Health Financing Progress Matrix
Country Training

Session 1:
Meeting objectives & agenda overview

22-24 June 2022
Victoria Falls, Zimbabwe
OBJECTIVES

BY END OF TRAINING PARTICIPANTS TO UNDERSTAND:

1. Conceptual foundations, normative dimension & causal relationships
2. How HFPM differs to other assessments, & the valued added
3. Four phases of implementation, decision points, choices
4. Jointly define need for, and key elements of, an online platform / community
5. Develop draft strategy for HFPM roll-out and use
6. A number of strategic issues e.g. capacity building, institutionalization, evidence into policy
## AGENDA

**GREEN = TECHNICAL FOCUS SESSION**

**BLUE = IMPLEMENTATION FOCUS SESSION**

**ORANGE = STRATEGIC FOCUS SESSION**

<table>
<thead>
<tr>
<th>TIME</th>
<th>WEDNESDAY 22 JUNE</th>
<th>THURSDAY 23 JUNE</th>
<th>FRIDAY 24 JUNE</th>
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<tbody>
<tr>
<td>Session 1</td>
<td><strong>08:30 - 10:00</strong>  Security briefing, objectives, agenda</td>
<td><strong>OPENING OF THE MEETING</strong></td>
<td><strong>HFPM STAGE 2</strong></td>
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<td><strong>INTRODUCING THE HFPM</strong></td>
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<td><strong>INSTITUTIONALIZING HEALTH FINANCING POLICY</strong></td>
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<td><strong>TEA/COFFEE BREAK</strong></td>
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<td><strong>ANALYSIS:</strong></td>
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<td><strong>HOW THE HFPM CAN CONTRIBUTE</strong></td>
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<td>Session 2</td>
<td><strong>10:00 - 10:30</strong>  Tea/coffee break</td>
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<td><strong>HFPM STAGE 1 &amp; NHA INTEGRATION</strong></td>
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<td><strong>IMPLEMENTATION PHASES 1 &amp; 2</strong></td>
<td><strong>PLENARY DISCUSSION</strong></td>
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<td><strong>DRAFT COUNTRY STRATEGIES FOR</strong></td>
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<td><strong>LUNCH</strong></td>
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<td><strong>HFPM ROLL-OUT AND USE</strong></td>
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<td>Session 3</td>
<td><strong>13:00 – 14:30</strong>  THE HEALTH FINANCING ALIGNMENT AGENDA</td>
<td><strong>HF CAPACITY BUILDING</strong></td>
<td><strong>SUMMARY OF MEETING</strong></td>
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<td><strong>GETTING RESULTS INTO POLICY</strong></td>
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<td><strong>DISCUSSION OF OUTSTANDING ISSUES &amp; NEXT STEPS</strong></td>
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<td><strong>GROUP PHOTO</strong></td>
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<td><strong>MEETING CLOSURE</strong></td>
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<td>Session 4</td>
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<td>Session 5</td>
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FOLLOWING THE MEETING

• You will leave with many questions and have more once you reach home
• We are thinking of establishing an online platform, and throughout this event we will be asking you what you would find useful
• We will feed back to you at the end of the course what we have found
• We are also starting to test a platform with a phone app – we are looking for volunteers
• Julia Sallaku leading this process

• We will write a blog about the meeting
Health Financing Progress Matrix
Country Training

Session 1: Introducing the HFPM

22-24 June 2022
Victoria Falls, Zimbabwe
WHY DEVELOP THE HFPM?
WHAT IS DIFFERENT ABOUT IT?

A GLOBAL ASSESSMENT DATABASE & DASHBOARDS FOR STRUCTURED KNOWLEDGE SHARING

NEED FOR IMPROVED MONITORING OF PROGRESS OVER TIME, BEYOND QUANTITATIVE INDICATORS

BUILDING STRONG, SUSTAINABLE HEALTH SYSTEMS

CLOSER TO REAL-TIME INFO TO POLICY MAKERS ON "HOW TO MOVE THE DIAL"

PARSIMONIOUS PRESCRIPTIVE-BUT ONLY TO A POINT QUALITATIVE BUT OBJECTIVE COMPLEMENTS & DEPENDS ON OTHER ASSESSMENTS

BUILDS ON 20+ YEARS OF KNOWLEDGE SYNTHESIS / CYSTALLIZATION OF WHAT MATTERS IN HF MOVES BEYOND DESCRIPTION NORMATIVE / CAUSAL

THE SPECIFIC USE & TIMELINE FOR THE ASSESSMENT IS DRIVEN ENTIRELY BY YOUR COUNTRY NEEDS & PROCESSES
WHO STOCKTAKING OF GLOBAL PROGRESS ON UHC

Global progress in service coverage as tracked by UHC SDG indicator 3.8.1 and catastrophic health spending as tracked by SDG 3.8.2 indicator at the 10% threshold, 2000-2017

More people covered by health services is better

UHC Service coverage Index (SDG 3.8.1)

Global incidence of catastrophic health spending (2017)

Global population weighted service coverage Index (2017)

Notes: The vertical dotted line corresponds to the 2017 global incidence rate of catastrophic health spending (13.2%) defined as the proportion of the population with household out-of-pocket health expenditures exceeding 10% of household budget. The horizontal dotted line corresponds to the 2017 global population-weighted average service coverage (65).
Regional progress in service coverage as tracked by UHC SDG indicator 3.8.1 and catastrophic health spending as tracked by SDG 3.8.2 indicator at the 10% threshold, 2000-2017

More people covered by health services is better

Financial hardship (SDG 3.8.2, 10% threshold)

Global incidence rate of catastrophic health spending (2017)

Global population weighted service coverage index (2017)

Notes: The vertical dotted line corresponds to the 2017 global incidence rate of catastrophic health spending (13.2%) defined as the proportion of the population with household out-of-pocket health expenditures exceeding 10% of household budget. The horizontal dotted line corresponds to the 2017 global population-weighted average service coverage (65).
ROOTED IN STRONG CONCEPTUAL FOUNDATIONS

Figure 1: WHO's framework for health financing and UHC²

Health financing within the overall health system

- Creating resources
- Revenue raising
- Pooling
- Purchasing
- Service delivery

Benefits

Stewardship / Governance / Oversight

UHC intermediate objectives

- Equity in resource distribution
- Efficiency
- Transparency & accountability

Final coverage goals

- Utilization relative to need
- Financial protection & equity in finance
- Quality

