol, sugar-sweetened beverages, and fossil fuels. Conversely, governments sometimes contribute to health problems by subsidizing unhealthy behaviours, particularly through fossil fuel subsidies. This question is interested in the extent to which government uses fiscal policies as public health instruments.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

This question is concerned specifically with the explicit use of taxes and subsidies as a public health instrument. While the revenues raised through such instruments may be important, they are addressed in question 2.3 on the stability of funding flows on the overall mix of revenue sources. In addition to raising revenue, health taxes are important because they also reduce the negative externalities, and thereby reduce the associated health costs. In order to ensure that health taxes are effective, we need to ensure that they are designed and increased in such as ways as to reduce the affordability of harmful products. More information on pro-health taxes in particular can be found in the WHO [primer on health taxes](#). The key elements to well-designed health taxes include:

- Tax structure refers to the type of tax and how it is applied. Health taxes are excise taxes rather than sales taxes or tariffs. Excise taxes can be a specific tax (per unit) or ad valorem tax (percentage of value) or a mixed specific and ad valorem system. Generally, specific taxes, or mixed systems where the specific component is greater than the ad valorem component, are considered best practice. Uniform systems (i.e. a single rate for all products) are considered best practice while tiered systems are not encouraged unless they form part of thresholds on alcohol or sugar content. The tax base is also important. For specific taxes, the base is usually the number of cigarettes/packs or the volume of beverage. More complex systems may use the alcohol or sugar content as the base. Attention should be paid to the base of ad valorem taxes. Ad valorem systems that use the retail price as the base are preferred to those that use the wholesale, ex-factory or CIF price.
- Tax rates which are higher result in higher prices, particularly when the appropriate tax structures are applied. WHO recommends that excise taxes on tobacco should account for at least 70% of the retail price (or alternatively that total tax should account for at least 75%). Guidance for alcohol and sugar-sweetened beverages taxes are currently under development.
- The policy goal is to reduce the affordability of products. Well-designed taxes may not be sufficient, and government should evaluate trends in prices and affordability and regularly increase taxes to ensure that affordability declines over time.

### **LEVEL 1: EMERGING**

*There is no legal basis for health taxes, they are not used as an instrument to influence consumption, and subsidies may exist that are harmful to health.*

At this stage, there is no legal foundation for health taxes or else very few (perhaps one) may exist; however, they are poorly designed and not in line with WHO Best Practices. For example, tax structures may be poorly designed or tax rates well below recommended levels or regional and global benchmarks resulting in low prices and or becoming more affordable over time. No health justification for their implementation has been advanced,

and to the extent they exist, they are used primarily for revenue raising. Subsidies may exist or are widely used (e.g. fossil fuel subsidies or agricultural subsidies that support tobacco production).

#### **LEVEL 2: PROGRESSING**

*There is a legal basis for health taxes, and some exist but are set at levels too low to adequately influence unhealthy behaviours, and harmful subsidies may continue to exist.*

Here, some health taxes implemented (most typically on tobacco and alcohol) and a health basis for their implementation is acknowledged (e.g. tobacco taxes form part of an NCD strategy). However, many challenges exist with respect to tax design. For example, tax structures may be poorly designed or tax rates well below recommended levels or regional and global benchmarks resulting in low prices and or becoming more affordable over time. Subsidies may exist or are widely used (e.g. fossil fuel subsidies or agricultural subsidies that support tobacco production) but there has been acknowledgement of their harms.

#### **LEVEL 3: ESTABLISHED**

*Tax regime is in place for at least two potentially harmful products, fossil fuel subsidies are eliminated/reduced, and government is considering plans to increase rates in line with international guidance.*

Health taxes are widely implemented, and the health basis is a strong motivation for policy-makers. Additional health taxes are likely under consideration or already implemented (e.g. SSBs). Many best practice elements are present and progress on reforming tax systems to reduce challenges with respect to design and rates has been made. This has resulted in increases in taxes and prices and reductions in affordability in recent years, however, further scope for reform including increases in tax rates exists. Tax administration and enforcement is prioritized, including progress being made including implementation of ITP. Harmful subsidies are not widely used and where they may exist efforts are underway to further reduce or eliminate them. The country represents a good example to their peer groups.

#### **LEVEL 4: ADVANCED**

*Fiscal measures are used across a range of harmful products to discourage their use/consumption and are set at levels consistent with international guidance.*

Health taxes are widely implemented, and the health basis is a strong motivation for policy-makers. Best practice tax structures are present and tax rates are high enough and consistent with regional and global benchmarks to reduce consumption and have been increased regularly to ensure reducing affordability over time. Tax administration and enforcement is strong. No or few harmful subsidies exist and where they remain there are plans to eliminate them. The country being assessed represents an excellent example to others.

### **i QUANTITATIVE INDICATORS**

- The Affordability of the most sold brand of cigarettes is measured by the percentage of per capita GDP required to purchase 2000 cigarettes (100 packs) of the most sold brand. As the measure increases, cigarettes become less affordable. A positive trend growth rate means cigarettes have become less affordable, on average, between 2008 and 2018.
- The excise tax share is the percentage of price of the most sold brand accounted for by the excise tax. WHO recommends a target of 70% for the excise tax share. For some countries, total tax share may be a better indicator than excise tax share; total tax share includes import duties and levies.
- Tax structure refers to the type of tax (i.e. specific, ad valorem or mixed system), whether the tax is uniform or tiered, and if an ad valorem or mixed system, the tax base. WHO recommends uniform specific systems, or mixed systems with larger specific components.

Country-specific information for each indicator is available [here](#).

## 6. Pooling revenues

**i** THIS ASSESSMENT AREA LOOKS AT POOLING ARRANGEMENTS FOR HEALTH FINANCING. THE TERM “POOL” IS USED TO REFER TO A SEPARATE SCHEME OR PROGRAMME, WITH DEDICATED FUNDING, SERVING A SPECIFIC POPULATION GROUP E.G. A CIVIL SERVANTS INSURANCE SCHEME, OR A SET OF SERVICES E.G. A TUBERCULOSIS PROGRAMME. STAGE 1 PROVIDES A DESCRIPTION OF THE MAIN SCHEMES AND PROGRAMMES IN THE COUNTRY.

DESIRABLE ATTRIBUTES IN POOLING*		QUESTIONS
PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds.	prgrsv (2.4) poolpol (3.1) redistlim (3.2) revpool (3.4) vhispill (3.5) pfmalloprty (6.2) scrtyresp (7.4)
PR2	Health system and financing functions are integrated or coordinated across schemes and programmes.	data4gov (1.3) poolpol (3.1) fragsolve (3.3) pfmalloprty (6.2) prgalgnply (7.1) prgpoolalgn (7.2) scrtyprep (7.3)

\* Desirable attributes articulate ideal situations relevant to each assessment area.

### Question 3.1 (poolpol):

Does your country's strategy for pooling revenues reflect international experience and evidence?

#### **i** BACKGROUND TO THE QUESTION

This is a question on the country's policy, strategy and or vision regarding pooling arrangements. There is strong evidence that fragmentation in pooling arrangements has harmful consequences because, for any given level of prepaid funding, fragmentation limits the potential to redistribute to needs, meaning that the ability to support greater protection against financial risk and to enable greater equity in the distribution of resources to services are less than they would be in a larger pool. In addition, fragmentation often results in duplication of functional responsibilities between schemes and programmes, a reflection of inefficiency. Therefore, a policy or strategy for health financing that seeks to reduce fragmentation or mitigate its consequences is generally desirable. It should be recognized, however, that pool fragmentation is often a highly charged political issue, and often it is mitigation strategies that are more relevant than directly addressing existing fragmentation. However, a country strategy that explicitly increases pool fragmentation would be a concern.

There is also very strong evidence that voluntary affiliation to health insurance, particularly where there is reliance on individual contributions, is plagued by adverse selection and generally fails. Therefore, strategies that are defined based on the hope or belief that individuals can simply be convinced to join are not consistent with evidence. Contributory-based approaches for the informal sector that involve subsidies and strong local intermediaries are still challenging but at least reflect a more informed approach to policy than just hoping that people will simply enrol and re-enrol every year. Overall, it is critical to analyse a country's pooling strategy from a system-wide perspective rather than focusing on an individual scheme.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

In assessing this question, look for policy statements which recognize the problems of fragmentation and look to reduce or mitigate in some way; secondly, if there are policy statements related to voluntary health insurance, assess whether the limitations of this approach are recognized.

#### **LEVEL 1: EMERGING**

*Policy/strategy is contrary to key principles and lessons from international evidence.*

Does the country plan to have different schemes for different population groups (or responds to each new priority with a new scheme); to rely on voluntary affiliation to coverage schemes; to promote private VHI in a way that will fuel inequity (e.g. through tax subsidies) and add to greater segmentation of the population into different schemes; to have separate information systems and other administrative arrangements for each scheme or government coverage programme?

#### **LEVEL 2: PROGRESSING**

*Policy/strategy shows some understanding of key lessons but still segments the population without supporting or compensatory measures, or changes to the flow of existing budgetary revenues.*

A lack of supporting measures means that the policy assumes that people will eventually contribute and join a scheme, but there is no incentive or other policy action to support this. Lack of compensatory measures means that the policy does not address the likelihood some schemes – for higher income persons in particular – will be funded at a much higher level per capita than others.



**LEVEL 3: ESTABLISHED**

*Policy/strategy reflects main lessons from evidence, reducing fragmentation or mitigating its consequences, but key challenges such as tax subsidies for VHI or separate SHI schemes not fully addressed.*

Examples of policies to reduce fragmentation would be to combine previously separate funding sources (e.g. general budget revenues and SHI contributions) into a single pool. Examples of mitigating the consequences of fragmentation can include consolidation/merger of schemes, compensating schemes funded at lower levels with increased budget subsidies, and “as-if pooling” mechanisms such as the establishment of common databases /data platform across all schemes which allow monitoring for example of differences in service use. In many countries a separate SHI scheme is established for civil servants or other salaried workers.

**LEVEL 4: ADVANCED**

*Policy/strategy reflects core evidence and principles on pooling, with explicit actions to address or mitigate fragmentation, and to monitor/adjust unintended equity consequences.*

As with Level 3, measures to address fragmentation can include risk adjustment mechanisms, merger of schemes, compensation across schemes, common information and other systems. In terms of monitoring or adjusting for unintended consequences, an example would be that a unified pool may contribute to greater inequity in service use if there are large inequalities in supply-side service availability and provider payment mechanisms direct resources from the pool to where the services and providers are. An advanced strategy would account for these possibilities and include mitigation measures.

### Question 3.2 (redistlim):

To what extent is the capacity of the health system to re-distribute prepaid funds limited?

#### **i BACKGROUND TO THE QUESTION**

This question looks at how funds are distributed through the health system and what criteria, if any, drive these allocations. In many health systems, funds do not flow to those services and or populations defined as a priority in health policy documents; frequently, funds are allocated inequitable across different parts of a country, affecting both the quantity and quality of the supply of services.

Here, we look at the allocation of funds at the intermediate level of the health system e.g. from the national budget to purchasing organizations. This may be handled, for example, using a geographical allocation formula. Question 4.1 (allocneeds) looks at how funds are allocated from purchasers to providers.

Both theory and evidence show that pooling arrangements which are large in size, based on a diverse risk mix, and in which participation is automatic/mandatory, enable greater redistributive capacity with respect to prepaid revenues in the health sector. This question also takes the level of prepaid funding as “given”; the focus is on the extent to which pooling arrangements constrain the potential to redistribute the available prepaid funds in the system. A key policy concern for this question is the extent of fragmentation.

#### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

##### **LEVEL 1: EMERGING**

*Potential to redistribute available prepaid funds from lower to higher need populations is greatly constrained by structural barriers, and few/no mechanisms exist to compensate.*

For example, due to multiple health coverage schemes funded and managed separately, such as where there may be a small SHI scheme for the formal sector or even separate schemes for civil servants and private sector workers, and just supply-side subsidies for the rest of the population. It may also be reflected in contexts of fiscal decentralization where there is little/no equalization across subnational units, etc.).

##### **LEVEL 2: PROGRESSING**

*Some redistribution of available prepaid funds exists, but schemes reflect lack of diversity in population coverage and an over-reliance on voluntary participation.*

Redistribution may take place through a central government allocation formula, or some form of equalization mechanism. A lack of diversity in population coverage is seen when separate schemes exist for specific groups e.g. civil servants, private sector workers, and the rest of population, with no pooling or compensation across these schemes. Examples of voluntary participation are when people decide whether to join a CBHI scheme, or informal sector workers to join SHI) for the rest of the population.

**LEVEL 3: ESTABLISHED**

*System enables a good degree of redistribution of prepaid funds but fails to include the entire population.*

For example, redistribution may take place by pooling some budget revenues with SHI contributions to cover non-contributors; a common SHI scheme for civil services and private sector workers is another example; a fiscal revenue redistribution formula that reduces variation in public spending on health per capita by region; compensation from budget funding may enable reduction of large inequalities in per capita funding across schemes.

**LEVEL 4: ADVANCED**

*Highly effective re-distributional mechanisms in place that include the entire population.*

Examples for this scenario include a unified single pool with budget transfers that enable inclusion or coverage of the entire population; risk adjusted transfers across pools, whether defined as “insurance” or geographic subnational units, to enable a virtual single pool, with the “adjustors” in the formula capturing differences in health resource needs due to individual (e.g. age, sex, health risks, relative deprivation) or geographic (e.g. remoteness) factors. Potential unintended consequences for equity arising from supply side imbalances even with unified pool are addressed through actions in service delivery, workforce or purchasing.

** QUANTITATIVE INDICATORS**

The financial flows described in Stage 1 are an important reference for this question, in particular per capita public expenditure by scheme, and over time, if available. In addition, per capita public expenditure by geographic region would provide useful information. Similarly, it may be useful to compare the share of total (or public) health expenditure flowing through each scheme relative to the share of the total population affiliated to each scheme.

