



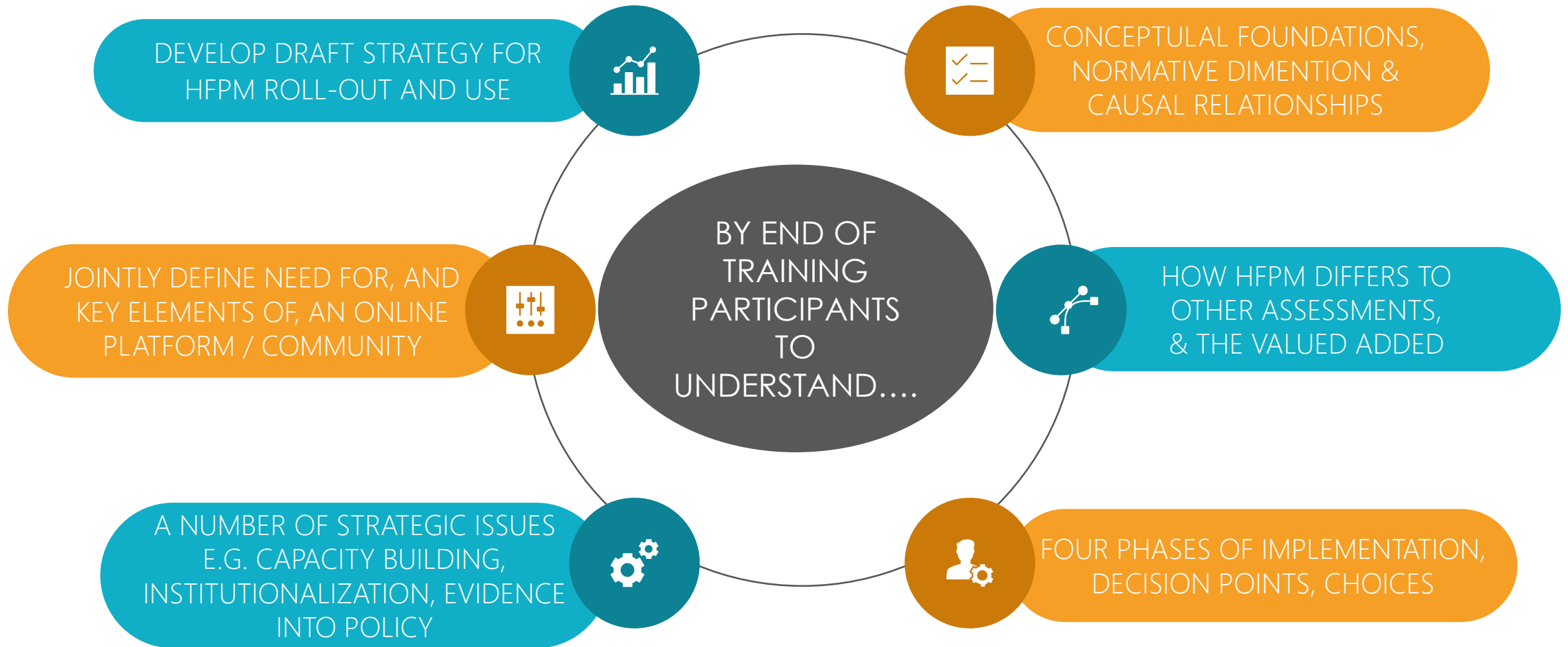
World Health
Organization

Health Financing Progress Matrix Country Training

Session 1:
Meeting objectives &
agenda overview

22-24 June 2022
Victoria Falls, Zimbabwe

OBJECTIVES



AGENDA

GREEN = TECHNICAL FOCUS SESSION

BLUE = IMPLEMENTATION FOCUS SESSION

ORANGE = STRATEGIC FOCUS SESSION

	TIME	WEDNESDAY 22 JUNE	THURSDAY 23 JUNE	FRIDAY 24 JUNE
Session 1	08:30 - 10:00	Security briefing, objectives, agenda OPENING OF THE MEETING	HFPM STAGE 2	INSTITUTIONALIZING HEALTH FINANCING POLICY ANALYSIS: HOW THE HFPM CAN CONTRIBUTE
		INTRODUCING THE HFPM		
	10:00 - 10:30	Tea/coffee break	Tea/coffee break	Tea/coffee break
Session 2	10:30 – 12:00	HFPM STAGE 1 & NHA INTEGRATION	IMPLEMENTATION PHASES 1 & 2	PLENARY DISCUSSION DRAFT COUNTRY STRATEGIES FOR HFPM ROLL-OUT AND USE
			IMPLEMENTATION PHASES 3 & 4	