Improved pop. health & equity in health

Socio-econ determinants of health

Variety of fiscal & PFM issues

Political economy

Demand-side barriers
THE REALLY NEW PART

DESIRABLE ATTRIBUTES OF HEALTH FINANCING

Table 1: Desirable attributes of health financing systems

<table>
<thead>
<tr>
<th>Health financing systems</th>
<th>GV1</th>
<th>GV2</th>
<th>GV3</th>
<th>GV4</th>
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<tr>
<td></td>
<td>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.</td>
<td>There is transparent, financial and non-financial accountability, in relation to public spending on health.</td>
<td>International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments.</td>
<td>Health expenditure is based predominantly on public (or compulsory) funding sources.</td>
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<td>The level of public (or compulsory) funding is predictable over a period of years.</td>
<td>The flow of public (or compulsory) funds is stable and budget allocation is high.</td>
<td>Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms.</td>
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<td>Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds.</td>
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<td>Health systems and financing functions are integrated or coordinated across schemes and programmes.</td>
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<td>Resource allocation to providers reflects population health needs, provider performance, or a combination.</td>
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<td>Purchasing arrangements are tailored in support of service delivery objectives.</td>
<td>Purchasing arrangements incorporate mechanisms to ensure budgetary control.</td>
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<td>Entitlements and obligations are clearly understood by the population.</td>
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<td>A set of priority health service benefits within a unified framework is implemented for the entire population.</td>
<td>Benefits of all services are subject to cost-effectiveness and budgetary impact assessments.</td>
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<td></td>
<td>Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments.</td>
<td>Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers.</td>
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<td>Benefit design includes explicit limits on user charges and protects access for vulnerable groups.</td>
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<td>Health budget formulation and structure support flexible spending and are aligned with sector priorities.</td>
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<td>Providers can directly receive revenues, flexibly manage them, and report on spending and outcomes.</td>
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https://www.who.int/publications/i/item/9789240017405
HFPM ASSESSMENT STRUCTURE

Figure 2: Overview of the HFPM assessment

Stage 1: Landscaping of country's health schemes and programmes

Stage 2: Detailed assessment across seven technical areas

19 Desirable Attributes
33 Questions

Policy, Process & Governance 3 Questions
Revenue Raising 5 Questions
Pooling 5 Questions
Purchasing 6 Questions
Benefit & Conditions of Access 5 Questions
Public Financial Management 5 Questions
Public Health Functions & Programmes 4 Questions

Objectives / UHC Goals

Efficiency
Equity in Resource Distribution
Transparency
Equity in Finance
Fin Protection
Quality
Utilization vs Need
Health Security
## Countries using globally

<table>
<thead>
<tr>
<th>WHO REGION</th>
<th>COUNTRY</th>
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<td>Burkina Faso</td>
<td>Mauritius</td>
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<td>Burundi</td>
<td>Mozambique (2023)</td>
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<td>Cameroon</td>
<td>Namibia</td>
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<td>Comoros</td>
<td>Nigeria</td>
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<td>Bangladesh</td>
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<td>Bhutan</td>
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<td>India (State level)</td>
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<td>WESTERN PACIFIC</td>
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<td>Lao PDR</td>
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<td>Mongolia</td>
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<td>Vietnam</td>
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Database of country assessments

IDEA 1

IDEA 2
Developed to support countries identify current strengths & weaknesses in their health financing systems, as well as the policy priorities to accelerate progress to UHC

Demand for improved tracking of country progress in health financing closer to “real-time”; at least two-year lag on most quantitative indicators

Based on and synthesis of 20-30 years of global evidence of what works in health financing to drive progress to UHC
LINKING HF POLICY WITH PERFORMANCE IN THE HFPM

ASSESSING COUNTRY HEALTH FINANCING SYSTEMS
THE HEALTH FINANCING PROGRESS MATRIX

ANNEXES 3, 4, 5 QUESTIONS BY DESIRABLE ATTRIBUTE

ANNEX 6 QUESTIONS MAPPED TO INTERMEDIATE OBJECTIVES AND GOALS

https://www.who.int/publications/i/item/9789240017405
Health Financing Progress Matrix
Country Training

Session 2:
HFPM Stage 1 & NHA data integration

22-24 June 2022
Victoria Falls, Zimbabwe
WHY DEVELOP STAGE 1 OF THE HFPM?

- Health financing landscape often becomes complex over time.
- This matters for how a country performs on universal health coverage.
- To what extent is there structural fragmentation in the health system?
- Together, do the schemes make a coherent system?

- Free MCH programme
- Insurance for civil servants
- Large vertical disease programmes
- Government health budget
CRITERIA FOR INCLUSION IN STAGE 1

MAPPING THE HEALTH COVERAGE LANDSCAPE

- SCHEMES WITH SIGNIFICANT POLITICAL SUPPORT
- SCHEMES TAKING A REFORMIST APPROACH
- SCHEMES THROUGH WHICH SIGNIFICANT FUNDS FLOW
- START WITH THE GOVERNMENT HEALTH BUDGET – SUPPLY SIDE FUNDING
- IDENTIFY SCHEMES WITH A DISTINCT POOL OF FUNDS / POLICIES
- IDENTIFY SCHEMES MANAGED “SEPARATELY”
DESCRIBING THE KEY DESIGN ELEMENTS OF EACH SCHEME

Overall focus of the scheme
Target population
Covered population
Basis for entitlement
Summary of entitlements
Co-payment (design)

Conditions of access
Revenue sources
Pooling arrangements
Governance arrangements
Provider payment
Service delivery and contracting

DROP-DOWN CODING
### Bangladesh Stage 1

#### Stage 1: Health Coverage Schemes in Bangladesh: Health Financing Arrangements

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Public Sector</th>
<th>Universal Primary Health Care</th>
<th>Material Vulnerable Voucher</th>
<th>Meknawo Subsidy (Kushalbari) Program</th>
<th>Private Insurance</th>
<th>Corporations, Autonomous Bodies and Private Companies</th>
<th>Private Sector</th>
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#### STAGE 1: HEALTH FINANCING ARRANGEMENTS

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<th>EXPENDITURES</th>
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### Conclusion

By implementing strategic health financing arrangements, Bangladesh can address gaps in coverage and ensure equitable access to health services for all its citizens. This includes enhancing the capacity of the public sector, promoting universal primary health care, and targeting vulnerable groups through innovative schemes such as the Meknawo Subsidy Program. Further, partnerships with private and corporate sectors can help bridge remaining funding gaps and support the sustainability of health financing initiatives.
BANGLADESH STAGE 1
with expenditure flows from NHA

- **Public Budget System** - (21.2% of CHE), (98.0% of Public)
- **Urban PHC** - (0.4% of CHE), (1.7% of Public)
- **Maternal Voucher Scheme** - (0.1% of CHE), (0.3% of Public)
- **SSK** - (0.01% of CHE), (0.03% of Public)

**PUBLIC EXPENDITURE PER CAPITA (US$)**

- Public Budget System: 7.60
- Urban PHC: 2.17
- Maternal Voucher Scheme: 18.30
- SSK: 4.00

**PRIVATE EXPENDITURE PER CAPITA (US$)**

- Private (OOPs): 9.00
- Private Insurance: 95.15
- Private Corporations: 23.00
HEALTH EXPENDITURE BY STAGE 1 COVERAGE SCHEMES - UGANDA

- Government Health Budget: 24.4% of CHE
- Results based financing: 0.5% of CHE
- CBHIs: 4.4% of CHE
- OOPs: 39.7% of CHE
- Vertical programs: 32.8% of CHE