### Question 3.3 (fragsolve):

What measures are in place to address problems arising from multiple fragmented pools?

#### **i** BACKGROUND TO THE QUESTION

This question is particularly relevant where there is fragmentation in the health system, in terms of multiple coverage schemes and or health programmes; the extent should be apparent from Stage 1. The previous question 3.2 is concerned with structural fragmentation and whether countries make progress over time by merging or integrating different schemes, or alternatively by enabling redistribution of resources between them. In contrast, this question assesses whether interventions or mechanisms are being used to overcome or mitigate the negative consequences of fragmentation, when addressing fragmentation through merging, integrating or redistributing funds between schemes is not taking place.

Fragmentation can drive inequities in access to and use of services, as well as the direct financial cost to patients, and affects coherence in the health financing data architecture. For example, data generated by different schemes/programmes becomes difficult to collate and compare, which is important for a system wide analysis of progress towards UHC.

In responding to this question, identify actions which compensate for the negative equity and efficiency consequences of fragmentation, rather than actions which change the structure of pooling itself, which should be captured in Question 3.2. Examples include pro-equity interventions e.g. the harmonization of benefits across schemes and pro-efficiency measures such as unifying patient information systems. For policy-makers, much of the scope for action lies in the purchasing function, although decisions about benefit design and overall health system governance can also mitigate fragmentation. Question 7.2 also considers this issue, but with a specific focus on health programmes (e.g. TB, HIV). Therefore, you do not need to go into depth on that issue here.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

- Making progress on this issue means putting in place and implementing policies which address the various issues arising from fragmented pooling, as described above. Examples of mechanisms which support this include:
- Harmonizing benefit entitlements across schemes (note that this issue is considered in more detail in Question 5.1 (benexplct)).
- Ensuring that provider payment mechanisms are coordinated and coherent across schemes/programmes for example through a unified payment system.
- Building a common or unified health information system across schemes/programmes. This means progressively harmonizing information across purchasing agencies, which can be achieved through interoperability by adopting common definitions (semantic interoperability) and terminologies (syntactic interoperability), or through the development of interoperability layers to transform heterogeneous data into comparable and compatible information (technical interoperability).

**LEVEL 1: EMERGING**

*There are no compensating measures to address inequity and inefficiency arising from fragmentation.*

For example, no mechanisms to address common problems arising from pool fragmentation exist, such as when separate health coverage schemes (separate pools), have separate and unequal benefit entitlements, separate governance arrangements, separate information systems, etc. A common example is when schemes use different payment methods, and or different payment rates for the same type of services, generating incentives that may contradict each other, and which do not support progress towards UHC. In this scenario, services provided to better-off individuals may be remunerated with attractive payment methods and or higher rates compared with services provided to less-well off population groups.

**LEVEL 2: PROGRESSING**

*Some measures in place to address inequity and inefficiency arising from fragmentation.*

Examples of such measures include benefits being harmonized across some schemes, steps taken to develop a unified or interoperable approach to information management across a few schemes, but multiple different forms exist, and information is not yet managed through a common database; for example, different data forms may exist for each scheme, and schemes may use different uncoordinated provider payment rates for the same services.

**LEVEL 3: ESTABLISHED**

*Substantial measures in place, though with room for improvement, to address inequity and inefficiency arising from fragmentation.*

Examples of such “substantial measures” go beyond those of level 2, such as:

- harmonizing benefits for most of the population
- significant development of a single information platform with common standards for data collection and submission, irrespective of a patient’s scheme or insurance status. This allows a comprehensive picture of health care activity across the health system to be developed, such as which services are being purchased, for whom, from whom, and by whom, to inform policy analysis and development.
- payment methods and or rates for the same health service are well harmonized, although some remaining disparities create conflicting incentives for providers such that patients from certain schemes are still financially more attractive than from other schemes.
- Explicit channels for coordination across the different schemes and Ministry of Health have been set up;
- Measure to reduce supply-side imbalances are being put in place;

**LEVEL 4: ADVANCED**

*Compensation measures fully implemented to enable equity and efficiency challenges arising from pool fragmentation to be fully addressed.*

Examples of such measures would be the harmonization of common/standard or minimum benefits, unified forms and facility-level data collection processes for all patients regardless of scheme or insurance status feeding into a single national database, single provider payment system used across schemes, and provider types.

### Question 3.4 (revpool):

Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?

#### **i** BACKGROUND TO THE QUESTION

Different revenue sources and fund flows within a health system may or may not complement each other. Public funding streams include health budgets, compulsory health insurance contributions, and external/donor funds; these various revenue sources should ideally complement each other; private revenues include voluntary health insurance contributions whether for profit or non-profit schemes. There may also be complementarity between private and public sources e.g. an individual's health insurance contributions that are matched by a public subsidy (as in China). The issues raised by the question can apply both to the flows from revenue sources to pools (e.g. whether different sources are pooled together to fund a benefit package) and also to the flows from pools/purchasers to providers (this latter will also be reflected in Question 4.2). Promised benefits/entitlements and the way that funds flow to or for this is of great importance to analysing the issues raised by this question.

Refer to Stage 1 which may tease out some of these issues. Questions in Section 7 address a similar issue, but in the specific context of disease-specific or other public health programmes.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

##### **LEVEL 1: EMERGING**

*There is no coordination of fund flows from different revenue sources.*

A common example is that each revenue source flows to its own distinct pool, and taken together, they are not explicitly organized to fund a common benefit. It may also be observed in payments from a social health insurance fund to providers do not account for direct government budget funding to the same providers. Other examples include governments at different levels funding different budget line items, the lack of a well-defined minimum benefit framework that indicates funding sources, and RBF operating as a vertical initiative uncoordinated with other funding streams.

##### **LEVEL 2: PROGRESSING**

*Complementarity exists among some revenue sources, but there is no population-wide (universal) framework of health benefit entitlements indicating the specific role of different funding sources/streams.*

For example, there is some pooling of budget allocations and SHI contributions but only for a small part of the population, and other mechanisms such as donor-funded RBF are not well-integrated with or defined in a way which complements other flows; there is no clear or explicit complementary role defined for voluntary/private sources to what is funded from public revenues.

##### **LEVEL 3: ESTABLISHED**

*A benefit framework exists for most of the population with funding responsibilities clearly defined across different revenue streams, but private prepayment still not well-integrated.*

Examples of complementarity are where SHI contributions for formal sector employees are pooled with budget transfers to fund a common benefit for most of the population; or where RBF/P4P mechanisms are designed and implemented in a where which recognizes and is complementary to "base payment" funding flows, for e.g. budget funding of salaries.

**LEVEL 4: ADVANCED**

*There is explicit complementarity of different revenue sources to fund a defined benefit package for the entire population.*

Examples include the health budget and SHI contributions jointly funding benefit entitlements for all citizens, possibly with an explicit (but small) role for individual prepaid contributions. Another example is where a SHI scheme covers variable costs, with the government budget directly funding fixed costs such as salaries; if co-payments are defined as necessary for certain (partially) publicly funded services, these are clearly organized to be complementary. A third example would be where the benefit framework and public funding responsibilities for it leave explicit gaps in either service coverage or cost coverage (i.e. co-payments) that establish the space for complementary voluntary health insurance (as compared to VHI that covers the same services and costs as are also covered by the public benefit framework). Overall, a key feature of an advanced situation would be the existence of a publicly guaranteed benefit package framework with explicit indication of how different funding sources combine to provide this on behalf of the entire population.

** QUANTITATIVE INDICATORS**

The indicator “Government subsidy to social health insurance as% of social health insurance” provides a sense of how budget and payroll tax revenues are used in a complementary way. This should be used in combination with data regarding population coverage in the SHI scheme. Country-specific information is available on the accompanying dashboard [here](#).

### Question 3.5 (vhis pill):

What is the role and scale of voluntary health insurance in financing health care?

#### **i** BACKGROUND TO THE QUESTION

This question is based on experience which shows that the effects of voluntary health insurance (VHI) depend critically on the role it plays in the health system. VHI can be complementary to public funding, covering either services or costs (co-payments) not covered by the main public system, but the conditions for this to happen are stringent, and such complementarity has only been identified in a few countries e.g. France, Slovenia. Elsewhere, VHI can play a supplementary role, covering services and providers that may also be covered by the main system. In most countries, this supplementary role is small (both in population coverage and financial terms), and the gains or losses for UHC are not significant. In an important number of countries, however, there is evidence that VHI schemes, and especially commercial private VHI that serves higher income people, concentrates scarce health system resources such as workforce to the service of the privately insured population, with harmful consequences for both the cost and availability of services for the rest of the population.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

First, look at whether VHI exists and whether it is significant in scale or minimal (refer to the quantitative indicators); if non-existent or minimal the other part of this question need not be answered. If VHI is significant, the issue is whether the role it plays (the benefits it offers), is explicitly supplementary or complementary to those benefits funded by the main public system, or whether it overlaps with them. Where there is overlap, there is a risk of negative impact on the public health system and on progress to UHC.

#### **LEVEL 1: EMERGING**

*VHI coverage largely benefits the rich, fragments the system, and has a large inequity impact.*

In this scenario there is much higher level of total health spending flows through VHI than the population covered by such schemes, with likely harmful implications for the overall distribution of health system inputs and putting upward pressure on wage and other prices as a result. The increasing price of key inputs diverts scarce health workforce to serve the private system, while the main public system suffers from staff shortages. Government may be contributing to this inequity by promoting VHI growth through tax subsidies that favour the rich. The role of VHI in the overall health system is not clearly defined by government, and there is considerable overlap between the services covered by such schemes and those covered by public funding.

#### **LEVEL 2: PROGRESSING**

*VHI coverage benefits the richer population and is a source of segmentation and fragmentation; spillover effects are limited however, despite government still promoting VHI.*

VHI contributes to system inequities, although the magnitude of resources flowing through VHI is not large (e.g. under 5% of overall health spending). It is concentrated on the richer population and covers services also covered by the main system. There is some limited evidence of “internal brain-drain” with providers leaving public service to earn more money serving the privately insured. Overall, the negative spillover effects are important but not large. Government still uses inequitable tax subsidies to promote VHI growth.



**LEVEL 3: ESTABLISHED**

*Health financing policy enables VHI to play a supplementary role for faster access or to obtain services from providers not contracted by the main/public system, with no major spillover effects.*

Government has defined a role for VHI in the system and has a regulatory framework in place. The role may be supplementary but with some limits on what VHI can offer. In financial terms, the market is small (at most 3% of overall health spending and does not have significant harmful spillover effects for the rest of the system. Important inequities remain, however, in service use and quality between the insured and uninsured population.

**LEVEL 4: ADVANCED**

*VHI either does not have negative effects or plays a clear complementary role within a publicly defined benefit package, with subsidized coverage for the poor.*

For example, VHI a very limited role representing low health expenditure overall, or plays an explicitly complementary role, covering co-payments or those benefits excluded from the public system, thereby adding to overall progress towards UHC. Government addresses inequities by ensuring that coverage for poorer people is either subsidized or provided through compulsory arrangements for the same benefits as the complementary VHI.

** QUANTITATIVE INDICATORS**

Calculate VHI expenditure as a% of total health expenditures (CHE), relative to the population covered by VHI. This ratio gives an idea of the likelihood of negative spillover; where the share of total health expenditures flowing through VHI is much greater than the share of total population coverage with VHI, it is very likely that this will have negative effects on the availability of system resources for most of the population.

Government transfers to VHI, such as tax-breaks for the uptake of VHI, are likely to constitute a public subsidy for already better-off groups in society. This data may be available from national health accounts studies.

## 7. Purchasing and provider payment

**i** PURCHASING AND PROVIDER PAYMENT IS ONE OF THE MOST POWERFUL WAYS IN WHICH POLICY MAKERS CAN LEVERAGE CHANGE IN THE WAY THAT HEALTH SERVICES ARE PROVIDED, AND HOW THEY ARE ACCESSED.

DESIRABLE ATTRIBUTES IN PURCHASING AND PROVIDER PAYMENT*		QUESTIONS
PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination.	allocneeds (4.1) ppmcohrnt (4.2) info4prch (4.5) pfmallocprty (6.2)
PS2	Purchasing arrangements are tailored in support of service delivery objectives.	ppmqlcrd (4.3) ppmeff (4.4) info4prch (4.5) prvdauton (4.6) pfmallocprty (6.2) bdgtcntrl (6.4) scrtyprep (7.3)
PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	ppmeff (4.4) info4prch (4.5) bdgtcntrl (6.4)

\* Desirable attributes articulate ideal situations relevant to each assessment area.

### Question 4.1 (allocneeds):

To what extent is the payment of providers driven by information on the health needs of the population they serve?

#### **i** BACKGROUND TO THE QUESTION

This question is concerned with the way in which funds flow from purchasers to service providers; it does not focus on the allocation of funds at the intermediate level i.e. from national to subnational purchasers for example through geographical allocation formula, which is captured in Question 3.2 (redistlim). The way in which providers are paid is one of the most powerful ways to influence the performance of providers, from several perspectives including the quality (see Question 4.3) and efficiency (see Question 4.4) of services provided.

Specifically, this question looks at whether information on the health needs of the population served by a provider is used to influence the financial allocations they receive; if not, then there may be significant misalignment between the needs of the population being served and funds received for some providers relative to others.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Specifically, look for the type of allocation mechanisms used, particularly for budget funds; input-based budgets are often driven by infrastructure and staff numbers or norms which may, but most likely does not, reflect population health needs. Using simple capitation as the basis for allocations reflects population size, and further adjustments which reflect health needs directly or indirectly will positively increase alignment. Finally, some form of variable, volume, activity or performance related allocation can further increase alignment between financial allocations and population health needs.