	12:00 – 13:00	LUNCH	GROUP PHOTO LUNCH	LUNCH
Session 3	13:00 – 14:30	THE HEALTH FINANCING ALIGNMENT AGENDA	HF CAPACITY BUILDING GETTING RESULTS INTO POLICY	SUMMARY OF MEETING DISCUSSION OF OUTSTANDING ISSUES & NEXT STEPS MEETING CLOSURE
	14:30 - 15:00	Tea/coffee break	Tea/coffee break	Tea/coffee break
Session 4	15:00 – 16:30	BREAKOUT GROUPS	BREAKOUT FACILITATED GROUP DISCUSSION	INFORMAL DISCUSSIONS DEPARTURE OF PARTICIPANTS
		GROUP FEEDBACK IN PLENARY	GROUP FEEDBACK IN PLENARY	
		RECEPTION	CLOSING DINNER	

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



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Health Financing Progress Matrix Country Training

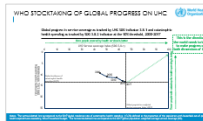
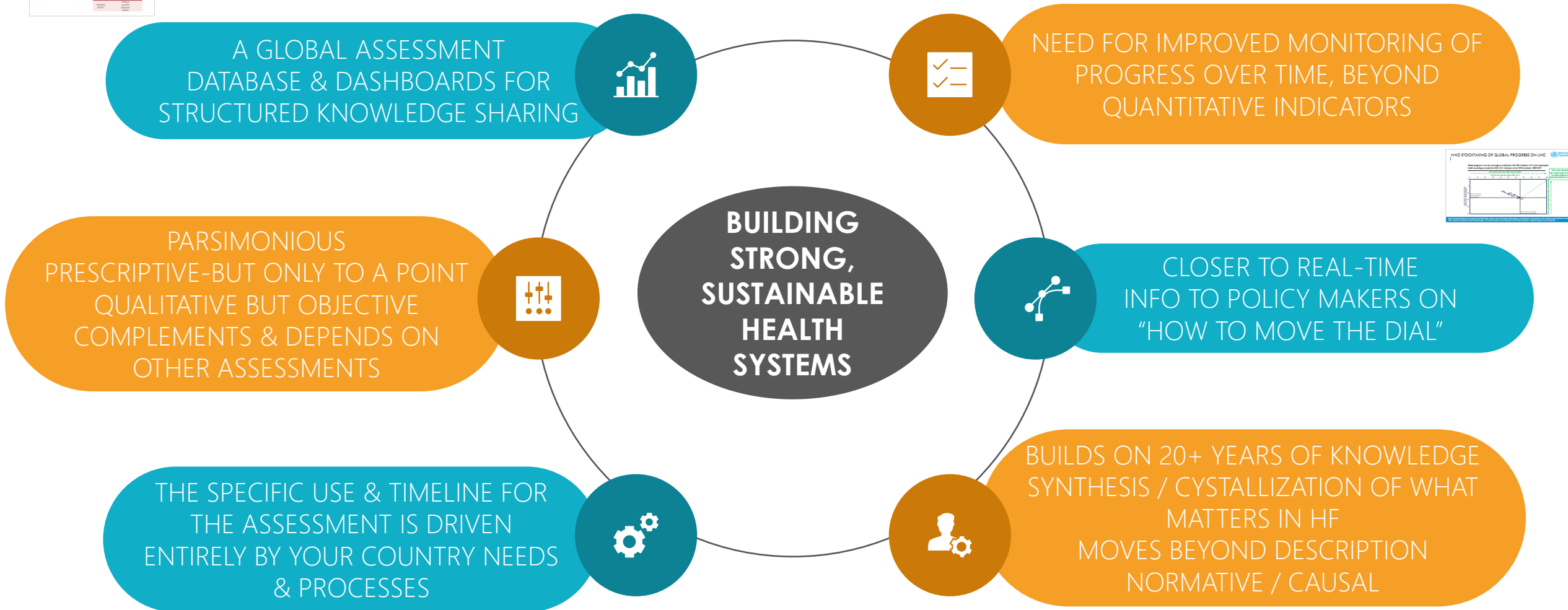
Session 1: Introducing the HFPM

22-24 June 2022
Victoria Falls, Zimbabwe

WHY DEVELOP THE HFPM? WHAT IS DIFFERENT ABOUT IT?