Public - 15.1% of CHE
Private - 42.9% of CHE
External - 42% of CHE
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>PUBLIC SYSTEM (Federal and State budgets)</th>
<th>PRIME MINISTER NATIONAL HEALTH PROGRAM</th>
<th>SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWASOCIAL HEALTH PROTECTION INITIATIVE)</th>
<th>SOCIAL HEALTH PROTECTION INITIATIVE GILGIT BALTISTAN</th>
<th>EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)</th>
<th>Armed Forces</th>
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</thead>
</table>
| Benefits / entitlements covered | Vaccinations  
Public health programs  
Subsidised care - primary, secondary and tertiary, depending on the level of facility (basic health unit, rural health center, district headquarters hospital, and tertiary care hospital) | Cashless indoor healthcare  
1. **Secondary care**: PKR 50,000/family/year  
2. **Tertiary care** (priority disease): PKR 250,000/family/year  
Priority diseases  
1. Cardiovascular Disease  
2. Hospitalization required for Complications of Diabetes Mellitus  
3. Emergency and Trauma  
4. Organ Failure Management  
5. Chronic Infections complications  
6. Cancer management  
7. End Stage renal disease  
**Additional benefits**  
1. Admission Coverage: One day pre-admission coverage  
2. Medication: Five days medicine at time of discharge  
3. Follow-up: One free follow up visit after discharge  
4. Referral Transportation of indoor patient: Responsibility of Insurance Company | Cashless indoor healthcare  
1. **Secondary care**: PKR 30,000/member/household/year  
2. **Tertiary care** (priority disease): PKR 240,000/household/year  
Priority diseases  
1. Cardiovascular diseases including:  
2. Complications from Diabetes Mellitus requiring hospitalization  
3. Emergency and Trauma including:  
4. Oncological diseases a. Chemotherapy (Day care or hospitalization)  
5. Radiotherapy (Day care or hospitalization)  
6. Medical and Surgical management requiring hospitalization  
5. HCV & HBV Complications  
6. Organ failure management  
7. Cerebro-Vascular Accidents (CVA)  
**Additional benefits** | | | |
| | Both outpatient and inpatient services, and there is a financial cap on the latter | Both outpatient and inpatient, but there is no explicit package for inpatient services | | | | |
CAMBODIA STAGE 1
Extremely limited universality in the health system

NSSF = 10% pop
HEFs = 15% pop

“All services need to be paid for in the public sector, a bit cheaper than private clinics. So, if people are not covered by SHI or HEF, they need to pay from OOP.”
ESSENTIAL BACKGROUND INFO FOR THE 33 QUESTIONS IN STAGE 2

STAGE 1 IDENTIFIES STRUCTURAL FRAGMENTATION / DUPLICATION / GAPS

ITERATE AND REVISE DURING STAGE 2 OR LATER

HFPM STAGE 1

FINAL POINTS
Health Financing Progress Matrix Country Training

Session 2:
Sierra Leone Presentation
22-24 June 2022
Victoria Falls, Zimbabwe
Why Perform HFPM?

**Current landscape of HF**

- National Dialogue around HF on the increase
- Policy formulation on UHC in the beginning stages
- Road Map to UHC was developed
- First Health financing strategy being developed
- Debate over the launch of a National Health Insurance Scheme ongoing

- This led to increasing debate among us on where we are as a country?
- The launch of the HFPM – webinar
Why is it useful?

how can it help answer our questions?

SERVES AS A DIAGNOSTIC TOOL

STIMULATE FURTHER INTERESTS AND DISCUSSIONS

INFORMS ONGOING DIALOGUES AND POLICY FORMULATION
Process

- Participation in HFPM Launch
- Team Setup in March (MOHS, HDPS)
- Going Through the Tools
- Meetings/Discussions Analysis Held Virtual and Face to Face
- Research
HEALTH FINANCING LANDSCAPE: high FRAGMENTATION

The team identified nine (9) different financing schemes:

1. Government health budget
2. Free Health Care initiative
3. SLeSHI
4. Performance-Based Financing
5. School health program
6. Global Fund disease program (Malaria, HIV/Aids, TB)
7. Nutrition
8. Reproductive and Child health (family planning, EPI/Gavi (vaccines), Quality of Care)
9. Private health insurance schemes
Compressed schemes into three

<table>
<thead>
<tr>
<th>KEY DESIGN FEATURE</th>
<th>GOSL HEALTH BUDGET</th>
<th>FHC INITIATIVE</th>
<th>VERTICAL DISEASE PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) FOCUS OF THE SCHEME</td>
<td>Provide Essential Health services to all the people of Sierra Leone</td>
<td>To reduce high burden of maternal and child mortality by providing free essential services to all the target population</td>
<td>Coverage under these financing schemes is based on disease – if someone is sick or requires treatment for Malaria, HIV/AIDS, TB or severe malnutrition, or is requiring family planning services or vaccinations, they are covered under this financing scheme.</td>
</tr>
<tr>
<td>B) TARGET POPULATION</td>
<td>General Population</td>
<td>Under 5 children, Pregnant and Lactating women</td>
<td>People infected with the diseases</td>
</tr>
<tr>
<td>C) POPULATION COVERED</td>
<td>Not clear</td>
<td>Target population of Pregnant and lactating women and under 5 children</td>
<td>People diagnosed with the diseases</td>
</tr>
</tbody>
</table>
Challenges

- Definition and classification of schemes – esp external program funding, even local programs – like FHC
- Lack of written out policies for schemes – FHC
- Data – availability and quality
Lessons learned

• Scheme not having clear policy documentation in line with HF
• Use the ongoing health financing strategy process to align different vertical programs under
• Ensure they use the same financial policies and processes as general government financing.
• Align budgeting processes of the different vertical programs with the government budgeting cycle.
Thank you
Health Financing Progress Matrix Country Training

Session 2: Georgia Presentation
22-24 June 2022
Victoria Falls, Zimbabwe
HFPM Georgia

Reflections on Stage 1

Mariam Kirvalidze, MD MPH
Aging Research Center, Karolinska Institutet
Principal Investigator for HFPM assessment in Georgia
mariam.kirvalidze@ki.se
### Stage 1: first draft

<table>
<thead>
<tr>
<th>KEY DESIGN FEATURE</th>
<th>Universal Health Care Programme (UHCP)</th>
<th>COVID-19 Management Programme</th>
<th>Hepatitis C Elimination Programme</th>
<th>Private Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YEAR ESTABLISHED</td>
<td>2013</td>
<td>2020</td>
<td>2015</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**A) FOCUS OF THE SCHEME**

- Universal Health Care Programme (UHCP) was established as a demonstration of political commitment to improving access to health care, protecting the population from the financial risks of health care costs, and reducing health inequalities. The introduction of UHCP extended the breadth of coverage to almost the whole population, most of whom had no health coverage prior to 2013.

- UHCP has undergone several cycles of major policy changes, related to population entitlement, services covered, copayment mechanisms and purchasing arrangements. The information on the scheme below is based on the most recent (September 2021) information.

- The aim of the COVID-19 Management Programme is to ensure prevention, early detection and treatment of infections caused by novel coronavirus (SARS-CoV-2). This programme was established in 2020 to effectively mobilize available resources in response to the COVID-19 pandemic.

- From 2014, private health insurance plays a minor role in the Georgian health system. In 2019, it accounted for 6% of current spending on health and 9% of private spending on health. It is provided by private insurance companies.

- In 2007-2014 the management of state assignments for health insurance for vulnerable (targeted) groups of the population was transferred to private insurance companies that became the health service purchasers for these groups.