#### **LEVEL 1: EMERGING**

*Historical patterns or input-based norms used without reference to data on population health needs.*

No evidence of use of data on service use or population size in allocations to providers; entirely or predominantly historical pattern plus/minus an increment in line with overall budget availability. In the public sector, budget allocations would be based on inputs such as the number of hospital beds or staff and tends to be paid as rigid line-item budgets. For reimbursements of non-government providers, this is simply paying whatever is claimed by the providers (e.g., unmanaged fee-for-service) without analysing the data to understand patterns and influence in a desired direction (e.g. to promote more preventive services).

#### **LEVEL 2: PROGRESSING**

*There is some use of simple measures of need within payment mechanisms in at least some schemes or government budget allocations.*

For example, simple (unadjusted) capitation has been introduced for a part of provider payments as the size of the population served is a crude measure of need, and or epidemiological and service use data inform explicit choice regarding the amounts made available for primary health care relative to higher-level referral care. However, this may only apply to one or two schemes or programmes, or to only some line items (e.g. excluding personnel). One may also find use of pay-for-performance (P4P, RBF, PBF) mechanisms to steer service use and resource allocation towards some high priority services (e.g. immunization), though not on a national basis.

**LEVEL 3: ESTABLISHED**

*More sophisticated mechanisms of adjusting for health needs, service mix and provider performance are incorporated into payment methods and applied to most prepaid funding in the system.*

For example, capitation formulae include age and sex adjustors and or consider service use and needs (such as disease burden or poverty rate of a catchment area). Measures of the relative severity of case mix (e.g. use of DRGs for case-based payment weights) informs allocations across and within (inpatient) facilities. These mechanisms apply within the schemes (including government budgets that flow directly to providers) that account for most public funding in the system but may not yet fully include personnel. There may also be nationwide use of P4P/RBF/PBF mechanisms to steer service use and resource allocation to needs-related prioritized services (e.g. immunization, communicable disease services, RMNCH).

**Level 4: Established**

*The main provider payment methods used in the health system involve methods that incorporate data on population health needs, risk factors, provider performance and service mix.*

Payment methods with needs-adjustors are applied to most of the prepaid funds in the health system, including for personnel. The adjustors (e.g. for capitation or risk-adjusted global budgets or reimbursements) go beyond age and sex and incorporate other individual characteristics (e.g. historical utilization data, disability status, relative deprivation measures, relative severity). Price incentives for high-priority services (based on need, such as immunization) exist within the core payment system or as an add-on P4P element.

## Question 4.2 (ppmcohrnt):

**Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?**

### **i BACKGROUND TO THE QUESTION**

When multiple payment methods exist across different purchasing agencies (i.e. coverage schemes or health programmes), or within one purchasing agency, these need to be coordinated and harmonized to ensure a coherent set of incentives for providers. Provider payment is one of the main ways in which the behaviour and performance of providers in terms of patient financial protection, equitable access and quality services, can be influenced in support of UHC. In many countries purchasers set payment rates and methods without considering what other purchasers are doing; from the provider perspective, this often means multiple, incoherent and often competing incentives, which incentivize behaviour inconsistent with UHC. This frequently occurs when insurance schemes are set up for a specific population group, and when programmes for diseases, conditions or interventions establish their own provider payment approach without coordination.

Look at the payment methods used in different schemes, and then at payment levels/rates; this information should be available from Stage 1. However, unless a more in-depth analysis has been conducted, it may be difficult to assess how provider behaviour is being influenced in practice; further analysis using for example the Analytical guide to assess a mixed provider payment system (2) may be recommended.

Look also at cost-sharing mechanisms (user fees and co-payments) and whether these are harmonized across different schemes and programmes; again Stage 1 should provide some a useful starting point. Where these are not harmonized, provider behaviour may be influenced in a negative way. For example, certain population groups may pay lower or no cost-sharing, while those covered under another scheme must make payments. When cost-sharing is retained at the level of the health facility, providers may be inclined to prioritize those patients who make higher cost-sharing payments (despite otherwise harmonized payment methods), which may create inequities in access and treatment.

### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

This question considers that some programmes may warrant specific payment methods but that they should be aligned with overall system objectives. Differences in payment methods and payment rates can negatively affect provider behaviour and health system performance. Look within individual purchasing agencies, and across agencies; refer to information from Stage 1; consider whether there have been efforts to harmonize with and across purchasers to make a coherent set of incentives overall, minimizing undesirable provider behaviour, which can include:

- Resource shifting is when resources such as staff time and attention, beds, and other materials are shifted to certain services or hospital wards, units, departments, technologies or equipment which providers consider more financially attractive.
- Service shifting refers to a situation where providers prefer to shift or refer a patient to another provider in order to avoid the costs of his or her treatment.
- Cost-shifting occurs when health care providers shift costs by charging higher rates for the same service to one purchaser, to compensate for a lower payment from another, or when revenue from another source reduces (relative to costs or trends).

**LEVEL 1: EMERGING**

*There is no alignment or harmonization of provider payments within or across purchasers.*

For example, for the same type of services, different payment methods and or rates are used across different health coverage schemes, e.g., better-off individuals are covered by a health coverage scheme with financially more attractive payment methods and higher rates. Neither is there any alignment of payment methods and funding flows for different types or levels of care coming from the same purchaser. Payment levels (and hence the power of their incentives) may be set for one programme that are well-above those for the rest of the system without regard for system-distribution impacts. Instead of being guided by population needs and preferences, providers may change their behaviour to benefit as much as possible financially. As such, provider behaviour is characterized by resource shifting, cost shifting and or service shifting that most likely has negative consequences for system-wide equity and efficiency.

**LEVEL 2: PROGRESSING**

*There is some limited alignment or harmonization of provider payments for some key services across a few purchasers. There is alignment within major health programmes(s) or scheme(s) across types and levels of care.*

Payment methods and or rates for the same type of health services are harmonized across a number of schemes/programmes, but considerable disparities still remain leading to incoherent or competing incentives for providers; as a result, patients covered under one scheme are financially more attractive than those from another. There are considerable risks or indications of resource, cost and or service shifting by providers.

**LEVEL 3: ESTABLISHED**

*Payment methods are aligned or harmonized for most services across most purchasers. Payment methods and funding flows are largely aligned for different types and levels of care within most programmes or schemes.*

Payment methods are aligned or harmonized for most services across most (but not all) purchasers. Payment methods and funding flows are also largely aligned for the different types and levels of care within most (but not all) health programmes or schemes. Payment methods and or rates for the same type of health services are harmonized, but there are still a few disparities creating incoherent or competing incentives for providers across schemes; as a result, patients from one scheme are still financially more attractive than those from another. There are some remaining risks or indications of resource, cost and or service shifting by providers.

**LEVEL 4: ADVANCED**

*Provider payment methods and rates are unified or fully harmonized within each purchaser and across purchasers.*

Provider payment methods and rates are unified or fully harmonized across purchasers and within each purchaser. Each purchaser has fully aligned their payment methods internally, and fund flows for different types or levels of care levels incentivize providers to focus on priority services and patients and population groups with the highest needs. The incentives created by the mixed provider payment system is coherent and does not generate significant detrimental resource, service and or cost shifting behaviour.

** QUANTITATIVE INDICATORS**

Service utilization rates, disaggregated by various criteria e.g. population, income or patient groups, would be useful when answering this question. Information on the level of spending per beneficiary of each scheme, if available from Stage 1, is also useful; similarly, data on the actual rates of payment (prices) by scheme for the same services.

### Question 4.3 (ppmqldrd):

#### Do purchasing arrangements promote quality of care?

##### **i** BACKGROUND TO THE QUESTION

Purchasing arrangements (the combination of payment methods, prices paid, the unit of payment, contracting mechanisms, the administrative review processes used, payment system data analysis, and overall governance of the purchaser(s)) can have an important influence on the quality of care provided by health facilities. When strategic, purchasing instruments can directly affect quality for example through provider selection mechanisms, and through adjustments in provider payment methods which promote better quality; these may be included in contracts, for example with specifications about minimum clinical standards, and requirements for data collection and reporting. Improved coordination of care across types of service (from primary prevention through to rehabilitation) and levels of care, is increasingly seen as key to developing patient-centred services, and improvements in quality of care. Care coordination focuses on synchronizing patient care across multiple providers and specialists, with the goal of improving health outcomes and reducing health care costs, for example by eliminating unnecessary tests and procedures.

This question is interested in whether purchasers are taking active measures to influence provider behaviour and performance specifically to improve quality of care, through contracts or agreements, data analysis and feedback, and payment methods. Do contracts of performance agreements exist at all, is facility accreditation considered, is selective contracting part of a strategic purchasing strategy? Are the terms of agreements with providers based on the range and quality of services offered, their proximity to the communities which require services, and other relevant factors? Are the data generated by provider payment systems used to analyse practice patterns and provide feedback to providers, particularly for those determined to be outliers?

##### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Look for purchasing instruments which specifically promote quality of care, including performance agreements, policies or instruments for selective contracting, better coordination of care through blending or bundling of payment methods e.g. capitated provider networks, specific financial incentives, and the existence and use of standardized quality indicators across payers and providers. Other instruments include an effective information management system and governance arrangements that strengthen the accountability of purchasers and providers.

##### **LEVEL 1: EMERGING**

*Purchasing arrangements do not provide incentives that promote better quality or coordination of care.*

There are no aspects of purchasing which promote service quality, for example through performance contracts, selective contracting, quality-related requirements within agreements, or financial incentives through the payment system; similarly, there is little data available which reflects provider quality. Purchasing is generally passive. Provider accreditation systems do not exist or function well; all public providers automatically funded, mainly through line-item budgets, while there is little oversight of the methods used or the data arising from the mainly fee-for-service payment of private providers.

**LEVEL 2: PROGRESSING**

*Purchasing arrangements include a few mechanisms which incentivize improved service quality and care coordination, but these are limited in scope.*

Performance contracts increasingly used, with providers having to meet license or registration requirements; some quality-related reporting conditions are included in contracts, but these are limited, are not aligned across different schemes or providers, and are not monitored and enforced in a systematic way. There may be some interest and thinking about possible selective contracting under certain schemes or programmes. There are no incentives to promote better care coordination.

**LEVEL 3: ESTABLISHED**

*Purchasing arrangements include mechanisms that encourage providers to focus on service quality and care coordination, but measurement of impact is limited.*

A provider payment database includes quality-relevant elements that allow comparison of provider practice patterns (e.g. treatments for specific conditions, prescribing behaviour, surgical outcomes) with some analysis taking place and feedback given to providers. This may also be used to adjust payments according to performance on quality, for example quality-related bonuses or penalties (e.g. non-payment for major surgical errors such as leaving instruments in the patient, or for avoidable problems such as injuries due to falls from the hospital bed), and capitation contracts that include conditions or reporting requirements for certain quality measures (e.g. average time for consultation). Quality metrics may be used as add-on P4P payments attached to other payment mechanisms or as adjustors within payment formulas, and may be applied to all cases at a health facility (e.g. quality-adjustment as a percentage of the overall payment for meeting targets related to clinical effectiveness, safety or the timeliness of care provided), or at the level of a specific case group (for meeting specific guidelines), or at the level of an individual patient case (for which specific quality guidelines are met). Pay-for-coordination elements are used to enhance care coordinate among providers of different care levels or across specialists or disciplines. Some quality measures may also be included in an accreditation mechanism that may also affect the level of provider payment to facilities.

**LEVEL 4: ADVANCED**

*Purchasing instruments such as financial incentives are used to promote quality of care and coordination; information and indicators which measure both elements are routinely available.*

There is a rigorous process of provider accreditation, and contracts with conditions including reporting on quality measures is used system-wide rather than on a scheme basis. The provider payment database includes quality-relevant information and is used either to adjust payments for quality or to identify practice variations (like for Level 3), with routine feedback to providers, as support for a wider quality improvement strategy. Moreover, P4P mechanisms may be used to support the implementation of quality improvement or relevant reporting more broadly. Coordination of care is incentivized through bundled payment methods. For example, the purchaser pays a single fee to a contracting entity to cover all primary care needed to manage a chronic condition to increase multidisciplinary collaboration for chronic disease management. Linkages across providers and care levels may also be realized in the form of referral systems and coordinated provider networks focused on improving the delivery of care through aligned goals, harmonized processes, and shared information management across services.



### Question 4.4 (ppmeff):

**Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?**

#### **i BACKGROUND TO THE QUESTION**

Most health systems face problems of both under-supply of some services, and over-supply of other services; over-provision can lead to cost-escalation, a common problem in many health systems, while under-provision of essential services limits progress towards UHC. This question looks specifically at whether, and if so how, purchasing arrangements in the health system are organized to deal with this issue.

The way providers are paid, in terms of both the method and the rate (price, tariff), is one of the most important levers to influence provider behaviour. Aligning or harmonizing payment methods means balancing the undesirable incentives of one method with the positive incentives from another. Predominant or heavy reliance on open-ended fee-for-service payment systems almost always leads to service over-provision, or provision of unnecessary services. Formula-based payment mechanisms can improve alignment with strategic objectives. Case-based systems e.g. Diagnosis Related Groups (DRG) provide incentives for greater cost-control per admission but require complementary measures such as a global budget and utilization review to manage the risk of unnecessary admissions or premature discharge. Capitation is effective for cost control but may lead to under-provision, and so the potential for this needs to be monitored.

Blended or bundled payments are examples of how purchasers can combine methods and prices to generate desirable incentives for providers while mitigating undesirable incentives. Even in well-designed payment systems, administrative mechanisms are needed to ensure that incentives remain aligned over time. Providers may respond in ways which are entirely predictable, but inconsistent with purchaser intentions e.g. upcoding under DRGs to increase revenues. Monitoring provider behaviour e.g. through a utilization review, can inform payment strategies, and administrative controls such as audit, claims review and fraud control, can also help to prevent overprovision.

#### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

Stage 1 provides information on the payment methods used in the different schemes and programmes. Look for movement away from singular payment methods with few appropriate incentives, such as input-based and fee-for-service payment methods. Movement away from defined “tariffs” and towards a formula-based approach to payment, generally represents progress by providing the opportunity to translate policy objectives into specific payment adjusters, together with administrative measures to counter unintended consequences.

#### **LEVEL 1: EMERGING**

*Payment system incentives allow providers to over- or under-provide services, and there are no complementary administrative measures in place to limit this.*

There is no significant strategy to align payment methods to address under or overprovision in the health system. For example, the payment system of most schemes/programmes is largely based on a single payment mechanism for a specific type of care e.g. input-based line item budgeting for public providers, and fee-for-service for private providers. Administrative processes to check on and address over- or under-provision (e.g. utilization review) either do not exist or are not implemented).

**LEVEL 2: PROGRESSING**

*Provider payment system starts to introduce incentives aligned with objectives, but only cover a small share of the population. Limited review of administrative data to control for fraudulent reporting.*

There is recognition by a purchasing agency that the use of a single payment method creates incentives for either over- or under-provision, although only a relatively small share of the population or overall health spending may be affected. Nevertheless, recognition of these concerns by one purchaser is important, and measures may have been introduced such as a shift to capitation payments and or DRGs, with some deliberate mix of payment methods (e.g. capitation plus output-based payment) to counteract the limited effects of a single method. There may also now be some analysis of service use data to identify outliers (e.g. in terms of average length of inpatient stay, or number of patient contacts) as a means to track fraudulent reporting, with follow-up action taken (e.g. through information or penalties).

**LEVEL 3: ESTABLISHED**

*Purchasing strategies which address over- or under-provision are implemented in schemes covering most of the population, including either or both payment methods and administrative controls.*

Addressing under- or over-provision is high priority for most purchasers (or the agency through which most prepaid funding flows, or which covers most of the population), and meaningful measures have been implemented. Examples include the greater use of deliberate or explicitly mixed payment methods to balance incentives (e.g. case-based payment or fee-for-service within an overall budget cap or volume ceilings; budgets or capitation combined with elements of output-based (“performance-based”) payment); output-based criteria and risk adjustment factors to determine budgets; administrative measures such as utilization reviews or claims analysis applied on a routine basis including automated checks for outliers (e.g. length of stay greater or less than defined thresholds, prescribing of more than a fixed number of items per contact) that in turn require detailed analysis to derive measures to address over- or under-provision; finally, feedback processes to providers from administrative analyses occur regularly. The transition from tariffs to formula-based methods has been initiated. Some payment formula may include a budget neutrality factor to ensure that total payments do not exceed available funds.

**LEVEL 4: ADVANCED**

*Payment methods aligned across the health system to set coherent incentives to address over- or under-provision, and regularly reviewed; administrative mechanisms in place to control for unintended consequences.*

Patterns of service use are routinely analysed for over- or under-provision, with rates, coefficients, or the mix of payment methods used (and the share of total payment under each) adjusted accordingly. This may involve greater use of mixed (blended or bundled) payment methods to share financial risk between purchasers and providers. Examples include an institutionalized process to review payments to a provider using case-based payment with a global budget to control overall spending; another example is review of a prospective payment (e.g. salaries, fee-for-service, capitation) blended with performance or output-based payments.

Payment methods are formula-based and adjust for budget neutrality by, for example using an explicit coefficient to adjust for both revenue availability and higher or lower volume than initially planned, combined with an initial base rate and adjustors for severity, needs, relative deprivation, teaching, or other relevant factors. Additionally, or alternatively, bundled payment is used, through which several components of health care for a specific intervention are put and paid for together, based on the expected costs of patient cases, episodes of care over a specified time-period. Purchasers may periodically adjust relative payment rates to promote certain services (e.g. immunization) or deter others (e.g. high-tech diagnostics), or more generally to incentivize greater use of PHC services while concurrently paying lower relative prices for high-cost but low-priority services; finally, analysis of provider-level utilization data is used on a routine basis to identify outliers and take action to modify behaviour.

The database on service utilization includes a set of automated outlier checks (e.g. length of stay below or above defined thresholds, repeat admissions within 30 days) requiring further review to determine if care was under- or over-provided. Overall, purchasers manage the payment system dynamically and anticipate changes (e.g. in

cost structures, technology, provider behaviour) that are anticipated to arise from the use of certain payment mechanisms (e.g. under-provision in primary care with capitation, under-provision per case with case-based payment, repeat admissions with case-based payment) while regularly adjusting and optimizing payment methods. Utilization reviews, claims analysis, fraud detection measures or alike are in place, and the process of routine feedback to providers is well-established.

### Question 4.5 (info4prch):

Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?

#### **i** BACKGROUND TO THE QUESTION

A detailed picture of provider activity, including those in the private sector, is a requirement to make purchasing more strategic. In many health systems, purchasers accumulate data on provider activity as part of a claims process for retrospective reimbursement, for example where fee-for-service or case-based payments are used. When payment is prospective e.g. budgets, capitation, other mechanisms are required to ensure the necessary data flow to purchasers.

Progress means that purchasing agencies generate more reliable, detailed and timely information on provider activity over time, while minding the efforts required from providers to submit such information. This requires capturing progressively more detailed and comprehensive information for each patient encounter in terms of demographic information, health risks and health status, medical history, provider administrative data on diagnosis and treatment i.e. service and input uses. One window of opportunity to make progress on that aspect is through the digitization of data submissions, although this is not always a guarantee of improved information management for purchasing.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

The focus in this question is on the availability and quality of patient encounter data (including "claims data" in the context of retrospective reimbursement by insurers); this will depend on the actual requirements for data submission which exist, and the quality of those submissions in terms of the level of detail, relevance, and timeliness. It will also depend on the standardization of information collected across the schemes or programmes identified in Stage 1. Importantly, any workload resulting from reporting requirements should not be excessive, and hence harmonization of reporting forms and processes (see Question 3.3) can reduce the burden on providers. Progress also implies that information is analysed and used to inform future purchasing decisions.

#### **LEVEL 1: EMERGING**

*Information on patients' activities submitted to purchasing agencies is basic and of limited use to inform purchasing decisions.*

Information submitted by providers is non-existent or rather basic, typically reported in aggregates through routine data systems. In addition, there are concerns over the reliability of data, and there are frequent delays in submission. There are a number of data submissions across the health system e.g. the main public health system, and health programmes and health insurance or other coverage schemes. The data collected and submitted are limited in range, partly due to non-compliance, which in turn may be due to low capacity and or weak enforcement. Early efforts at digitization are not yet improving data quality and timeliness and do not address duplication across schemes and programmes.

**LEVEL 2: PROGRESSING**

*Although still limited, the comprehensiveness and reliability of provider activity data are improving. However, quality issues persist limiting use for improving purchasing decisions.*

Information submitted by providers is more comprehensive as patient encounter records capture more detailed information; these include patient characteristics, diagnosis and services provided, irrespective of the payment methods used. However, multiple forms create high administrative burden for providers, leading to delays in submission limiting their use in decision-making. Digitization is still undertaken independently by some schemes and programmes, limiting efficiency gains in terms of workload, and no agency is tasked with developing a system-wide picture.

**LEVEL 3: ESTABLISHED**

*Providers' activity data collected through patient encounter records are greatly improved in terms of detail, reliability and timeliness, and is increasingly used to inform purchasing decisions.*

Information submitted by providers becomes more comprehensive, reliable and timely as patient encounter records capture more detail on key issues such as patient characteristics, services provided, key inputs used e.g. medicines, staff time. While each purchasing agency still has its own data system, patient encounter forms have standardized fields that ease data entry and reduce workload. This improves data quality and facilitates a coherent digitization process. Analysis of data by purchasers is conducted more systematically to inform strategic decisions.

**LEVEL 4: ADVANCED**

*Purchasing agencies regularly collect detailed, reliable information on provider activities; information is routinely analysed and used to inform purchasing decisions and broader health system stewardship.*

Information submitted by providers through patient encounter data forms provide detailed insight on provider activities e.g. information on a wide range of administrative, clinical and financial information, including the full mix of inputs used to treat patients. It is used as the foundation for an individual-patient records-based national database on patient encounters. The data from this system are coherent across purchasers, and a team at the national level is generating a system-wide situation analysis on a continuous basis, using it to guide purchasing decisions, both by individual purchaser to improve their operations and by governing bodies to steer the purchasing function and for wider health policy decision-making (see Question 1.2).

## Question 4.6 (prvdauton):

To what extent do providers have financial autonomy and are held accountable?

### **i** BACKGROUND TO THE QUESTION

This question complements earlier questions, in particular Question 4.2, Question 4.3 and Question 4.4, which considers the incentive environment for providers. It also links closely to Question 6.2, as the rules governing autonomy in the public sector are core to PFM. In order to respond to financial incentives, providers need autonomy i.e. authority over spending decisions, to respond to local needs as they change and as opportunities arise. With greater provider autonomy comes responsibility and the need for accountability mechanisms to ensure that performance improves in line with UHC goals.

The key to driving improvements in provider performance is to find a balance between payment system financial incentives, the autonomy given to providers over spending decisions, and the appropriate accountability measures. Where provider's lack the decision-making authority, or indeed the necessary skills and capacity, financial incentives will not have the desired impact. Where these elements are in place, but accountability mechanisms are weak, again performance may change in the way intended, for example revenue generation may be prioritized over patient financial protection. Regular review and adjustment are likely to be required.

In the private sector, the issue of financial autonomy is less central as providers are autonomous by status. However, where public purchasers can contract private providers, holding them to account is of critical importance.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

#### **LEVEL 1: EMERGING**

*Public providers have no or extremely limited autonomy and cannot respond to financial incentives through the payment system.*

Providers have no financial or management authority; all decisions on spending or reallocation must be approved by higher-level administrative offices, a situation common in health systems which rely heavily on central command-and-control. Where private providers are contracted, very limited accountability measures (e.g. reporting requirements) are in place, making it difficult to assess performance.

#### **Levels: 2 Progressing**

*Public providers are given greater managerial and financial autonomy, but accountability mechanisms are weak.*

Public sector facilities are granted partial financial autonomy with control over certain revenues e.g. retained patient co-payments, and for these funds they have their own bank or Treasury account. However, rules governing the use of these funds are either overly restrictive or place no conditions at all, raising concerns about either inadequate flexibility or insufficient accountability. Where there is widespread contracting of private providers by public purchasers, reporting and accountability requirements are clearer although it remains difficult to obtain quality information, in terms of how funds are used, on a regular and timely basis.

**LEVEL 3: ESTABLISHED**

*Public providers are granted further increases in managerial and financial autonomy and compliance with accountability requirements is progressively improving.*

Public providers have spending authority over an increased proportion of funds received, for example from patient co-payments, health insurance scheme reimbursements, and performance-based allocations, but not over their core budget. They can manage their discretionary funds flexibility, but with strong and enforced accountability measures, in terms of both financial and activity reporting. In the private sector, there is good compliance overall with the reporting requirements, but further improvements are needed. There is increased decision-making over support (non-clinical) staff.

**LEVEL 4: ADVANCED**

*Providers enjoy substantial managerial and financial autonomy, have clear incentives to improve performance and are held accountable for their performance.*

In the public sector, providers have control over their budget including but not limited only to additional income e.g. from patient co-payments and can reallocate across budget lines without pre-approval. Often, mechanisms are in place that allow them to directly receive, manage, and account for all sources of funds. Provider-level managerial authority and involvement in staffing decisions is significant. This is accompanied by clear, comprehensive reporting requirements and oversight mechanisms are in place for large providers and or provider networks) e.g. boards. Payment incentives are regularly reviewed and assessed, and overall these translates into performance improvements. Private sector providers comply with accountability requirements which are also regularly reviewed. Purchasers can measure provider performance across the health system.

## 8. Benefits and conditions of access

**i** *BENEFIT POLICY COMPRISES BOTH DECISIONS ON POPULATION ENTITLEMENTS I.E. PUBLICLY FUNDED SERVICES, MEDICINES AND OTHER MEDICAL PRODUCTS. ALSO PART OF BENEFIT POLICY DECISIONS ARE DECISIONS ON THE CONDITIONS OF ACCESS, SUCH AS THE NEED FOR A CO-PAYMENT OR ADHERENCE TO A REFERRAL SYSTEM. TOGETHER, THESE TWO ASPECTS CAN SHAPE THE WAY IN WHICH PUBLICLY FUNDED SERVICES ARE DELIVERED, AND HOW THEY ARE ACCESSED.*

DESIRABLE ATTRIBUTES IN BENEFITS AND CONDITIONS OF ACCESS*		QUESTIONS
<b>BR1</b>	Entitlements and obligations are clearly understood by the population.	benexplct (5.1) benundrstd (5.3) copaydsgn (5.4)
<b>BR2</b>	A set of priority health service benefits within a unified framework is implemented for the entire population.	benexplct (5.1)
<b>BR3</b>	Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments.	benprcss (5.2)
<b>BR4</b>	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers.	allocneeds (4.1) benrevalgn (5.5) pfmallopcrty (6.2)
<b>BR5</b>	Benefit design includes explicit limits on user charges and protects access for vulnerable groups.	copaydsgn (5.4)

\* Desirable attributes articulate ideal situations relevant to each assessment area.



### Question 5.1 (benexplct):

Is there a set of explicitly defined benefits for the entire population?

#### **i** BACKGROUND TO THE QUESTION

International experience shows that general declarations of UHC or benefit entitlements for the population are not enough to make real progress; in contrast, being explicit and clear about entitlements and any related conditions of access, reduces uncertainty for the population (which generally constitutes a barrier to accessing services) is a move in a positive direction. Increasing transparency does not mean defining benefits in detail, as this can be confusing especially where covered services are defined in long complicated lists. Many countries are becoming more explicit about what the population is, and is not, entitled to for example through essential packages of services.