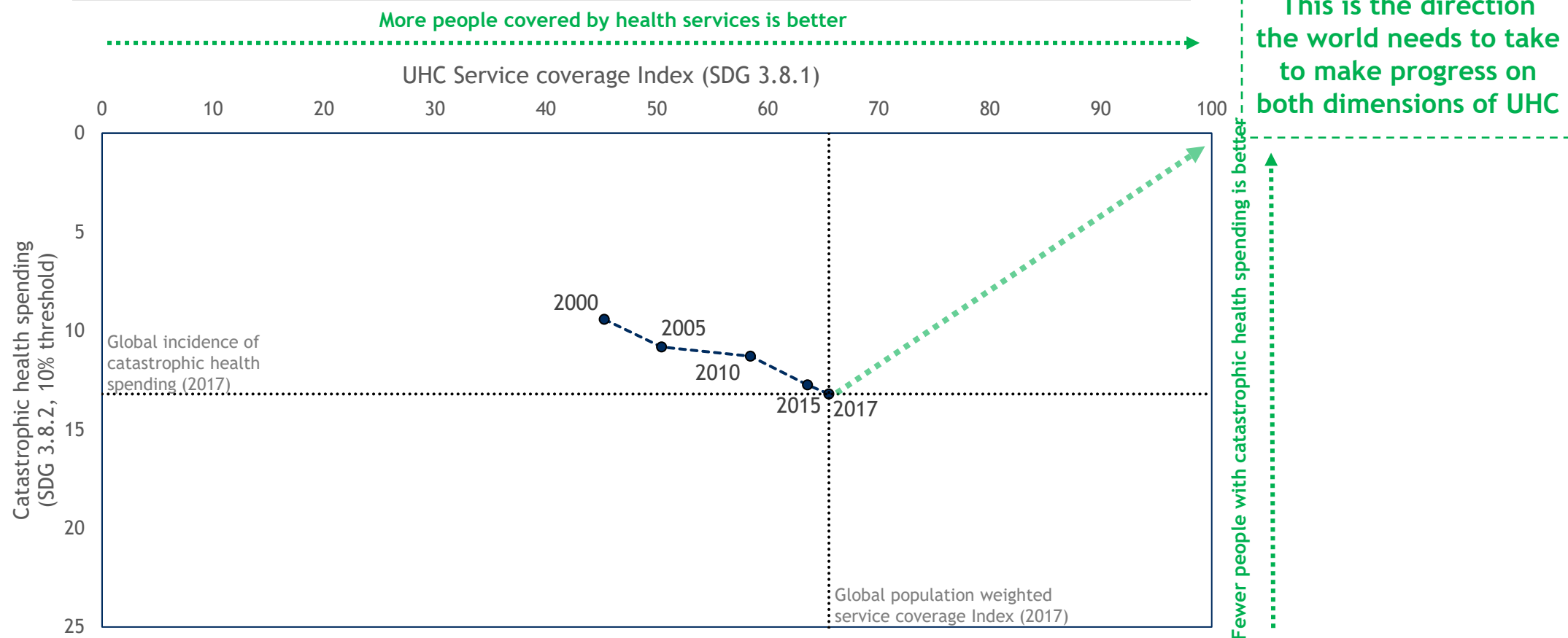
Countries using globally

Region	Country	Year
Africa	Algeria	2018
	Angola	2018
	Botswana	2018
	Kenya	2018
Americas	Argentina	2018
	Brazil	2018
	Chile	2018
	Colombia	2018
Europe	France	2018
	Germany	2018
	Italy	2018
	Spain	2018
South-East Asia	India	2018
	Indonesia	2018
	Malaysia	2018
	Philippines	2018
Western Pacific	China	2018
	Japan	2018
	South Korea	2018
	Taiwan	2018