---

**What are we missing here?**

[?]
Thought process: budgetary information

<table>
<thead>
<tr>
<th>Healthcare budget</th>
<th>1 498 582 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Universal Health Coverage Program (UHCP)</td>
<td>800 000 000</td>
</tr>
<tr>
<td>Total vertical programmes*</td>
<td>651 235 000</td>
</tr>
<tr>
<td><em>(includes only program costs)</em></td>
<td></td>
</tr>
<tr>
<td>diabetes program</td>
<td>16 000 000</td>
</tr>
<tr>
<td>maternal and child health programme</td>
<td>8 000 000</td>
</tr>
<tr>
<td>immunization</td>
<td>27 958 000</td>
</tr>
<tr>
<td>TB care</td>
<td>17 159 000</td>
</tr>
<tr>
<td>mental health care</td>
<td>28 900 000</td>
</tr>
<tr>
<td>HIV</td>
<td>14 060 000</td>
</tr>
<tr>
<td>hepatitis C</td>
<td>7 000 000</td>
</tr>
<tr>
<td>cancer and other screening programmes</td>
<td>2 800 000</td>
</tr>
<tr>
<td>Rural Doctors Programme</td>
<td>25 000 000</td>
</tr>
<tr>
<td>Medicines financed under the medicines program (in 2019)</td>
<td>7 204 329</td>
</tr>
</tbody>
</table>

*Total of 23 programmes, not all listed here
## Stage 1: second draft

### Rationale
- **Largest programme (both in budgetary volume and scope)**
- **Relevant today, could become challenging financially**
- **Now we encompass all programs and services**
- **Changes through history, source of inefficiencies**

### Key Design Feature

<table>
<thead>
<tr>
<th></th>
<th>Universal Health Care Programme (UHCP)</th>
<th>COVID-19 Management Programme</th>
<th>Vertical (priority) programmes</th>
<th>Private insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>YEAR ESTABLISHED</strong></td>
<td>2013</td>
<td>2020</td>
<td>Not applicable</td>
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</tr>
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<td>The aim of the COVID-19 Management Programme is to ensure prevention, early detection and treatment of infections caused by novel coronavirus (SARS-CoV-2). This programme was established in 2020 to effectively mobilize available resources in response to the COVID-19 pandemic.</td>
<td>This heterogeneous group of programmes comprises of more than 20 schemes designed to address specific diseases or specific population groups. Vertical programmes have been established in various years (starting from 1995), to address different challenges and gaps. These programmes are often responsible for structural and financial inefficiencies and duplication of work (see Stage 2 below), and integration some of them into larger schemes (such as UHCP) is being considered. However, currently, it is important to map these programs to take a closer look at administrative and financial drawbacks in Stage 2 of this assessment. Following is a list of vertical programs in 2021:  - Early disease detection and screening</td>
<td>From 2014, private health insurance plays a minor role in the Georgian health system. In 2019, it accounted for 6% of current spending on health and 9% of private spending on health. It is provided by private insurance companies. In 2007-2014 the management of state assignments for health insurance for vulnerable (targeted) groups of the population was transferred to private insurance companies that became the health service purchasers for these groups.</td>
</tr>
</tbody>
</table>
Reflections

• Looking at the “big picture” of the budget helps identify the most important programmes
• Smaller programmes/schemes are often sufficiently similar to allow grouping
• At Stage 1, you can already think about what to include to be useful for Stage 2
• You can always dive into more specific details in Stage 2, referring to the descriptions in Stage 1
Health Financing Progress Matrix
Country Training

Session 3:
The Health Financing Alignment Agenda
22-24 June 2022
Victoria Falls, Zimbabwe
Health Financing Progress Matrix
Country Training

Session 3:
AU and Tracker Presentation
22-24 June 2022
Victoria Falls, Zimbabwe
Introduction to the AU ‘Africa Leadership Meeting’ (ALM) declaration on health financing

WHO HFPM meeting, Victoria Falls, Zimbabwe
a. A brief introduction to the ALM
“The African Union should monitor and evaluate the implementation of the 15% Abuja target”

AWA Consultative Expert Committee Meeting Nouakchott, Mauritania, May 2014
2016: AU Assembly adopts the Africa Scorecard on Domestic Financing for Health
Scorecard provided the data
• Became clear that Africa is not investing sufficiently in health

• The then AU Chairperson, H.E. President Paul Kagame, and the AUC convened the Africa Leadership Meeting on investing in health (the ALM)
In the AU Assembly ALM Declaration, Africa’s Heads of State committed to:

- Increase domestic investment in health and measure progress against the benchmarks of the Africa Scorecard on Domestic Financing for Health.
- Convene African Ministers of Finance and Health every 2 years to discuss health financing and to review progress against benchmarks.
- Complement the Africa Scorecard with a domestic health financing ‘Tracker’.
- Establish regional health financing Hubs in each of Africa’s five regions.
- Better engage the private sector to strengthen public health systems and expand access to health services.
In the AU Assembly ALM Declaration, Africa’s Heads of State committed to:

- **Increase the coherence of investment** in health by better aligning development partner and private sector efforts to the priorities of the continent.

- **Improve public financial management (PFM) capacity** to help improve tax collection and/or increase the proportion of tax revenue collected as a percentage of GDP.

- **Digitize the Africa Scorecard on Domestic Financing for Health** so that data is more widely available.

H.E. President Kagame was also **appointed** as AU Leader on domestic health financing.

**AU Commission to lead implementation** of these interlinked components of the ALM Agenda and coordinate the alignment of partners to Africa’s priorities.

---

AU Assembly ALM Declaration Assembly/AU/Decl.4 (XXXII)
ALM components are interlinked and mutually reinforcing

They work together to drive and support country-led health financing reform

- **Scorecard** provides insight into some of the potential challenges in country (over-reliance on development partners?; insufficient tax collection?; declining prioritisation of health?).

- **Tracker** enables countries to diagnose challenges and bottlenecks and provides guidance and support for countries as they work through implementing the recommended reforms.

- **Hubs** will coordinate technical assistance to support countries as they implement the reforms diagnosed by the Tracker and facilitate peer-to-peer learning across the various Tracker ‘action areas’. They will also support countries to provide better stewardship of private sector investment in health and to drive increased coherence of investment through improved alignment of multilateral, bilateral and private sector efforts to the priorities of the continent.

The AU meeting of African Ministers of Finance & Health will provide occasion for ministers to meet at regional and continental levels to review progress, provide strategic direction and coordinate implementation.
Tracker is not simply a diagnostic tool.

It forms part of a broader ecosystem:

- Head of State leadership
- Regular meetings of MoF & MoH to agree priorities and review progress.
- Coordination and leadership by the Hubs (RECs)
- Technical support provided through the Hubs
Tracker as the tool through which to identify challenges, set priorities, harmonise, align and work through fixing them together.
The Parameters that Heads of State set for the Tracker

Form follows function – and the function of the Tracker was specified by Heads of State.
The function of the Tracker is contained in the HoS AU Assembly decision

“Complement the Scorecard with a domestic health financing ‘Tracker’ that will guide health financing reforms and track country progress in implementing these ‘enablers’ of progress.”
The function of the Tracker is contained in the HoS AU Assembly decision

“Complement the Scorecard with a *domestic health financing Tracker* that will guide health financing reforms and track country progress in implementing these ‘enablers’ of progress.”