In addition, many countries are starting to move away from having multiple health coverage schemes each targeting a different population group; Stage 1 should provide a picture of whether this is the case in the country under question. When the “coverage landscape” is fragmented in this way, each scheme tends to have its own set of benefits, with differences and hence inequities in entitlement depending which scheme an individual happens to be covered by. Efforts to move away from this approach are central to making progress towards UHC and include establishing and strengthening a common minimum set of benefits for all citizens, again often through some form of essential package or set of guaranteed services for the entire population.

Where there is no universal set of entitlements, countries still face choices about how to prioritize spending; measures which specifically target the more vulnerable in society, and those with higher health needs, are also consistent with a pathway towards UHC. An important consideration is the extent to which specific earmarked contributions e.g. for health insurance, drive entitlements and subsequently access to care. Progress towards UHC is strengthened when benefit entitlements, or coverage policy, is based on a right to health care rather than a benefit of employment.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

For this question, for the extent to which entitlements to health benefits are explicitly defined, universal in nature, and have some focus on more vulnerable parts of the population. Look for:

- explicit statements of benefits rather than general declarations; for example there may be a defined list of guaranteed services (either positive or negative lists), or levels of care e.g. PHC.
- clear statement that a specific set of entitlements are universal in nature i.e. for all citizens, and not dependent on an earmarked financial contribution; this may exist alongside other coverage e.g. insurance schemes. At the system level, a softening of any link between contributions and entitlements generally represents progress.
- there is no co-payment for these services, or if there are these are negligible and with exemptions for priority groups e.g. those below the poverty line
- there is an effort to prioritize spending on the most vulnerable in society

Start by reviewing the information compiled in Stage 1 which should outline the way in which, and where possible the details, of benefits under different coverage arrangements.

**LEVEL 1: EMERGING**

*Entitlements are implicit for most of the population, and there is no prioritization for vulnerable population groups.*

In some cases, benefits are defined in general or vague terms with all services are nominally considered to be free at the point of service. In practice there is little or no targeting, and there is shortage of supplies, and patients may pay unofficially. In other cases, there may be multiple schemes targeting different parts of the population, with benefit entitlements highly variable across the schemes or programmes, and for a small group driven by their employment status.

**LEVEL 2: PROGRESSING**

*Explicit entitlements are linked to contributions for relatively well-off groups but are implicit for most of the population, other than perhaps some vertical programmes.*

There have been some developments which make benefit entitlements more explicit, but only for better-off sectors of the population, such as salaried workers in public and private sectors. Common examples are the establishment of a contributory-based insurance scheme for civil servants. Beyond this, little has changed for most of the population with most benefit entitlements being largely implicit, although there are some targeted programmes such as for HIV, TB, immunization and MCH.

**LEVEL 3: ESTABLISHED**

*Entitlements are explicit for most of the population, and measures taken to explicitly universalize certain benefits on a non-contributory basis; differences in entitlements across schemes remain.*

Significantly more policies and measures are established, in which the government make explicit the population's entitlements; there is a strong universal dimension to the measures put in place e.g. for primary health care, and or a package of inpatient/specialist services, and these are not dependent on individuals making an earmarked financial contribution. There remain several health coverage schemes, however, and entitlements still vary across these schemes, with the structural inequities this creates.

**LEVEL 4: ADVANCED**

*Benefit entitlements are defined explicitly for the entire population with provisions for vulnerable groups and or for other health policy goals.*

Universal benefit entitlements are specified explicitly, either through positive or negative lists, form the basis of the health system. There are no significant differences in entitlements across the population, in terms of their level of income, their employer, where they live, or other socioeconomic characteristics. This is the case even where there are multiple coverage schemes. Where necessary, provisions exist e.g. no co-payments, for priority vulnerable groups, and or for services defined as priority health policy goals.

## Question 5.2 (benprcss):

Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?

### **i** BACKGROUND TO THE QUESTION

While benefit design can influence health system performance, and should be rooted in evidence, difficult choices on trade-offs will need to be made and hence many decisions are also inherently political. A transparent process which considers both technical evidence and societal values is important to make priorities with widespread support. Many countries are now establishing such processes. Overarching concerns which guide decisions include efficiency, equity, and financial protection, but the balance between these will vary across countries. Incorporating population demands or preferences is also important, as is the budget impact of any decisions; funding public or semi-public goods is also of critical importance.

Efficiency concerns will incorporate cost–effectiveness/health technology assessments for available diagnostics and treatments, equity decisions will consider both vertical and horizontal equity and identify conditions which are more likely to affect vulnerable groups, the direct and indirect costs facing patients, supply-side readiness to provide the services across the country, and estimates of the impact on the health budget in the short, medium and longer term (Question 5.5 looks deeper at this issue). Using such evidence forms the basis of identifying priority services and using limited resources in the best way possible and to maximize progress towards UHC. Mechanisms to elicit and incorporate the views of different stakeholders in society is essential for political support and broad acceptability, for what can be a heavily technocratic exercise.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

A clear process for making decisions on benefit entitlements, which lays out explicit criteria as the basis for decisions, is central to making benefit decisions transparently. Transparency is important for accountability and broader public support for the use of public funds. Evidence needs to be generated to facilitate deliberations around these criteria, and guidelines to take account of the perspective of different stakeholders.

#### **LEVEL 1: EMERGING**

*Decisions on publicly funded benefits are not made transparently, with no criteria or process defined as the basis for decisions, and no inclusion of stakeholder perspectives.*

There is little active decision-making on how public funds are used or could be better used. Each year, funds are allocated in line with the previous year's budgets which does not reflect programmatic priorities. There are no stated criteria guide benefit decisions e.g. improving efficiency, financial protection, reducing unmet needs, which. As a result, higher priority services are often underfunded.

#### **LEVEL 2: PROGRESSING**

*Some decisions on publicly funded benefits are assessed against selected criteria and plans to establish a formal process are being considered, but decision-making is largely opaque (not transparent).*

Some interventions, including for medicines, are assessed their effectiveness and cost, for example under a health programme such as tuberculosis or malaria. Discussions and plans to establish a formal process (e.g. HTA) are being considered, but most decisions are implicit through annual budget allocations, or arbitrary and or dominated by professional or political interests. Differences in benefit coverage across population groups

remain but are to some extent reduced and redistributed based on criteria e.g. age, gender is in place to improve equity.

**LEVEL 3: ESTABLISHED**

*Larger number of assessments conducted to inform benefit decisions, and decision taken to institutionalize an explicit process that includes criteria such as cost–effectiveness and budgetary impact.*

Larger number of assessments are being conducted to inform benefit decisions, on either service interventions or medicines; increasingly these are domestically funded rather than externally supported. A decision has been taken to institutionalize a systematic process to inform decisions, including criteria such as cost–effectiveness, and impact on equitable access, financial protection, and projected budget spending.

**LEVEL 4: ADVANCED**

*Laws or regulations in place requiring proposed changes to publicly funded benefits to be subjected to systematic assessment and deliberation; expert and non-expert stakeholders are incorporated.*

Laws and or bureaucratic regulations are in place, defining both the process to be used, and the criteria against which proposed changes to publicly funded benefits must be assessed prior to political approval. Criteria are aligned with health system objectives, such as cost–effectiveness (efficiency), equity and financial protection; budget-impact analysis is also required. The political process for decision-making includes both experts and stakeholders from broader society. In this scenario, benefits fully addresses population health needs and promotes equity in access to health care.

### Question 5.3 (benundrstd):

To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?

#### **i** BACKGROUND TO THE QUESTION

This question focuses on how aware the population is, and how well it understands, its entitlements i.e. what it can access free (or with a limited co-payment) at the point of service. Publicly funded services, including medicines, represent a promise by the government to the population. For benefit decisions, or coverage policy, to lead to positive change in health system performance, it is essential that people clearly understand their entitlements i.e. what they can access free at the point of service, whether user charges must be paid and, if so, how much these are and how they are structured; given the importance of financial obligations this is addressed in detail in Question 5.4 (copaydsgn).

This question focuses on non-financial conditions of access, such as the requirement to use a referral system, or limitations in benefit e.g. generic medicines (rather than branded), specific treatment for a health problem, or services accessible only in certain services. Progress on Question 5.1 (benexplct) and Question 5.2 (benprcss) will contribute to progress on this question.

Coverage policy, in terms of both entitlements and conditions of access must be clearly defined and easy to understand for the population; when unsure, patients may decide not to seek the care they need; transparency is hence a key objective of health systems, and requires avoiding overly-detailed, differentiated and complicated entitlements and conditions of access; it means avoiding non-technical language and generally keeping things simple but clear.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Assess the health system in terms of those aspects which increase clarity and transparency in populations entitlements, and non-financial conditions of access. These include explicit statements, which are not overly detailed, kept clear, concise and simple, which are widely communicated to the population.

##### **LEVEL 1: EMERGING**

*Entitlements and conditions of access are not clearly defined, and people do not understand them.*

Entitlements are not clearly defined, but rather implicit with little investment in ensuring people are clear on the services, medicines etc. they are entitled to receive. Neither are any conditions of access clearly understood by the population; there may such as following a referral system or accessing specific facilities.

##### **LEVEL 2: PROGRESSING**

*Entitlements and conditions of access are clear for part of the population but remains uncertain for most; some efforts made to communicate but limited.*

Entitlements and conditions of access are explicit and clear only in some schemes, and or for a relatively small proportion of the population; these are not conveyed in simple language however. In most cases, patients are not sure before going to a health facility, or when they arrive, whether the treatment they require (including medicines and other products) is covered or not.

**LEVEL 3: ESTABLISHED**

*Significant action taken to make entitlements and conditions of access explicit for most of the population but remains unclear for many.*

Concerted effort has been made to define entitlements and conditions of access explicitly across schemes and or for the majority of the population. However, benefits are often excessive in detail, and focus on lists of conditions and diagnoses rather than, for example, levels of care. This approach compromises understanding for much of the population; for example, it is difficult or not possible, to fully understand entitlements due to multiple overlapping benefit packages, and excessive detail.

**LEVEL 4: ADVANCED**

*Entitlements and obligations are clearly defined on the key dimensions and are clearly communicated and understood by the population.*

Entitlements and obligations are specified clearly for the entire population, even where multiple coverage schemes and programmes exist. Entitlements are defined simply and clearly in terms of, for example, the basis for entitlement, the level of care (e.g. PHC) for first contact services where part of a referral system, those providers included in a preferred network; there may be additional detail in terms of benefit entitlements for referral care, as in Chile AUGE, but this is not overly detailed. There is widespread communication to the population in appropriate language, and clear channels for the population to contact relevant authorities for questions and clarifications.

** QUANTITATIVE INDICATORS**

Where survey data on client satisfaction is available this may provide useful information on levels of (mis)understanding of benefit entitlements and related non-financial conditions of access.

### Question 5.4 (copaydsgn):

Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?

#### **i** BACKGROUND TO THE QUESTION

One of the most widespread conditions of access to publicly funded, benefits, is the requirement that patients make a user fee (user charge) also known as a co-payment. When patients are uncertain whether they must make a co-payment at a facility, or if they are unsure how much they may have to pay, this can create a significant barrier to seeking care. If the patient still seeks care, co-payments potentially lead to financial difficulties for the patient.

Even low co-payments can constitute an obstacle to service use particularly for low income individuals. However, given severely limited resources in many countries, patients are likely to have to direct payments for at least some health services. Evidence shows that out-of-pocket payments for medicines are a major cause of poor financial protection across the world, in part driven by growth in noncommunicable diseases and need for long-term medication to control risk factors combined, frequently, with the exclusion of outpatient medicines from benefit packages.

Evidence shows that co-payment policy needs to be explicit, clear and simple, and designed in a way that minimizes any negative effects. When defined as a percentage of the bill or invoice, there is likely to be significant uncertainty about the total amount to be paid – indeed the health facility may not know themselves. Patients may also be unsure about the indirect costs they will incur, for example on transport, food and accommodation, medicines and other supplies. Time costs are also an important element of indirect costs, and fall unevenly across the population, often being highest for the poor. Finally, the time involved in accessing services may lead to lost income.

Fixed amount co-payments are easy for people to understand and reduce uncertainty about the payment required. Additional policy measures which protect patients against excessive payments include annual caps on total co-payments, and the use of exemptions; in both cases implementation will be difficult where administrative capacity is weak, and detailed information not available. Simpler approaches such as targeted exemptions for certain services, or geographical areas, are more likely to be administratively feasible.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Refer to the information provided in Stage 1 which also provides some coding of responses. If there are no formal patient co-payments in the health system this question can be skipped. However, please highlight evidence of any unofficial payments in the health system, with supporting information where possible. Look at the way co-payments are structured; fixed amount co-payments are clear, whereas percentage co-payments bring uncertainty, although annual caps can have a mitigating effect, as can exemptions, when implemented effectively.

#### **LEVEL 1: EMERGING**

*Regardless of policy design, patients typically must make informal payments in order to obtain care.*

Public funding is inadequate to meet health needs and purchasing is weak. As a result, patients typically make informal payments to obtain care. Large number of fees exist for different services or else informal payments widespread. User charges (co-payments) are poorly designed and implemented, leading to access barriers and financial hardship.

**LEVEL 2: PROGRESSING**

*Patient co-payments are highly detailed and or defined in percentage terms and linked to treatment provided rather than ability to pay; some protection mechanisms in place.*

More attention is paid to the design of user charges, but the design is highly detailed and includes co-payments defined as a percentage of price, so people have limited understanding of what they will have to pay out of pocket. Some indirect targeting mechanisms are in place to protect vulnerable populations e.g. geographic targeting, or primary health care level services, but these are inadequate due to poor implementation. There are no caps on co-payments. Efforts are made to inform patients of their financial obligations, but difficult to understand (e.g. large number of different prices requiring self-diagnosis to understand financial responsibility).