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

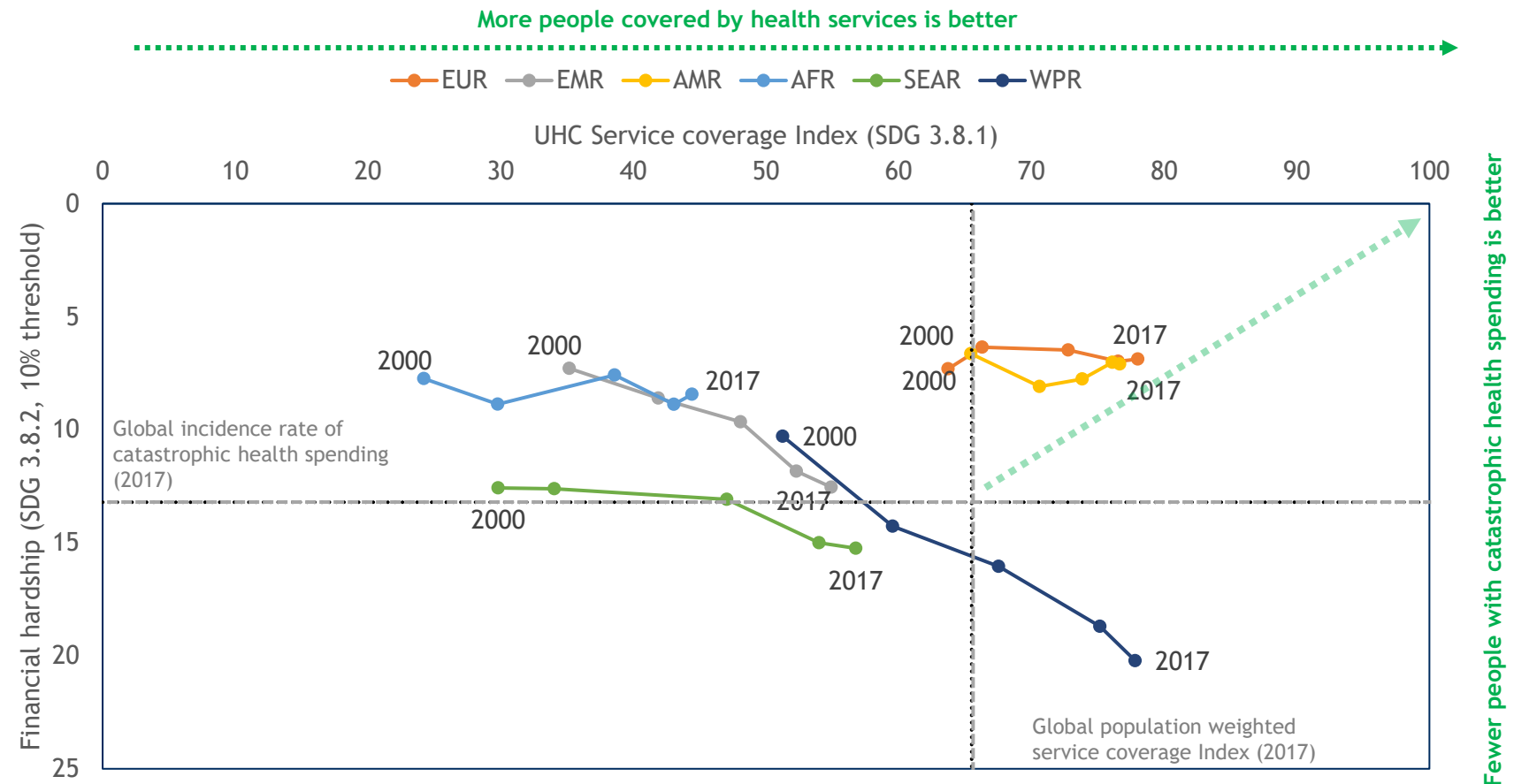


Notes: The vertical dotted line corresponds to the 2017 global incidence rate of catastrophic health spending (13.2%) defined as the proportion of the population with household out-of-pocket health expenditures exceeding 10% of household budget. The horizontal dotted line corresponds to the 2017 global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