- There must be synergy between the Tracker and the Scorecard
The function of the Tracker is contained in the HoS AU Assembly decision

“Complement the **Scorecard** with a *domestic health financing Tracker* that will guide health financing reforms and track country progress in implementing these ‘enablers’ of progress.”

- The Tracker rapidly diagnoses and provides guidance to improve the outcomes that the **Scorecard** measures countries against:
  - Health financing
  - Fiscal space / revenue raising
  - Political prioritisation of health
  - Equity
Scorecard indicators are not repeated in the Tracker

### Africa Scorecard on Domestic Financing for Health, 2021

#### A. UHC (2017)

<table>
<thead>
<tr>
<th>AU Member State</th>
<th>UHC service coverage index</th>
<th>Per capita</th>
<th>as % of GDP</th>
<th>as % of Govt budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benchmark</strong></td>
<td>100% ✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### B. How much does government spend on health? (Current expenditure, 2018)

<table>
<thead>
<tr>
<th>#8</th>
<th>#9</th>
<th>#10</th>
<th>#11</th>
<th>#12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Govt.</td>
<td>Voluntary pre-paid insurance</td>
<td>Out-of-pocket</td>
<td>Other private health spending</td>
<td>Development Partners</td>
</tr>
</tbody>
</table>

#### C. Sources of health spending, by percentage (Current expenditure, 2018)

<table>
<thead>
<tr>
<th>#8</th>
<th>#9</th>
<th>#10</th>
<th>#11</th>
<th>#12</th>
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<td>Voluntary pre-paid insurance</td>
<td>Out-of-pocket</td>
<td>Other private health spending</td>
<td>Development Partners</td>
</tr>
</tbody>
</table>

#### D. Fiscal space (Latest available data)

<table>
<thead>
<tr>
<th>#13</th>
<th>#14</th>
<th>#15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual GDP growth rate</td>
<td>Govt. debt (Total)</td>
<td>Tax collected as a % of GDP</td>
</tr>
</tbody>
</table>

#### 1st quartile

1. **Algeria** 78%  
   - $168 ▲ 4.1 ▼ 10.7 ▲  
   - 40% 1% 33% 27% 0%  
   - Add up to 100% of total (current) health expenditure

2. **Seychelles** 71%  
   - $620 ▲ 3.8 ▼ 10.2 ▲  
   - 74% 1% 24% 1% 0%  
   - 27% 3% 39% 31% 0%  
   - Government

3. **Tunisia** 70%  
   - $144 ▲ 4.2 ▼ 13.6 ▲  
   - 45% 1% 28% 16% 9%  
   - 54% 36% 8% 1% 2%  
   - Voluntary pre-paid insurance

4. **Cabo Verde (formerly Cape Verde)** 69%  
   - $117 ▲ 3.2 ▼ 10.4 ▲  
   - 33% 12% 11% 2% 43%  
   - 43% 6% 49% 2% 1%  
   - Out-of-pocket

5. **South Africa** 69%  
   - $284 ▲ 4.5 ▼ 13.3 ▲  
   - 46% 41% 8% 0% 5%  
   - 77% 9% 3% 3% 6%  
   - Other private health spending

6. **Eswatini (formerly Swaziland)** 63%  
   - $89 ▼ 2.1 ▼ 6.0 ▼  
   - 22% 1% 47% 30% 0%  
   - 45% 12% 23% 19% 1%  
   - Development Partners

7. **Mauritius** 63%  
   - $282 ▲ 2.5 ▼ 10.0 ▲  
   - 58% 0% 16% 0% 26%  
   - 19% 0% 75% 4% 2%  
   - Add up to 100% of health expenditure

8. **Namibia** 62%  
   - $217 ▲ 3.7 ▼ 10.7 ▲  
   - 6% 41% 8% 0% 5%  
   - 33% 12% 11% 2% 43%  
   - As % of GDP 2021

9. **Botswana** 61%  
   - $374 ▲ 4.5 ▼ 14.3 ▲  
   - 33% 12% 11% 2% 43%  
   - 43% 6% 49% 2% 1%  
   - Tax collected as a % of GDP

10. **Morocco** 70%  
    - $70 ▲ 2.1 ▼ 7.2 ▲  
    - 22% 1% 47% 30% 0%  
    - 45% 12% 23% 19% 1%  
    - GDP growth rate 2017-2020

11. **Gabon** 49%  
    - $128 ▲ 1.6 ▼ 9.4 ▲  
    - 58% 0% 16% 0% 26%  
    - 19% 0% 75% 4% 2%  
    - As % of GDP 2021

12. **Lesotho** 48%  
    - $72 ▲ 5.4 ▼ 11.6 ▲  
    - 24% 7% 62% 6% 1%  
    - 22% 2% 11% 35% 31%  
    - GDP growth rate 2017-2020

13. **Equatorial Guinea** 45%  
    - $62 ▲ 0.6 ▼ 3.2 ▲  
    - 24% 7% 62% 6% 1%  
    - 22% 2% 11% 35% 31%  
    - As % of GDP 2021

#### 2nd quartile

1. **Egypt** 68%  
   - $36.1 ▲ 1.4 ▼ 4.7 ▼  
   - 24% 7% 62% 6% 1%  
   - 22% 2% 11% 35% 31%  
   - Government

2. **Rwanda** 57%  
   - $18.4 ▲ 2.4 ▼ 8.9 ▲  
   - 24% 7% 62% 6% 1%  
   - 22% 2% 11% 35% 31%  
   - Voluntary pre-paid insurance

---

[Diagram and table data as depicted in the image]
The function of the Tracker is contained in the HoS AU Assembly decision

• “Complement the Scorecard with a domestic health financing ‘Tracker’ that will guide health financing reforms and track country progress in implementing these ‘enablers’ of progress.”

➢ Must provide guidance to Member States on what to implement to make progress against Scorecard outcome indicators
  ➢ Countries have long requested this and the Tracker (Part II) provides this guidance.
The function of the Tracker is contained in the HoS AU Assembly decision

• “Complement the Scorecard with a domestic health financing ‘Tracker’ that will guide health financing reforms and track country progress in implementing these ‘enablers’ of progress.”

➢ Tracker not simply a ‘collection of indicators’.
➢ To ‘enable progress’ the Tracker must set out clear actions of ‘what to do next’.
   ➢ Scorecard sets out ‘this is your performance’
   ➢ Tracker part I identifies areas where intervention will realise biggest ‘return on effort’ and part II provides actionable guidance for how to make progress.
b. Introducing the ALM Tracker

→ What is the Tracker
Tracker facilitates a structured dialogue between MoH & MoF officials to identify challenges, set priorities and work through fixing them together.
The Tracker has 2 parts

Tracker: Part 1

• A very short diagnostic of questions across 4 objectives that countries can use to diagnose which areas of health reform will provide the greatest return on effort.

• The pilot will test 23 questions and from this, 12-15 will be chosen.

Tracker: Part 2

• A Resource Pack of what to do next in the areas identified after conducting the Tracker (Part I).
The Tracker has 2 parts

Tracker: Part 1

• A very short diagnostic of questions across 4 objectives that countries can use to diagnose which areas of health reform will provide the greatest return on effort.