**LEVEL 3: ESTABLISHED**

*Co-payment schedule is limited and clear, organized by level of care, structured as fixed fees, and includes mechanisms to exempt the poor; implementation challenges remain.*

User charges are organized by level of care rather than diagnosis and in the form of fixed rather than percentage co-payments. There are exemptions or other mechanisms to protect people at risk of poverty or social exclusion and people with chronic conditions. There are caps on co-payments. Challenges remain, however, with the design and implementation of protective mechanisms.

The fee schedule has a limited set of charges organized by level of care rather than diagnosis, uses fixed fee levels rather than percentages, is generally enforced, and includes provides exemptions or other mechanisms to exempt the poor or limit payments by persons with chronic conditions. Challenges remain, however, with the implementation of these protective mechanisms.

**LEVEL 4: ADVANCED**

*Co-payment schedule is easy to understand, and has a structure and design that protects vulnerable persons.*

User charges are carefully designed and communicated in a way that is easy to understand. They are used sparingly, in the form of low, fixed co-payments rather than percentage co-payments. They do not present a barrier to access or lead to financial hardship because there are exemptions for people at risk of poverty or social exclusion and people with chronic conditions, as well as an annual cap on all co-payments. The annual cap is linked to household income and implemented in a user-friendly way.



### Question 5.5 (benrevalgn):

**Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?**

#### **i BACKGROUND TO THE QUESTION**

Decisions by policy-makers on benefit design i.e. both entitlements and conditions of access, can be one of the most powerful instruments or levers through which health system performance can be improved, especially when realistically aligned with available revenues and coordinated with complementary reinforcing policies such as the development of programme budgets and improvements in strategic purchasing.

When entitlements significantly exceed available funds, there is misalignment or imbalance, and implicit rationing will take place, for example through delays or non-payment of salaries, shortage of medicines and other supplies which reduces service quality, or through increases in unofficial payments. When misalignment plays out in such ways, the result is greater unmet health needs and or worsening financial protection. For this reason, defining benefit entitlements explicitly, concisely and clearly using simple language (see Question 5.1) supports progress towards UHC. While Question 5.2 looked at the use of criteria in benefit decisions, this question zooms specifically into the issue of alignment with revenues.

However, even when revenues and benefits are aligned, money does not automatically flow to priority services without an explicit link or mechanism which ensures this; hence the importance of a strategic purchaser to operationalize benefits, as well enforcing conditions of access; for a purchaser to be effective, reforms to public financial management systems may also be needed. Pricing considerations are also important here, for example if the amount paid by the purchaser reflects the actual cost of delivering the service, there will be alignment, but where this is not the case (and where not part of a deliberate strategic purchasing policy), there is misalignment and providers may charge patients unofficially; alternatively, providers may officially “balance bill” i.e. charge patients more than what they receive from the purchaser; in both cases there is the risk of a high financial burden falling on the patient.

#### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

Here we look specifically at whether benefit decisions have been subject to budget impact analysis and adjusted accordingly, which is critical to ensure that the funds are available for officially declared benefits. Furthermore, we look for budgetary and purchasing instruments in place to ensure that funds flow to those services and related products defined as a priority. Relevant budgetary mechanisms such as programme budgets are looked at in detail in Question 6.2 (pfmalloprty); this question hence looks more closely at whether systems establish rules and incentives through provider payment mechanisms to incentivize the allocation of funds to service delivery priorities. Examples include the strategic use of price, or tariffs to reflect priorities. Price schedules, together with information on quality information may be made publicly available.

**LEVEL 1: EMERGING**

*Decisions on benefit entitlements are made without consideration of available funds, no mechanisms in place to ensure funds flow to entitlements.*

Benefit statements are vague and imply that all services are covered even though this is clearly not the case. In practice, there is chronic underfunding of essential services, and allocations to many providers covers only a small portion of recurrent costs, leading to implicit rationing such as shortage of essential supplies, unofficial payments by patients, long waiting lists or low utilization, patient dissatisfaction. Budgets and health priorities are not connected.

**LEVEL 2: PROGRESSING**

*Costing of interventions and explicit provider payment mechanisms exist for some benefits but are small scale and typically outside the core public financial management system.*

Costing and budget estimates are conducted in relation to some benefit entitlements, often externally funded or for vertical health programmes, but these do not feed into realistic budget adjustments and misalignment remains. Provider payments still only cover part of the total cost of most services, and hence implicitly rationing remains widespread.

**LEVEL 3: ESTABLISHED**

*Additions to publicly funded benefits are supported by new revenues and increasingly there is an explicit provider payment link with priority services.*

Additions to promised benefits are supported by new revenues and sometimes explicit provider payment mechanisms linked to the benefits. For example, where user fees have been eliminated for services such as MCH, it is recognized that replacement funds are required by the health facility, and a specific flow of funds is established for MCH. In practice however, service delivery challenges remain, and PFM bottlenecks constrain the flow of funds to providers, limiting the full realization of benefit policies.

**LEVEL 4: ADVANCED**

*Benefit expansion decisions are subject to budgetary impact, available funds, and service readiness, and are supported with incentive and accountability mechanisms for providers.*

Decisions on benefit expansion are carefully costed, and deliberations of available funds made prior to political approval. Furthermore, benefits are not approved unless there is service readiness across the country, to avoid an increase in inequitable access and utilization. Explicit accountability mechanisms exist with respect to provider performance, and often specific provider payment incentives as well. The price or amount providers are paid covers the total costs of provision, unless this runs contrary to strategic purchasing, so that quality of care is not unduly sacrificed, and informal payments are avoided.

## 9. Public financial management

**i** AS A CROSS-CUTTING ISSUE IN HEALTH FINANCING, PUBLIC FINANCIAL MANAGEMENT HAS CONSIDERABLE OVERLAP WITH OTHER ASSESSMENT AREAS; HENCE QUESTIONS FROM OTHER AREAS ARE ALSO MAPPED TO THE DESIRABLE ATTRIBUTES BELOW. SIMILARLY, SEVERAL QUESTIONS IN THIS SECTION DRAW ON ATTRIBUTES FROM OTHER SECTIONS.

DESIRABLE ATTRIBUTES IN PUBLIC FINANCIAL MANAGEMENT FOR HEALTH*		QUESTIONS
PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities.	prvdauton (4.6) pfmallocprty (6.2) scrtyresp (7.4)
PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs.	prvdauton (4.6) pfmallocprty (6.2) bdgtcntrl (6.4) expinfmon (6.5)

\* Desirable attributes articulate a number of ideal situations relevant to each assessment area.

\*\* Note that several questions in the PFM assessment are linked with desirable attributes in the Revenue Raising section.

## Question 6.1 (pfmdiag):

Is there an up-to-date assessment of key public financial management bottlenecks in health?

### **i** BACKGROUND TO THE QUESTION

This question is concerned with whether a health-sector specific assessment of PFM bottlenecks has been conducted. A broad assessment of the PFM system looks at weaknesses in budget formulation, budget execution and budget reporting i.e. the key steps of the budget cycle. Country assessments are generally conducted with the support of the Public Expenditure and Financial Accountability (PEFA) Secretariat and use a pre-established framework that includes a scoring system per PFM subcategory.

Public Expenditure Reviews (PER) conducted with the support of the World Bank, and the related Public Expenditure Management and Financial Accountability Reviews (PEMFAR) are also helpful resources. Consulting these resources, if available, will be helpful to begin understanding the key PFM bottlenecks which impact on overall public spending in the country. However, to effectively address bottlenecks in the health sector, a detailed health-specific diagnostic analysis is required, rather than only a general PFM assessment. It is crucial to capture the sector-specific issues that may impact public spending in health. While some issues may be common with other sectors, health is particularly sensitive to the way the budget is formulated and spent, and to the level of flexibility provided when programming and utilizing public resources. In recent years, guidelines have been developed by several partners to support health sector specific assessment. See for example the WHO process guide (3) which assessed alignment issues between PFM and health financing policies; the World Bank toolkit (4) on PFM and health service delivery, and the UNICEF guide (5) on PFM in health with a focus on children. Study outputs are generally accessible locally and will be a helpful resource for this question.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

This question looks for the existence of country PFM diagnostics across the public sector overall, and for the health sector specifically. What also matters is the quality and depth of the analysis undertaken. Health-specific assessments should provide detailed information on key PFM bottlenecks that affect health spending at both central and subnational levels.

#### **LEVEL 1: EMERGING**

*No generic PFM assessment exists or only an outdated assessment.*

A generic PFM assessment may have some relevance for health sector PFM issues, but usually this is very limited. For “recently”, think in terms of the past 3-4 years.

#### **LEVEL 2: PROGRESSING**

*Only a generic PFM assessment has been conducted which is up-to-date.*

The generic assessment will inform on key bottlenecks for the overall PFM system. It is a good start but generally not specific enough to allow the design of health sector-specific policy actions.

**LEVEL 3: ESTABLISHED**

*A rapid health-specific assessment was conducted in the last 2 years which examined some bottlenecks in health spending.*

The assessment looked specifically at the health sector, but only at certain aspects i.e. not comprehensively from budget formulation to execution and reporting.

**LEVEL 4: ADVANCED**

*Extensive, up-to-date health-specific diagnosis/assessment conducted; key bottlenecks identified.*

Assessment covers all aspects, from budget formulation to execution and reporting, and identifies specific issues which undermine the quality of health spending.

** QUANTITATIVE INDICATORS**

PEFA country assessments are available [here](#) and provide a rapid overview of the quality of PFM systems. For each PFM subcategory, countries are provided a score; for an example go to:

<https://www.pefa.org/assessments/summary/486>.

## Question 6.2 (pfmalloprty):

**Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?**

### **i BACKGROUND TO THE QUESTION**

This question looks at the extent to which the design and implementation of health budgets enables public funds to be “matched” to stated priorities and aligns with related reforms in the purchasing of services. Budget structure refers to the organization of a government budget and is based on standard classifications (6); the main budget classifications used across sectors are: input (sometimes called “economic”), administrative, functional and programmatic. Input-based budgets introduce rigidities for health spending as they are often presented as detailed line-items and do not allow re-allocations across budget lines. Where that is the case, there is a misalignment with provider payment mechanisms aimed at driving providers towards more efficient organization and use of their resources. This question therefore has important implications for strategic purchasing, and in particular links to question 4.1 on linking payment to needs, and question 4.6 on provider autonomy.

Countries introduce alternative budget classifications with the view to provide more flexibility in the programming and use of budgets, but also to strengthen the link with expected outputs, referred to as programme budgets. There are three key advantages for health spending: 1) they support better alignment with health sector policies and strategies; 2) they can provide more flexibility in fund management, notably at the service provider level, enabling providers to respond to the incentives designed into provider payment reforms; and 3) they cultivate stronger financial and non-financial transparency and accountability with a focus on results.

However, in the absence of sector-specific guidance and, in general, limited preparation of key stakeholders, governments may take a range of different steps and approaches as they transition to programme budgets. As a result, most countries frequently get stuck at the pilot stage due to severe bottlenecks in reform design. In other cases it has led to hybrid models and incomplete transformation. For this question, it is important to assess the reform status and capture its implications for how Ministry of Health budget allocations are formulated (i.e. whether by line items, programmes or functions) and to what extent the programme envelopes match with the policy priorities and needs of the health sector. A mapping of programmes and national health priorities will help to get a better understanding of their alignment (7, 8, 9, 10, 11). In addition, consider how budgets are spent; often, even after a change in budget formulation, public funds continue to be spent, authorized, controlled and or reported by detailed line-items. This substantially limits the ability of fund-holders (e.g. managers of central-level health programmes, district health programmes, and health facilities) to manage spending to improve performance in response to provider payment incentives, and to be held accountable.

### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

What matters for this question is flexibility in budget structure, and flexibility in budget execution. Also of importance is the level of alignment between pooling (programme) structure, purchasing mechanisms, provider autonomy, and PFM processes and mechanisms. Ideally, public funds flow to priority populations, interventions and services, and payment to providers is based on service outputs and performance. Ideally, disbursements are aligned with health priorities, flow of funds is predictable, and there is flexibility in purchasing and provider payment which ensures efficiency and value for money. Where a Programme Budget exists, Programme Managers should also be given the authority to use funds flexibly within a given envelope for that pool of funds. Where the system is decentralized, lower levels of government should also have the appropriate authority over spending decisions. At the provider or facility level, managers should have the authority to retain and use funds.

Refer to the [WHO repository of health budgets](#) which consolidates open source information on finance laws and related documents applicable to the health sector for more than 100 countries.

#### **LEVEL 1: EMERGING**

*Health policy priorities are poorly defined, and not reflected in the budget; rigid input-based line-item budget dominates.*

- Budgets are structured by administrative and input lines without mechanisms for adjustment/re-allocation (i.e. virement policy is strict), and with tight line-item ex-ante expenditure control.
- No flexibility in resource use and rigid ex-ante central controls (no financial managerial autonomy for public providers); spending responsibility remains in Treasury.

#### **LEVEL 2: PROGRESSING**

*Input-based line-item budget and ex-ante financial control still dominates; some piloting of programme-based budgets provides more flexibility in resource use, and performance information is increasingly used.*

- Central Ministry of Health has some degree of flexibility to use and reallocate across budget lines (i.e. virement policy has been updated and or line-items are aggregated into broader lines); institutional arrangements being made in Ministry of Health to take on greater responsibility for spending.
- There is some piloting of programme-based budgets to reflect sector priorities and provide more flexibility in resource use, performance information is starting to be used in budget deliberations. However, funds remain disbursed by input-based line-item and rigid ex-ante financial control still dominate.
- Reforms in provider payment methods may have been introduced, but the rigidities in budget design and implementation at both purchaser and provider levels limits or even contradicts their intended impact.