UHC PROGRESS IN THE AFRICAN REGION

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



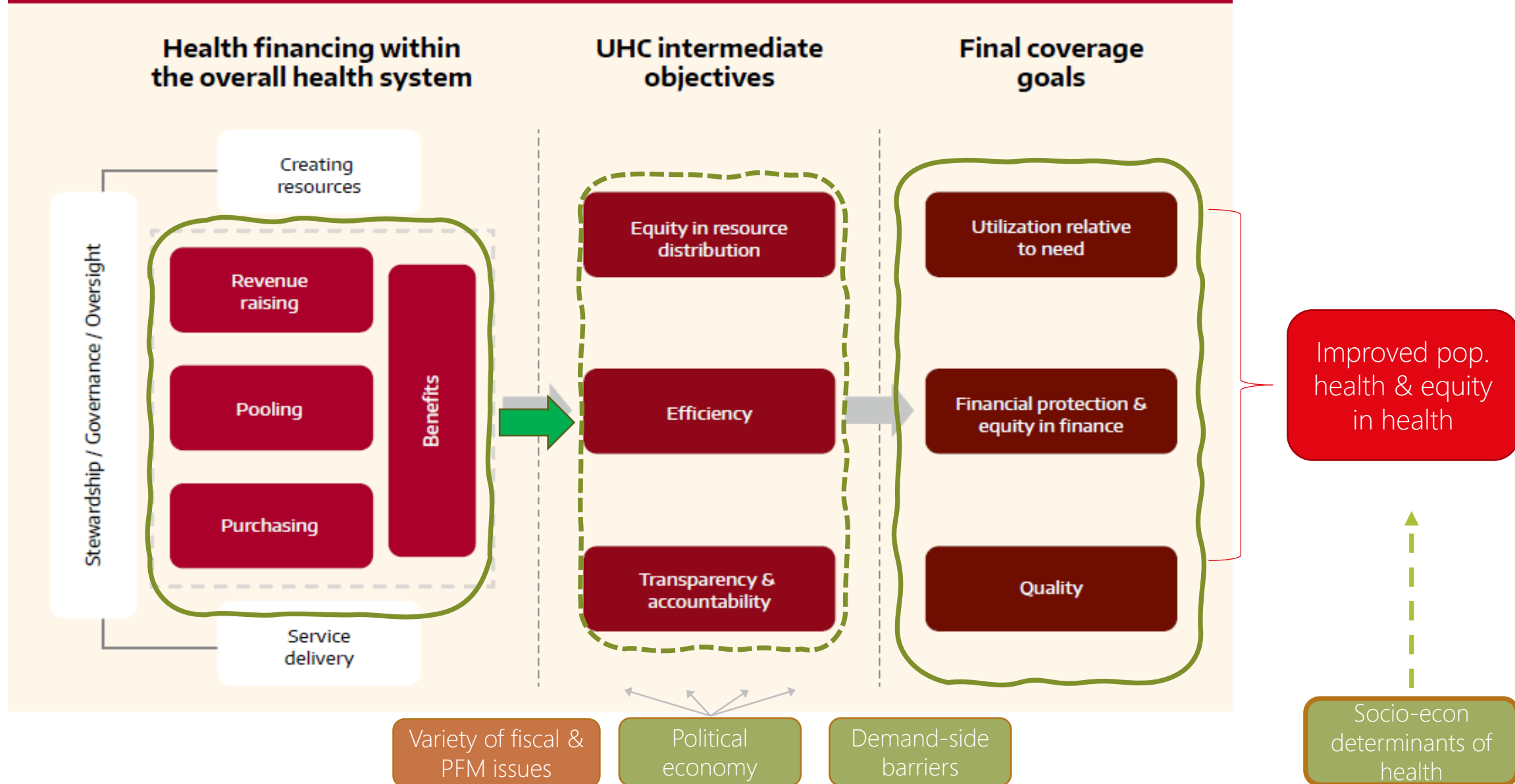
Systematically tracking the implementation of health financing policies can complement, and help to overcome the limitations of, quantitative data



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).