• The pilot will test 23 questions and from this, 12-15 will be chosen.

Tracker: Part 2

• A Resource Pack of what to do next in the areas identified after conducting the Tracker (Part I).
The Tracker has 2 parts

Tracker: Part 1
• A very short diagnostic of questions across 4 objectives that countries can use to diagnose which areas of health reform will provide the greatest return on effort.
• Emphasis is not on the tool but on the process: MoF & MoH officials jointly diagnosing, prioritising, and figuring out how to start addressing prioritised challenges.

Tracker: Part 2
• A Resource Pack of what to do next in the areas identified after conducting the Tracker (Part I).
Objectives: What change is the Tracker trying to drive?

1. ‘More money for health’

2. ‘More health for the money’

3. Equity / improved financial protection in health

4. Strengthened country leadership of the health financing agenda and improved coordination
Objectives: Countries use the Tracker to identify priority areas to focus on

Objectives

1. ‘More money for health’
2. ‘More health for the money’
3. Equity / improved financial protection in health
4. Country leadership and improved coordination

Action areas

1. Raise: Growing the size of the pie for all sectors
2. Allocate: Budget Prioritisation for Health
4. Efficiency: Tackle main areas of inefficiency within govt health spending
5. Effectiveness: Investing in the right priorities
7. Equity in Service Coverage
8. Equity in Financing
9. Financial protection
10. Country leadership of the health financing agenda
11. Governance & Coordination
12. Strengthened data systems

Where can government realise the biggest return on effort?
<table>
<thead>
<tr>
<th>More money for health</th>
<th>Raise</th>
<th>Change in tax effort (year on year) [Tax collected / tax capacity]</th>
<th>Trends in tax–to–GDP ratio (year on year changes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocate</td>
<td>Increase prioritisation of health spending as public expenditure grows (elasticity of GGHE-D to GGE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spend</td>
<td>Ministry of Health budget utilisation / execution rate</td>
<td>PEFA indicator: “Predictability of in-year resource allocation”</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Percentage of government domestic health expenditure (GGHE-D) spent on salaries / wages</td>
<td>Is the country participating in a pooled procurement initiative to access medicines and commodities at the best pricing available to them?</td>
<td>Proportion (%) of pharmaceutical [public] procurement volume ($) that is generic</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Percentage of total [public] health spending allocated to Primary Health Care (PHC)</td>
<td>Percentage of government health expenditure that goes to medicines</td>
<td></td>
</tr>
<tr>
<td>Measurement &amp; Monitoring</td>
<td>Does the country use a priority setting mechanism to allocate health resources (e.g. a transparent and open priority setting dialogue, an HTA, or similar)?</td>
<td>Is provider performance monitored? If yes, is performance monitoring linked to purchasing decisions?</td>
<td></td>
</tr>
<tr>
<td>Equity in Service Coverage</td>
<td>Access to 'X' services by wealth quintile (e.g. RMNCH)</td>
<td>RMNCH Coverage Index</td>
<td></td>
</tr>
<tr>
<td>Equity in Financing</td>
<td>Are Benefit Incidence Analyses (BIA) of public spending in health carried out regularly with public participation?</td>
<td>Concentration Analysis of Resource Pools</td>
<td></td>
</tr>
<tr>
<td>Financial Protection</td>
<td>Medical Impoverishment (proportion of population pushed below poverty line by OOP spending)</td>
<td>Year 1: “What are the key drivers of OOP spending?”. Year 2 onwards: Measure the change in these key drivers of OOPs.</td>
<td></td>
</tr>
<tr>
<td>Country Leadership</td>
<td>In line with the AU ALM Declaration commitments, has government expressed in policy and/or legislation its commitments to (a) prioritise increased domestic investment in health, (b) improve the effectiveness of health spending, (c) strengthen efforts to improve the efficiency of health financing, and to better align (d) development partner and (e) private sector efforts to national, regional and continental priorities?</td>
<td>Is there an up-to-date health financing policy statement guided by goals and based on evidence?</td>
<td></td>
</tr>
<tr>
<td>Governance &amp; Coordination</td>
<td>Head of State / Government has a formal mechanism/structure to (a) improve the quality of collaboration between MoF/MoH and other relevant ministries on health financing reform and (b) to ensure that MoF/MoH jointly coordinate the alignment by partners with national plans and budgets?</td>
<td>Worldwide Governance Indicators (WGI) project indicator: “Government effectiveness index”</td>
<td></td>
</tr>
<tr>
<td>Data Systems</td>
<td>Is health financing information systematically used to monitor, evaluate, and improve policy development and implementation?</td>
<td>World Bank: Statistical Capacity Indicator (SCI) score</td>
<td></td>
</tr>
</tbody>
</table>
### EXAMPLE: SOUTH AFRICA: High-level analysis – Identify 2-3 priority ‘action areas’

<table>
<thead>
<tr>
<th>Objective</th>
<th>Identified ‘Action areas’ and summary high-level analysis</th>
<th>Is this Objective a priority? List all shortlisted ‘action areas’</th>
</tr>
</thead>
</table>
| More money for health                               | **Efficiency**: Wages / salaries consume significant portion of the budget. Opportunities for pooled procurement; Proportion of generic medicines procurement not measured / publicly reported.  
**Effectiveness**: 47% allocated to Primary Health Care  
Govt spending on medicines is low, however 84% of total medicines expenditure is through the private sector. Provides potential area for collaboration with the private sector to use government’s monopsony power to reduce the costs for the end user. | NO                                                                                                           |
| More health for the money                           | **Effectiveness**: 47% allocated to Primary Health Care  
Govt spending on medicines is low, however 84% of total medicines expenditure is through the private sector. Provides potential area for collaboration with the private sector to use government’s monopsony power to reduce the costs for the end user. | YES  • Efficiency  
• Effectiveness                                                                                           |
| Equity                                              | **Equity in Service Coverage**: No data.  
• Not a priority, but consider commissioning an analysis of ‘Equity in Service Coverage’ so that data can be available for future iterations of the Tracker. | NO                                                                                                           |
| Country Leadership & improved coordination          | **Governance & Coordination**  
Outside of the traditional decision-making structures of Government the President could require MoF and MoH to improve their collaboration, particularly in anticipation of the major structural changes anticipated with the imminent passing of the NHI Bill.  
• Establish regular / standing MoF & MoH meeting  
MoF & MoH could begin this collaboration by jointly chairing the development partner coordination forum  
• Opportunity for MoF & MoH to jointly chair the development partner coordination forum  
Much room for improvement on the "Government effectiveness index” | YES  • Governance & Coordination                                                                 |

Tracker process identifies **Efficiency, Effectiveness** and **Governance & Coordination** as priority areas for South Africa to focus on over the next 6-12 months to realise the biggest return on effort.
Health Financing Progress Matrix Country Training

Session 3: AFDB Presentation
22-24 June 2022
Victoria Falls, Zimbabwe
Strategy for Quality
Health Infrastructure in Africa
State of Africa’s Healthcare Systems

The Strategy focuses on areas that match the African Development Bank Group’s comparative advantage, including health infrastructure and building in flexibility to respond to the needs of Bank regional member countries.