#### **LEVEL 3: ESTABLISHED**

*Use of performance information and implementation of programme-based budgets are becoming widespread, better directing budgets to sector priorities using mechanisms that are consistent with provider payment incentives, thereby providing greater flexibility in resource use.*

- Changes in budget formulation are accompanied by flexible rules for expenditure management (e.g. flexible release and re-allocation of funds, with ex-post reporting).
- Spending authority is fully transferred to the Ministry of Health, and managers of central funds can use resource envelopes (e.g. budgetary programme) in a flexible and responsive manner; however, constraints may remain at lower levels of government.
- Public sector health facilities/providers have some limited authority to manage budget resources, including to move funds across certain line items (usually not salaries) without higher level approval.

#### **LEVEL 4: ADVANCED**

*Health sector priorities, medium term expenditure framework and annual budgets are fully aligned and structured around well-designed budgetary programmes, and stable, predictable funds are directed to health sector priorities and service providers.*

- Budgets are structured and executed to ensure that budget spending is flexible. Programme managers and providers have the flexibility to reallocate resources.
- Fund-holders can re-allocate funds across budget lines, including frontline providers, to better respond to health needs.
- The introduction of programme-based budgets in health has been harmonized with payment reforms, allowing a full output/population-based financing system to operate. Funds are released by programme envelope, providers are incentivized for the achievement of pre-defined outputs, and reporting is set against these targets.

### Question 6.3 (bdgtprcss):

Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?

#### **i** BACKGROUND TO THE QUESTION

Engaging in budget preparation, understanding guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval process, is essential for Ministry of Health. In many countries, the consequences of not doing so means that health policy-making, planning, costing and budgeting take place independently of each other, leading to a misalignment between health priorities and allocation and use of resources. This question aims to capture the level of Ministry of Health engagement in budgeting processes, and specifically to assess their inputs for the development of an integrated multi-year expenditure framework that would incorporate sector spending.

Look at the engagement process of Ministry of Health throughout the budgeting phase (is Ministry of Health informed of the budget calendar? When? Is there sufficient time for defining budget proposals? Are budget ceilings communicated in advance? Is the space for negotiation clearly identified/formalized (e.g. budget conferences)? Once the budget is approved, mid-year re-allocations are frequent. In some countries, the adjustment process is not transparent. Budget re-allocations are made without consultations with sectors like health. PI should check whether the revised budget law has been discussed with Ministry of Health and whether the final output has been communicated to relevant stakeholders in the sector. This has a crucial impact on budget execution and policy implementation.

Since the late 1990s, budgeting reforms worldwide have been concerned in a significant way with engineering a shift from planning and approving budgets for one year at a time to a multi-year perspective to improve predictability and sustainability in public funding. Given that the disconnect between planning and budgeting was recognized as a common feature of the health sector, health MTEF has increasingly come to be regarded as a central element of public expenditure management reforms. However, their introduction is heterogenous across countries. In addition, the quality of the overall MTEF, as well as sector-specific allocations, are often subject to various issues (e.g. poor quality of revenue forecasts, historical allocations). To date, health MTEF (and MTEF more broadly) have seen, however, a mixed impact on increasing funding predictability for health. To assess the impact of MTEF on sectoral allocations and their effectiveness in driving predictability, PI can conduct a retrospective comparison between MTEF and Ministry of Health annual allocations for the considered period.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

What matters here is the proactive engagement of the Ministry of Health in budget planning. This involves several steps: i) being aware of the budget calendar, requirements and templates; ii) engaging in sufficient technical preparation i.e. priority-setting, costing; iii) ensuring a consultation process with sector stakeholders; iv) developing a robust annual and multi-year budget proposal, v) promoting the budget request in negotiation processes.



**LEVEL 1: EMERGING**

*Current budget process often bypasses the Ministry of Health, with no or very limited dialogue between Ministry of Health and Ministry of Finance.*

There is very limited engagement of the Ministry of Health in the budget planning processes which is driven by Ministry of Finance, resulting in a disconnect between budget allocation the priorities and needs defined by the health sector. There may be no multi-year budget plan for the health sector.

**LEVEL 2: PROGRESSING**

*Budget process is consultative and transparent but to a limited extent, and input from health sector is minimal; Ministry of Health not consulted over mid-year re-allocations.*

There is greater engagement with and involvement of the Ministry of Health in the budget development process, but the approved finance still does not reflect the priorities and needs defined by the health sector. To the extent that there is a multi-year plan (e.g. MTEF), there is no linkage between that and the annual budget process.

**LEVEL 3: ESTABLISHED**

*Budget process is becoming institutionalized through formal budget meetings, and a systematic, broad consultation process including health sector and civil society stakeholders.*

The Ministry of Health develops robust budget proposals which is aligned with the priorities defined in health policy documents and costed; proposed annual and multi-year budgets are extensively discussed with sector stakeholders as well as with the Cabinet.

**LEVEL 4: ADVANCED**

*Budget process is consultative and transparent, based on dialogue between Ministries of Health and Finance, within a clear multi-year budgeting framework; all appropriate administrative levels are consulted and engaged.*

The budget dialogue process discussion focuses on budget definition, implementation mid-term review etc. and alignment of budget with sector priorities. Where relevant, lower administrative levels are consulted and engaged in budget definition process. Ministry of Health engagement is also directly aligned with the MTEF framework, and annual Ministry of Health budget allocations are aligned with MTEF forecasts.

### Question 6.4 (bdgtcntrl):

Are there measures to address problems arising from both under- and over-budget spending in health?

#### **i** BACKGROUND TO THE QUESTION

Budget under-execution has long been recognized as a chronic problem in the health sector in many low- and middle-income countries. Health financing reforms require effective budget execution to ensure that money flows to providers for the delivery of priority services. Poor budget execution refers to a deviation from the approved budget, i.e. the budget is not implemented according to authorizations granted by the law, either finance- or policy-related. Weak underlying processes are often the cause of underspending (the most common), overspending (when spending exceeds budget allocations) or misspending. Underspending and overspending may occur at the same time (e.g. between different budget lines or between different programs).

Assessing the quality of budget execution, and the extent to which expenditure deviates from approved plans, relies on effective reporting systems. Even where data exist, budget execution rates will differ whether the estimation is based on audited expenditure, payments or commitments. At the very least, a comparison of audited expenditure and gazetted budget allocations for the Ministry of Health should be made; data for both are typically available in the public domain.

Country assessments by the Public Expenditure and Financial Accountability (PEFA) framework characterizes poor budget execution as a deviation of audited expenditure equal or greater than 15% from the original budget, not from the revised budget. This equates to a PEFA indicator score C, where aggregate expenditure outturn is between 85% and 115% of the approved aggregate budgeted expenditure.

The source of budget financing can also add complexities when assessing budget execution. Some external funders channel support through the recipient government's budget process during the preparation phase but may subsequently execute activities outside the budget. This gives the perception of poor budget execution as different systems are used to monitor and report on spending. In many countries health budget underspending is a significant problem. Think about the underlying reasons for this such as over-estimated revenues, a disconnect between planning and budgeting, the lack of a formal budget preparation process, delays in operationalizing PFM reforms, or unrealistic plans with poor data. Other reasons may include late or misaligned disbursements, limited Ministry of Health capacity to plan expenditures, procurement delays, or rapidly rising prices of key goods and services.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

What matters is the level of spending relative to the annual budget allocation i.e. the budget execution rate for the Ministry of Health. What is also important is the timeliness of spending. Across sectors, there may pressure to spend, especially towards the end of a fiscal year, to reach satisfactory levels of execution and budget compliance; with the risk of spending being misaligned with sector priorities. Satisfactory annual execution rates can also hide major issues in expenditure management, such as the timeliness of disbursements within a fiscal year (i.e. late quarterly disbursements). Countries with a health budget composed of a high share of personnel expenditure may also experience better execution performance despite having weak expenditure management practices for other expenses. Where data exist, these aspects should be documented.

**LEVEL 1: EMERGING**

*Health budget implementation frequently fails to comply with basic budget discipline due to poor planning, insufficient or unpredictable revenue streams, and few if any measures are taken to address the issue.*

Public spending on health is disconnected from or misaligned with health sector needs and priorities, reflecting poor budget credibility. Cash budgeting may also be in place putting the health sector at risk of funds shortage, and high levels of unpredictability.

**LEVEL 2: PROGRESSING**

*Health budget implementation complies with basic budget discipline, but there are still major shortfalls and significant under-spending in health.*

For example, underspending represents more than 20% of the original budget. There may also be long, unplanned delays in the distribution of health budgets to the sector.

**LEVEL 3: ESTABLISHED**

*Limited under or over-spending on a yearly basis, but delays remain in fund releases for health service providers specifically.*

Good levels of overall budget execution for Ministry of Health, for example with a deviation of below 10%, but more detailed analysis may reveal specific weaknesses, such as end-of year spending misaligned with health sector priorities, poor execution for certain categories of spending, or delays in the release of funds to providers.

**LEVEL 4: ADVANCED**

*Health budgets are fully executed and comply fully with budget discipline; significant underspending rarely happens.*

Budgets are based on accurate forecasts and plans, with risk analysis. There is a planned, transparent and reliable cash management system, allowing the timely release, and stable flow of funds to frontline service providers.

** QUANTITATIVE INDICATORS**

If available, Ministry of Health budget execution rates would be useful when assessing this question, ideally for a five-year period.

## Question 6.5 (expinfmon):

Is health expenditure reporting comprehensive, timely, and publicly available?

### **i** BACKGROUND TO THE QUESTION

This question is concerned with transparency and accountability in the reporting of health expenditures, and an assessment of how robust the financial information system is, for example whether health expenditures reported regularly, whether financial information is transparent and publicly available, and whether information in relation to performance is also communicated. Many low- and middle-income countries have introduced Financial Management Systems, often referred to as FMIS, to monitor and track health expenditure.

Having information on both the financial and non-financial performance of the sector is essential from the perspective of holding spending agents to account. Often these two aspects of performance are monitored separately and not connected. The presence of a performance monitoring framework that encompasses both aspects, in order to allow an assessment of what the sector has achieved, and with what level of resources, is a feature of mature accountability systems. The public availability of this information is fundamental to a system which is both transparent and has strong accountability mechanisms.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

What matters for this question is the existence and quality of the financial information system and its application to health expenditures. Look, for example, whether the FMIS captures provider level expenditures, and if so in what level of detail. Also, assess the extent to which the information is both reliable and publicly available.

#### **LEVEL 1: EMERGING**

*No computerized systems for performance or expenditure monitoring; numerous parallel reporting systems with no centralized reconciliation.*

At this level, there is no reporting to the public in terms of how funds have been used, or what has been achieved, either by the Ministry of Health or the national health purchasing agency.

#### **LEVEL 2: PROGRESSING**

*Computerized system being developed and strengthened, but with limited or poor-quality routine data; financial reporting in health remains fragmented.*

The use of funds and performance of health budget are reported to the public, but not fully, and are not communicated in a way that the public can easily understand. Across the health system, financial reporting is still fragmented across schemes and health programmes.

#### **LEVEL 3: ESTABLISHED**

*A functioning financial information system is in place but not aligned with health sector accountability requirements.*

An FMIS has been scaled up including for the health sector providing a good overview of public spending for the sector, particular regarding expenditures, with details on inputs; information is made publicly available.

**Level 4: Progressing**

*Financial management information system allows monitoring by multiple categories; information is publicly available and used to inform new budget decisions.*

Tailored and integrated FMIS-type information systems allow for the consolidation of cross-category monitoring, for example by programme, by inputs, costs and by health facility.), up to lower levels of government. Information is publicly available. Information is used to inform the development of future budgets. Reporting on the use of funds and the performance achieved as a result of health spending are reported to the public on a regular basis and in a form that can be easily understood.

** QUANTITATIVE INDICATORS**

Country assessments using the Public Expenditure and Financial Accountability (PEFA) framework review the quality of the financial information system are a helpful resource for this question. In addition, consultations with key health stakeholders may be helpful to provide a more sector-specific perspective on the issue.

## 10. Public health functions and programmes

**i** TWO ISSUES ARE ASSESSED IN THIS SECTION; THE FIRST RELATES TO INTERVENTION- OR DISEASE-RELATED PROGRAMMES WHICH ARE OFTEN RUN SEPARATELY TO THE MAIN HEALTH SYSTEM. QUESTIONS ASSESS THE EXTENT OF COORDINATION AND COHERENCE BETWEEN FINANCING FOR THESE PROGRAMMES AND THE OVERALL HEALTH SYSTEM. FRAGMENTATION AND MISALIGNMENT CAN HAVE IMPLICATIONS FOR EFFICIENCY ACROSS THE HEALTH SYSTEM, FOR EXAMPLE WHERE FUNCTIONS ARE DUPLICATED. A MORE IN-DEPTH GUIDE TO CROSS-PROGRAMMATIC EFFICIENCY CAN BE FOUND [HERE](#).

THE SECOND ISSUE CONCERNS HOW WELL-ALIGNED A COUNTRY'S HEALTH FINANCING IS WITH THE GOAL OF HEALTH SECURITY WHICH REFERS TO THE ACTIVITIES REQUIRED, BOTH PROACTIVE AND REACTIVE, TO MINIMIZE THE IMPACT OF ACUTE PUBLIC HEALTH EVENTS.

DESIRABLE ATTRIBUTES IN HEALTH FINANCING OF PUBLIC HEALTH FUNCTIONS AND PROGRAMMES*		QUESTIONS
GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies.	prgalgnplcy (7.1)
PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds	scrtypesp (7.4)
PR2	Health system and financing functions are integrated or coordinated across schemes and programmes.	prgalgnplcy (7.1) prgpoolalgn (7.2) scrtypesp (7.3)
PS2	Purchasing arrangements are tailored in support of service delivery objectives.	scrtypesp (7.3)
PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities.	scrtypesp (7.4)

\* Desirable attributes articulate ideal situations relevant to each assessment area.