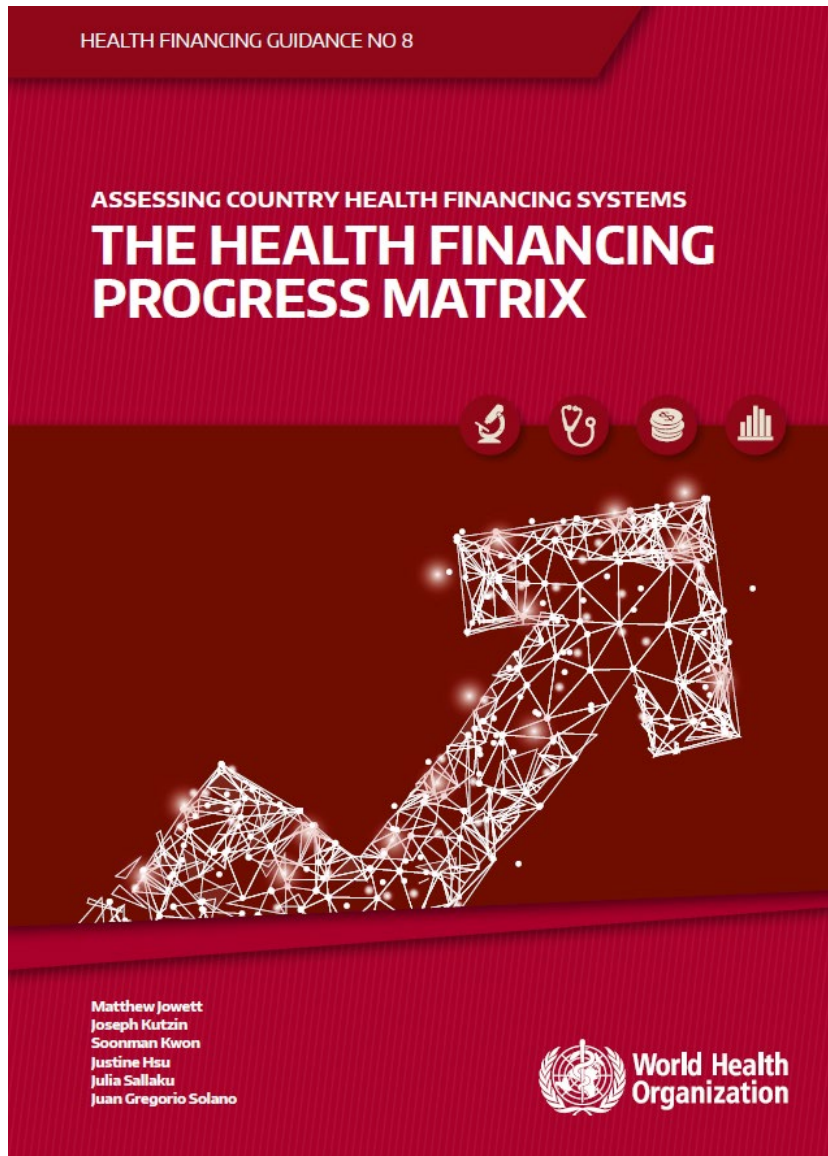
ROOTED IN STRONG CONCEPTUAL FOUNDATIONS

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



THE REALLY NEW PART

DESIRABLE ATTRIBUTES OF HEALTH FINANCING



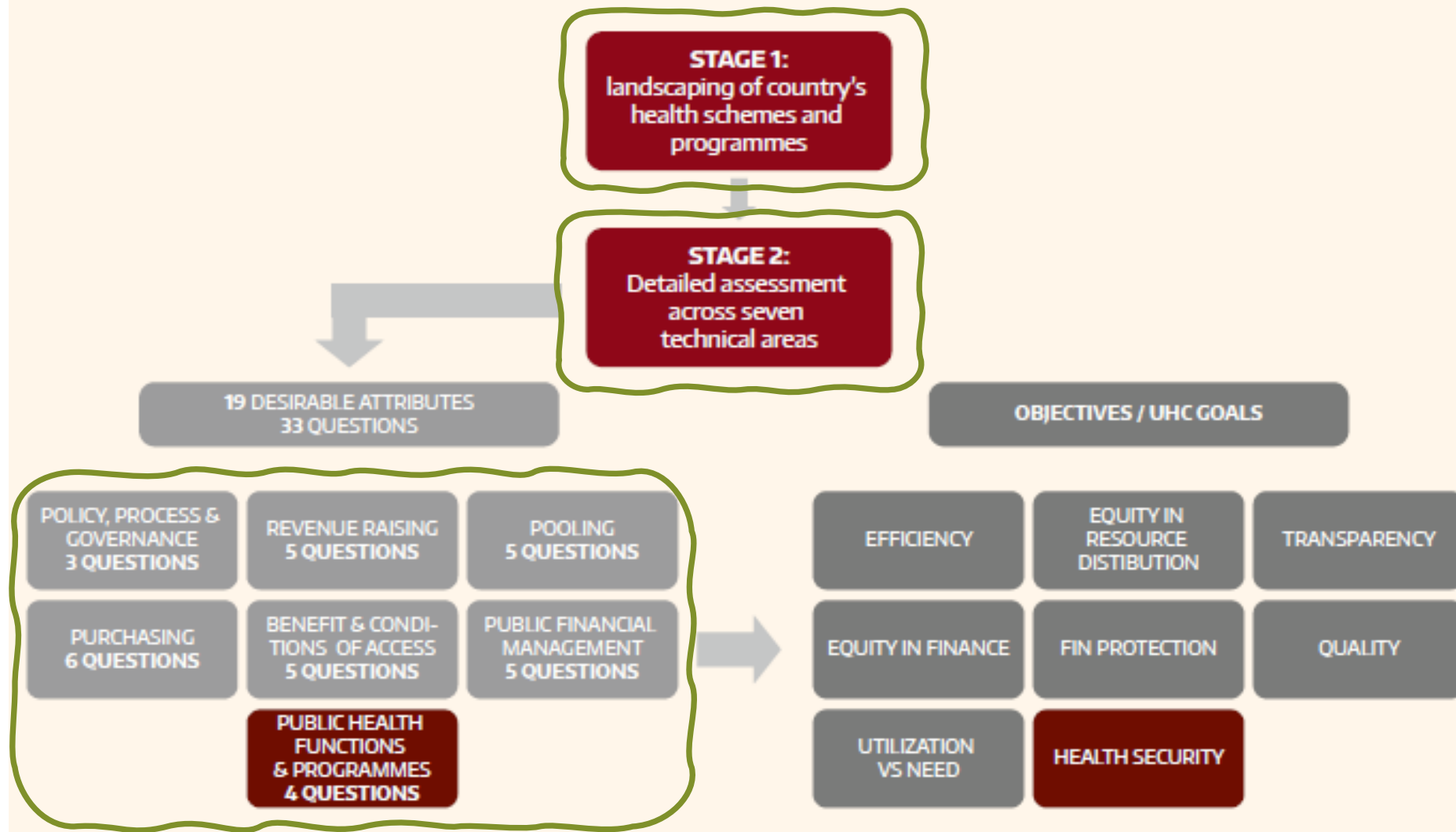
PAGE 5

Table 1: Desirable attributes of health financing systems

Health financing policy, process & governance	GV1	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
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs
Public health functions & programmes ³	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

HFPM ASSESSMENT STRUCTURE

Figure 2: Overview of the HFPM assessment



Countries using globally


WHO REGION	COUNTRY	
AFRICA	Botswana	Mauritania
	Burkina Faso	Mauritius
	Burundi	Mozambique (2023)
	Cameroon	Namibia
	Comoros	Nigeria
	Cote d'Ivoire	Rwanda
	Eswatini	Senegal
	Ethiopia	Sierra Leone
	Ghana	South Africa
	Kenya	Tanzania
	Lesotho	Uganda
	Liberia	Zambia
	Madagascar	Zimbabwe
	Malawi	

WHO REGION	COUNTRY
AMERICAS	Antigua & Barbuda
	Barbados
	Honduras
	Peru
EASTERN MEDITERRANEAN	Bahrain
	Kuwait
	Sudan
EUROPE	Tajikistan
	Georgia
SOUTH-EAST ASIA	Bangladesh
	Bhutan
	India (State level)
	Maldives
	Myanmar
	Nepal