The Covid-19 pandemic exposed serious shortcomings in Africa’s national healthcare systems, which are characterized by huge healthcare infrastructure and personnel deficits with high dependence on importation of pharmaceutical and medical supplies.

Africa bears 24% of the global burden of disease, although it is home to only about 15% of the world’s population and accounts for 50% of global deaths from communicable diseases. An estimated $2.4 trillion in annual output is lost due to poor health.

Against a backdrop of large and diverse needs, Africa’s health care infrastructure is underfunded by governments and donors. The estimated $4.5 billion in annual capital expenditure, falls short of the Bank-estimated financing need of $26 billion per year.
Africa’s health system faces serious bottlenecks, especially in terms of infrastructure.

The continent’s average bed density is only 1.3 per 1,000 people, compared to 21 per 1,000 people in Latin America and 6.1 per 1,000 people in Europe.

Thirty-one percent of Africa’s population lives more than 2 hours away from the nearest health facility.

Just half of primary health facilities have access to improved water and sanitation - one-third of primary health facilities have access to reliable electricity.

Only 15% of the African population have access to diagnostic services, and up to 50% of essential diagnostics are inaccurate.

The density of skilled healthcare workers - at only 1.3 per 1,000 people, lags behind World Health Organization minimum target of 2.3 per 1,000 people.
The Governors of the African Development Bank Group at its Annual Meetings in 2020 and reiterated in 2021, acknowledged the critical role of quality healthcare infrastructure for the African continent and requested the Bank to further articulate how to develop its role in this area.

Informed by a robust scoping study, the overall goal of the Bank’s Strategy for Quality Health Infrastructure in Africa is to increase access to quality health services, thus improving quality of life for the people of Africa and driving towards achievement of United Nations Sustainable Development Goal 3 and the African Union Agenda 2063.

The Bank’s strong track record in financing infrastructure strengthens its positioning to intervene in health service delivery infrastructure. As a trusted partner of choice, with convening power, and capacity to leverage the partnerships of other institutions, the Bank can deploy its wide-ranging instruments to provide financing and technical and knowledge advisory services to meet the needs of both public and private sectors in the healthcare space.

“The Bank’s strong track record in financing infrastructure strengthens its positioning to intervene in health service delivery infrastructure.”

Evolution of the Strategy for Quality Health Infrastructure in Africa
How will the Strategy Work

The African Development Bank Group’s Strategy is tightly focused on three categories of health infrastructure that match the Bank’s comparative advantage, while providing the flexibility to respond to the diverse needs of regional member countries.

The strategy also sets out three cross-cutting themes.

First, across all the pillars, the Bank will support innovations in health service delivery such as tele-medicine and digital health solutions.

Second, it will promote regional collaboration on shared health challenges and the harmonisation of health policies and regulations.

Third, all of the Bank’s health infrastructure investments will be packaged with knowledge work, policy dialogue and technical assistance, in partnerships with other health sector actors.

• THE FOCUS WILL BE ON THREE CATEGORIES OF HEALTH INFRASTRUCTURE

Primary healthcare infrastructure for under-served populations
Providing support facilities like connection to water and sanitation, energy, transport, and communications services.

Secondary and tertiary healthcare facilities
Developing new secondary and tertiary health care facilities, alongside specialist facilities for cancer, dialysis, and pain management. These investments will be particularly relevant in countries where the burden of non-communicable diseases is growing rapidly.

Diagnostic infrastructure
Utilizing a range of delivery models, including public-private collaborations to address serious bottlenecks in efficient and effective diagnosis of diseases across the continent.
Voices on healthcare in Africa

“We must give hope to the poor and the vulnerable, by ensuring that every African, regardless of their income level, gets access to quality health care, as well as health insurance and social protection.”

Dr. Akinwumi A. Adesina, President, African Development Bank Group

“Ebola was a signal. We can also look at Covid-19 as an indication that something more severe will come if we do not strengthen our health defences.”

Dr. John Nkengasong, Director, Africa Centres for Disease Control and Prevention

“I welcome the [Bank’s] Strategy, which is very comprehensive, and it is excellent to see that the Bank plans to support and align with national health system strengthening strategies, which are foundational for sustainable development.”

Dr. Lia Tadesse, Minister of Health of Ethiopia

“Covid-19 pandemic had exposed the fragility of health systems and infrastructure deficit in the ECOWAS region. The Ministers of Health in the ECOWAS region appreciate and commend the support and leadership role of their development partners such as the African Development Bank Group in the development of quality health infrastructure across the continent.”

Dr. Jsegie Ehanire, Minister of Health of Nigeria

Contact for more information
Dr. Babatunde Omiola, Public Health, Nutrition and Social Protection Manager
Email: b.omilola@afdb.org
Health Financing Progress Matrix
Country Training

Session 3:
GFF Presentation
22-24 June 2022
Victoria Falls, Zimbabwe
Government led alignment via in-country platform

Political commitment to UHC and PHC by Government which DPs center around

- **Government-led** realistic and costed plan with stakeholder participation and joint ownership.
- **Development partners** commit to aligning with plan and participating in country platform.
- **Government and donors** are transparent and realistic about resource availability, budget allocation, and execution.
- **Development partners** commit to greater use of in-country system (e.g., audit).
- **Clear results framework** against plan consistently used by Government and DPs.
- **Institutionalization of data** systems and processes to provide timely, complete, and reliable data for results tracking.

**AWG pilot in 4 countries, including Ethiopia and Rwanda**
1. HFPM key input into alignment diagnostic and plan

HFPM (and other) assessments

Alignment framework:
Diagnostic, maturity rating and plan

Use existing assessments

HFPM concretely informs, and monitors alignment
2. Contributes to DP instrument alignment, one M&E

.translate recommendations to indicators based on Government priorities.

HF Diagnostic

Select Recommendations
• Provide all PHC for free for anyone
• Make PBF indicators primary health based to increase progress to UHC. (move away from input financing)

Monitoring and Tracking
• MoF: Share of districts’ operational health budget going to PHC?
  
  Illustrative
  • Output-based payment indicator – e.g., DFF to PHC facilities

Operationalizing Recommendations
Donor financing: Credits & Grants

Illustrative
GFF co-financed WB project ‘Quality Essential Health Services and Systems Support Project’

Hub-and-spoke service delivery model to improve EHS quality

• Modify PFM to align Govt. and donor expenditures
• Institutionalize RMET and improve FM at district-level

Use indicators to inform funding or use existing indicators to track

Linking HFPM recommendations to existing indicators

Similar for other donors
Health Financing Progress Matrix
Country Training

Session 3:
WB Presentation
22-24 June 2022
Victoria Falls, Zimbabwe
REFLECTIONS ON HEALTH FINANCING ALIGNMENT EFFORTS IN ZIMBABWE

Discussion/Talking Points

Health Financing Progress Matrix (HFPM) Workshop

Victoria Falls, June 2022
The Government and partners have undertaken important steps to improve efficiency and effectiveness of health sector investments/spending since 2015.