## Question 7.1 (prgalgnplcy):

Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?

### **i** BACKGROUND TO THE QUESTION

Stage 1 maps out the key health intervention- or disease-specific programmes as separate schemes within the overall health system. These health programmes often are defined by a specific population, particular disease, a region or location, or specific interventions and available technology. How programmes are organized can vary across contexts. For some, this can involve a focused strategy combined with monitoring the delivery of services and outcomes. At the other extreme, it may include its own arrangements for service delivery, financing, human resources, facilities, information systems, and procurement. In some contexts, external funding reinforces this approach for priority issues e.g. HIV, immunization, and family planning. This can lead to autonomous, fragmented programmes seeking to optimize their own objectives without taking into consideration overall system efficiency. This question considers whether individual programmes develop their own financing-related policies and implementation plans which are disconnected from, and not aligned with, broader health sector strategies.

Note that this question may at least partly be answered in Question 1.1; however, for this question the Principal Investigator should look specifically at the issue of health programmes. In some countries this will not be a major issue while in others it will be of major significance.

### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

This question is specifically concerned with issues related to how health programmes are or are not aligned with overall health financing strategies and policies. Progress on this issue would involve clear health financing strategies that embed and align disease, intervention, or programme-specific considerations within the larger health system. This means that there aren't separate financing strategies by disease or programme, but rather they are part of a coherent strategy that focuses on aligning financing with service delivery objectives (e.g. integrated service delivery, PHC). Alignment and coordination are particularly important when there is disease, intervention or programme-specific revenue sources e.g. from external funders.

#### **LEVEL 1: EMERGING**

*Specific health programmes are not addressed in, or aligned with, overall national health financing policy.*

Health programmes have their own financing policies that do not consider coordination or integration with other programmes, schemes, or across the system. This is facilitated by often off-budget revenue streams coming from donors.

#### **LEVEL 2: PROGRESSING**

*Health financing policy considers health programmes but guidelines for aligning functions for integrated service delivery are purely aspirational.*

Health programme-related services are considered as part of benefits that should be delivered as part of broader health financing schemes. However, policies do not consider how to pool resources, coherently purchase related services, or integrate functions. The result is continued fragmentation of programmes from the overall system.

**LEVEL 3: ESTABLISHED**

*Health financing policy has guidelines for aligning health programme functions within the health system, but these have not been implemented.*

Health financing strategy explicitly includes financing for health programmes within the overall frame of health system financing. However, it does not provide targeted guidance or considerations for the special nature of certain services or how to integrate services at the point of delivery where applicable. As a result, guidelines have not been implemented.

**LEVEL 4: ADVANCED**

*Health financing policy reflects careful consideration of health programme services and funding flows.*

In this context, health programmes are well-integrated into overall strategic documents, and special consideration is given where appropriate for specific population needs/services. A tailored approach to pool programmatic funds for services with the pool serving other population needs (e.g. for PHC) is both clear and operational.

** QUANTITATIVE INDICATORS**

Further information about cross-programmatic efficiency analysis is available in a WHO guidance paper (12).



## Question 7.2 (prgpoolaln):

**Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?**

### **i BACKGROUND TO THE QUESTION**

Funding for health or disease-specific programmes is often separate from that for the main health system i.e. the provision of general primary and secondary care. Furthermore, external funding is often channelled directly into disease programmes which are off-budget in terms of expenditure monitoring and reporting, and often off-cycle in terms of domestic planning and budgeting processes. As a result, there may be separate and uncoordinated streams of money funding common functions, such as surveillance and laboratory systems, and supply chains. This question examines the impact of parallel financing flows on the organization of input functions (both human and physical resources) and ultimately service delivery. This question specifically focuses on the coordination of funds across health programmes and the health system, whereas Question 7.1 is focused on health financing policies, strategies and guidelines.

### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

Making progress on this issue involves ensuring health programme funds are on-budget or on-plan in that they are aligned with the domestic planning and budgeting processes of the overall health system. This includes all external funding as well as domestic funding. Pooling and budgeting arrangement should promote and enable coordination of funds towards common functions (e.g. supply chain, health workforce training, laboratories, surveillance systems) across programmes.

#### **LEVEL 1: EMERGING**

*All health systems functions remain separate for specific health programmes.*

In this case, parallel revenue and pooling functions for specific health programmes leads to completely parallel functions down to the level of service delivery (i.e. separate facilities for specific conditions in contradiction to clinical protocols).

#### **LEVEL 2: PROGRESSING**

*There have been some efforts to develop mechanisms to integrate certain functions across specific health programmes.*

While much of the organization of the identified health programmes remains separate, there is some effort at targeted integration and coordination of funding and related functions.

#### **LEVEL 3: ESTABLISHED**

*Substantial measures for integration and coordination of functions are in place, though with room for improvement, to address inefficiencies arising from separate pooling.*

There is an effort to consider health programme functions as part of overall health financing and systems, but key functions (e.g. supply chain or data systems) remain separate.

**LEVEL 4: ADVANCED**

*Full harmonization of all key functions across health system allows for functions to operate at the system level rather than being organized by programme.*

Health programme funds are on-budget and related functions are coherent and aligned with overall system policies.

** QUANTITATIVE INDICATORS**

Examples of cross-programmatic efficiency reports to be published online in late 2020 will be made available [here](#).

### Question 7.3 (scrtyprep):

**Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?**

#### **i BACKGROUND TO THE QUESTION**

Financing emergency preparedness is a critical function of the overall public sector. Mechanisms need to be in place in the case that emerging threats materialize. This capacity can be proxied by financing related to the International Health Regulations (IHR). The IHR represent the commitment of States Parties to collectively prepare for, and respond to, events that may constitute a public health emergency of international concern according to a common set of rules (e.g. COVID-19). Preparedness functions that support health security are often underfunded or are financed and organized in isolation from the rest of the financing system (e.g. through extra-budgetary mechanisms). Additionally, the multisectoral nature of these functions requires explicit coordination. This question looks at what type of financing arrangements in the country exist to support implementation of preparedness functions, as laid out by the core IHR capacities. These capacities and indicators include the following: *Legislation and financing, IHR coordination and NFP Functions, Zoonotic events and the human-animal interface, Food safety, Laboratory, Surveillance, Human resources, National health emergency framework, Health service provision, Risk communication, Points of entry, Chemical events, Radiation emergencies.*

While revenues are clearly necessary to finance these functions, they often represent a marginal amount in relation to overall health spending. These functions rely on public financing and therefore need to be clearly incorporated into health sector budgeting processes. Effective budgetary mechanisms need to be flexible and effective in ensuring funding reaches the front lines.

#### **i WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?**

Progress on this issue means that funds are available and financing mechanisms are in place to implement the health security-related capacities laid out in the International Health Regulations (IHR) across all levels of government and relevant ministries. It is important that the budget allocated for IHR capacities is flexible to adapt as needs change and can be distributed and executed in a timely manner. These functions rely heavily on existing health system functions and must be clearly incorporated into health sector budgeting processes that are coordinated across ministries and governments. Specifically, consider:

- How are resources managed by the public sector when a public health emergency occurs?
- Is there a mechanism that allows for resources to be rapidly distributed in response to a public health emergency?
- When a public health emergency occurs, does the country know where it can immediately access most of the financing needed to respond?
- How does the country ensure the coordination of funding allocated to a public health emergency response?

**LEVEL 1: EMERGING**

*There is no budgetary allocation available or identifiable to finance the implementation of IHR capacities*

Financing for IHR is handled through extrabudgetary means, revenues are not allocated to fund these functions, and there are no institutional mechanisms in place to ensure accountability for implementation.

**LEVEL 2: PROGRESSING**

*A budgetary allocation, or substantial external financing, is made for some of the relevant sectors to support IHR capacities but are not fully implemented.*

This only exists at the national level and is not fully implemented at all levels of government

**LEVEL 3: ESTABLISHED**

*Budgetary allocations for IHR capacities are made across relevant sectors to support implementation but there is no clear coordination across sectors in their execution.*

There is sufficient budget allocation for IHR capacities at national and subnational levels across sectors including (health, veterinary, agriculture, and all other relevant ministries or sectors); budget allocations are based on clear evidence and related needs.

**LEVEL 4: ADVANCED**

*Sufficient budget for IHR capacities is distributed, executed, and coordinated in a timely manner across all relevant ministries and levels of government.*

These funds are well coordinated and integrated with the overall health financing system.

** QUANTITATIVE INDICATORS**

WHO oversees the IHR SPAR assessment, in which all countries self-assess on several areas related to the International Health Regulations. Look at how the country performs on indicator “C.1.2 Financing for the implementation of IHR capacities” which assesses how the public health response to emergencies is financed, in terms of whether there is an explicit budget allocation for IHR, whether it is multisectoral, and whether funds are distributed to subnational entities

Supporting notes to the SPAR assessment further elaborate that “States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process. Budget is an itemized summary of expected income and expenditure of a country over a specified period, usually a financial year, whereas financing and funding refers to money which a government or organization provides for a particular purpose. In other words, budget is what is planned for, and financing is what is actually provided.”

Country-specific information is available on the background indicators dashboard [here](#). Ratings use a 1-5 scale where one is low, with scores represented as 20%, 40%, 60%, 80% or 100%. No supporting text or analysis is available for countries. Furthermore, to move away from exclusive self-evaluations, the IHR Review Committee has developed an approach for voluntary external evaluations involving domestic and international experts. This is known as the Joint External Evaluation (JEE) tool published in 2016. The purpose of the JEE is to measure country-specific status and progress in achieving the IHR targets and has the same indicator as SPAR.

The Guidance document for SPAR assessments (13) and the JEE 2<sup>nd</sup> edition manual (14) provide useful references.

### Question 7.4 (scrtypesp):

Are public financial management systems in place to enable a timely response to public health emergencies?

#### **i** BACKGROUND TO THE QUESTION

This question differs from 7.3 as it looks at whether and how health financing arrangements and mechanisms allow for and facilitate a timely response to public health emergencies. Central to this is that funds can be used flexibly and where necessary reallocated rapidly in support of the response to public health emergencies. Having a strong public financial management system will enable a rapid and comprehensive response to an emergency. This also encompasses whether health budget formulation supports alignment with a timely response to public health emergencies, as well as whether there is flexibility in spending to reallocated in the context of changing needs and demands. This question has similarities with Question 6.2 but focuses specifically on the capacities on public financial management required to respond to public health emergencies.

#### **i** WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Progress on this issue would mean that necessary funds are flexible and can be reallocated rapidly for the response to a public health emergency. This involves having a strong public financial management system that ensures the speed, transparency, and accountability of funds for public health emergencies that are coordinated across levels of government and relevant ministries. Specific questions to ask regarding the progress level:

- How are resources managed by the public sector when a public health emergency occurs? How are they gathered and disseminated from both public and private actors?
- Is there a mechanism that allows for resources to be distributed for responding to a public health emergency in a timely manner?
- When a public health emergency occurs, does the country know where it can immediately access most of the financing needed to respond to the emergency?
- Does each relevant ministry or public entity have a budget line in place for activities related to responding to public health emergencies?
- How does the country ensure coordination of funding related to response to public health emergencies?

#### **LEVEL 1: EMERGING**

*Funding to respond to public health emergencies is identified but public financial management system does not allow for effective or timely disbursement during a public health emergency.*

Funds are allocated and distributed in an ad hoc manner during a public health emergency. Extra-budgetary funds are created that are not coordinated with the overall public financing management system.

#### **LEVEL 2: PROGRESSING**

*An emergency public financing mechanism exists that allows for structured reception and rapid distribution of funds in response to public health emergencies*

In this context, the government has established these pathways; however, they are not operational and fully funded.

**LEVEL 3: ESTABLISHED**

*Financing for public health response is identified for immediate mobilization when needed at all levels of government for relevant sectors in advance of a public health emergency.*

For example, the functionality of the emergency public financing mechanism is ensured for the mobilization of funds when needed but funds are not released in a timely or transparent manner.

**LEVEL 4: ADVANCED**

*Financing can be executed and monitored in a timely and coordinated manner at all levels for all relevant sectors, with an emergency contingency fund in place to respond to public health emergencies.*

Public financial management systems are established and well-coordinated with the rest of the public sector. Speed, transparency, and accountability of all funds is ensured in response to a public health emergency.

** QUANTITATIVE INDICATORS**

WHO oversees the IHR SPAR assessment, in which all countries self-assess on several areas related to the International Health Regulations. Look at how the country performs on indicator “C.1.3 Financing mechanism and funds for the timely response to public health emergencies” which assesses whether a funding mechanism for emergency response is in place and executed rapidly to relevant sectors and levels of the system.

As noted in the previous question, supporting notes to the SPAR assessment further elaborate that “States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process. Budget is an itemized summary of expected income and expenditure of a country over a specified period, usually a financial year, whereas financing and funding refers to money which a government or organization provides for a particular purpose. In other words, budget is what is planned for, and financing is what is actually provided.”

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The guidance document for SPAR assessments can be found [here](#) and the JEE 2<sup>nd</sup> edition manual [here](#).

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**i** *THE HFPM SYNTHESIZES A WIDE RANGE OF DOCUMENTS ON HEALTH FINANCING AVAILABLE AT:*  
<https://www.who.int/health-topics/health-financing>

*ALL DOCUMENTS RELATED TO THE HFPM ARE AVAILABLE AT:*

<https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix/>





The Health Financing Progress Matrix (HFPM) is a standardized approach to assessing a country's health financing system. Primarily qualitative in nature, the HFPM considers health financing institutions, processes, policies and their implementation, assessing how aligned these are with universal health coverage. Country assessments highlight priorities for future action, allow progress to be monitored over time, and are used to build a Global Knowledge Database to facilitate learning between countries.



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