	Sri Lanka
WESTERN PACIFIC	Malaysia
	Lao PDR
	Mongolia
	Vietnam

Database of country assessments

HF PROGRESS MATRIX - COUNTRY ASSESSMENT DATABASE

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World Health Organization

WHO Region

- Select all
- AFR
- AMR
- EMR
- SEAR
- WPR

Income Level

- Select all
- Low
- Low-Mid
- Up-Mid

Go to

- Indicators
- Stage 1
- Sankey
- Stage 2
- Benchmark by question

HEALTH FINANCING PROGRESS MATRIX BY HF FUNCTION

Kenya

Country income group: Low WHO Region: AFR

Functions

- 1. Policy Development Process
- 2. Revenue Raising
- 3. Pooling Revenue
- 4. Purchasing & Provider Payment
- 5. Benefits & Entitlements
- 6. Public Financial Management
- 7. Governance

Go to

- Indicators
- Stage 1
- Stage 2
- Objectives
- Menu

HEALTH FINANCING PROGRESS MATRIX: COUNTRY ASSESSMENTS DATABASE

Country vs Income group average

Q1.1

COUNTRY COMPARISON BY QUESTION

S1 Country view (Stage 1) S2 Country view (Stage 2) Home

World Health Organization

Question code: Q3.4 Description: To what extent are there measures, related to benefit design, provider payment, or non-financial underlying systems, that address problems arising from fragmented pools?