- Zimbabwe's health system has been consistently financed by a mixture of domestic and external funding sources.
- Whilst the share of Government public health financing has been significant, it declined notably in 2019,
  - Economic, climatic and pandemic related shocks post 2018 adversely affected health financing.
  - COVID-19 commitments increased share of allocation to health.
- The current financial crisis and challenging macroeconomic prospects offer limited potential for expanding fiscal space due to slow growth, high debt and high taxation levels.
- Financing of the health sector response is fragmented leading to inefficiencies (HFS 2017, PER 2021).
  - e.g. Facilities draw on multiple financing sources to cover their operational costs.
- In light of the limited fiscal space, emphasis has been placed on improving the allocative and technical efficiency.
STATUS TOWARDS HF ALIGNMENT

- Acknowledgement of Fragmentation and the Need for Alignment
- Existence of Strategic Frameworks and Plans to Support Alignment
- Some Implementation Has Commenced
- Structured Tracking of Progress and Accelerated Implementation Offer Opportunities to Further Strengthen Current Efforts
EFFORTS TOWARDS ALIGNMENT

**Raising Revenue**
- Collective support for innovative mechanisms for revenue generation
- PFM Reforms e.g. Program Based Budgeting
- Health Development Partner Group Platform - Sharing Proposals

**Pooling of Resources**
- Continuation of Existing Pools - HDF to Health Resilience Fund
- Discussions on Virtual Pooling
- PFM Strengthening

**Strategic Purchasing**
- Institutionalizing RBF (including PFM Alignment)
- Integrated Service Delivery Models
- Resource Allocation Formula and EHB Package Building on Evidence

**Cross-Cutting:** NHS and Investment Case, Health Financing Policy and Health Financing Strategy, Health Sector Coordination Framework - (Partner Platforms, Technical Working Groups and Health Sector Working Group) and IC Implementation Matrix

**Expenditure Tracking**
- Data Availability through Annual RMET and periodic NHAs
- Alignment of NHA with RMET Tool
- Inclusion of NHA Module in Poverty, Income, Consumption and Expenditure Tracking Survey
**THERE ARE OPPORTUNITIES!**

- **Prioritisation of HF Reforms**
  - Prioritisation and Investing in the Priority HF Interventions. Build on Sustainable Financing for Health Accelerator (SFHA) Principles

- **Bi-Lateral/Partner Collaborations in HF Technical Assistance**
  - Collaborative planning and investments for support to HF Technical Assistance

- **Periodic Stock-Taking**
  - Institutionalise tracking of progress in implementing Health Financing Reforms. Introduce HFPM and related tools/approaches as part of routine HF TWG business processes.

- **Leverage the Government Led Platforms for HF Alignment**
  - Rally behind the Health Sector Working Group and other platforms to accelerate progress on alignment.
Health Financing Progress Matrix Country Training

Session 3:
SADC Presentation
22-24 June 2022
Victoria Falls, Zimbabwe
Domesticating the ALM in the SADC region

Dr Lamboly Kumboneki
Progress made thus far

**General**
- 2021: SADC Ministers approved the establishment of SADC Regional Hub
- Decision to pilot Tracker in the region
- June 2022: MoU with Global Fund
- 2 consultants recruited

**Tracker**
- SADC led development of Tracker
- Tracker to be piloted in 3 countries: Malawi, South Africa, Zambia
- Next: Country training
- Timeline: Complete by end-September 2022
- Coordinating with WHO on Matrix

**National HF dialogues**
- 2022
  - Malawi – advanced.
  - South Africa – preliminary
  - Zimbabwe – preliminary
- Early 2023 (exploratory)
  - Eswatini, Mauritius, Zambia

**Hubs**
- SADC health financing Hub launch in August 2022
What will SADC Hub do in year 1

- **Convene the SADC regional meeting of MoF & MoH** (May 2023)
- **Convene the SADC regional meeting of senior MoF & MoH officials** (Feb 2023)
- **Provide dedicated coordination and technical support to SADC countries**
  - 2 consultants, 1 coordinating MoH, another coordinating MoF
- **Support national health financing dialogues**
- **Support SADC Member States to pilot the Tracker**
  - Malawi, South Africa and Zambia. Then Eswatini & Zimbabwe
- **Start small. Build capacity. Demonstrate success.**
The Tracker has 2 parts

Tracker: Part 1

- A very **short diagnostic** of questions across **4 themes** that countries can use to **diagnose** which areas of health reform will provide the greatest return on effort.
- The pilot will test **23 questions** and from this, **12-15** will be chosen.

Tracker: Part 2

- A **Resource Pack** of what to do next in the areas identified after conducting the Tracker (Part I).
The Tracker has 2 parts

Tracker: Part 1

• A very short diagnostic of questions across 4 themes that countries can use to diagnose which areas of health reform will provide the greatest return on effort.

• The pilot will test 23 questions and from this, 12-15 will be chosen.

Tracker: Part 2

• A Resource Pack of what to do next in the areas identified after conducting the Tracker (Part I).
The Tracker has 2 parts

Tracker: Part 1

• A very short diagnostic of questions across 4 themes that countries can use to diagnose which areas of health reform will provide the greatest return on effort.

• Emphasis is not on the tool but on the process: MoF & MoH officials jointly diagnosing, prioritising, and figuring out how to start addressing prioritised challenges.

Tracker: Part 2

• A Resource Pack of what to do next in the areas identified after conducting the Tracker (Part I).
1. ‘More money for health’

2. ‘More health for the money’

3. Equity / improved financial protection in health

4. Strengthened country leadership of the health financing agenda and improved coordination
Objectives: What areas does the Tracker suggest the country should focus on?

Objectives

1. ‘More money for health’
2. ‘More health for the money’
3. Equity / improved financial protection in health
4. Country leadership and improved coordination

Action areas

1. Raise: Growing the size of the pie for all sectors
2. Allocate: Budget Prioritisation for Health
4. Efficiency: Tackle main areas of inefficiency within govt health spending
5. Effectiveness: Investing in the right priorities
7. Equity in Service Coverage
8. Equity in Financing
9. Financial protection
10. Country leadership of the health financing agenda
11. Governance & Coordination
12. Strengthened data systems

Where can government realise the biggest return on effort?
Opportunities for collaboration: Year 1

**Tracker:**
- Help review lessons learned from pilot
- Support countries to implement Tracker next steps
- Align work in the region to the framework of the Tracker: More money; More health; equity; country leadership

**National health Financing dialogues:**
- Development partner country focal points invited to be part of country organising teams

**Hubs:**
- Help to build capacity on HF in the hubs
- Help Hubs to take Tracker to scale.

**Work with and through the RECs. Communicate and coordinate.**
MERCI BEAUCOUP
MUIT OBRIGADO
THANK YOU VERY MUCH
12 Tracker ‘action areas’ – across 4 objectives

Objectives

1. ‘More money for health’
2. ‘More health for the money’
3. Equity / improved financial protection in health
4. Country leadership and improved coordination

Action areas

1. **Raise**: Growing the size of the pie for all sectors
2. **Allocate**: Budget Prioritisation for Health
3. **Spend**: Public Financial Management
4. **Efficiency**: Tackle main areas of inefficiency within govt health spending
5. **Effectiveness**: Investing in the right priorities
6. **Measurement & Monitoring**: Are countries using data for decision making
7. **Equity** in Service Coverage
8. **Equity** in Financing
9. **Financial protection**
10. **Country leadership** of the health financing agenda
11. **Governance & Coordination**
12. Strengthened **data systems**