Countries	Principal Investigator Assessment
Afghanistan	Nigeria Sri Lanka Afghanistan Basic package of health services and essential package of hospitals are two explicit packages the government promises to its citizens. Through not explicit every national and specialty hospital provide a range of services. Both BPHS and EPHS providers are paid on a lump sum payment schedule in exchange for achieving certain target output and outcome indicators. The MoPH in collaboration with the World Bank recently decided to make payment to the NGOs on a lump sum and on a fee for service basis for provision of the target services low in utilization. Third party will carefully measure performance against target and verify the reports.
Bangladesh	
Côte d'Ivoire	
Ethiopia	
Ghana	Lao People's Democratic Republic Benefit design, provider payment and information management are not yet harmonized across NHI and NSSF. Once the NHI and NSSF are merged, provider payments will be harmonized based on the NHI's mixed mechanism of capitation and case-based payments (NSSF was capitation only). It is not yet clear whether benefit packages will be standardized or remain differentiated. Having pre-paid, NSSF members will likely remain exempt from the co-payment.
Kenya	
Malaysia	
Mongolia	
Myanmar	Kenya Benefit packages are nominally uniform for budget funded health services (the Kenya Essential Package for Health) and the largest of the SHI schemes have a uniform benefit package (Supa Cover). However, there is evidence to suggest that adherence by service providers to these requirements is
Nepal	
Nigeria	
Pakistan	
Peru	
Sri Lanka	
Uganda	
United Republic of Tanzania	
Zambia	

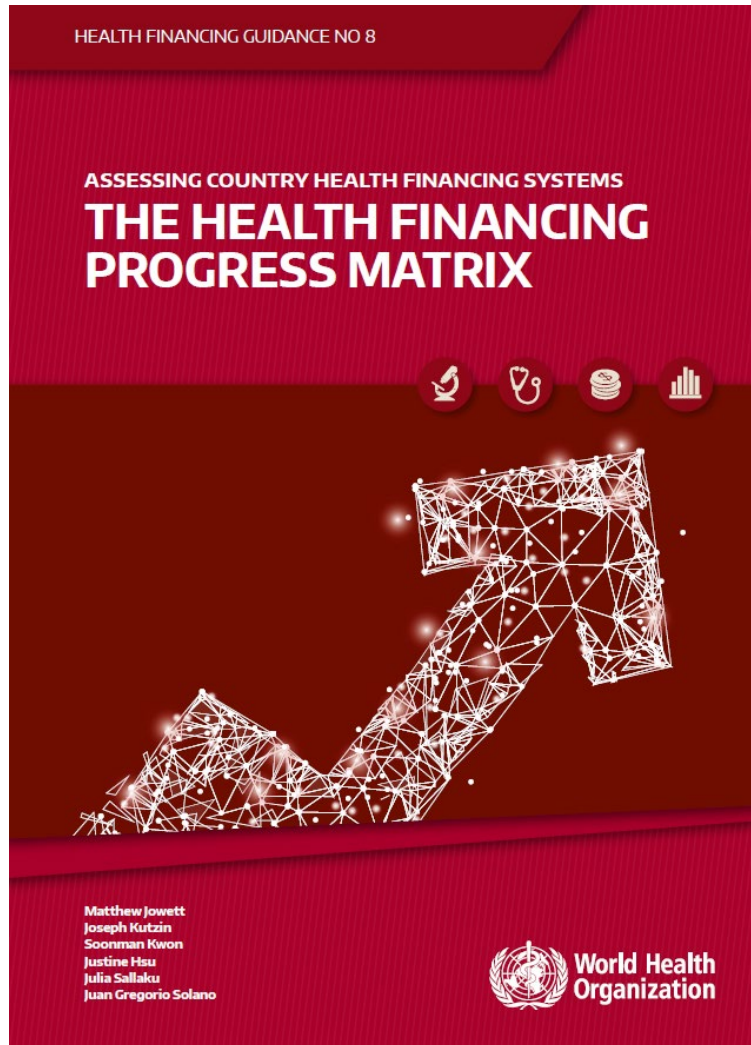
IDEA 1

IDEA 2



The Health Financing Progress Matrix:

Supporting countries to accelerate progress to UHC



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

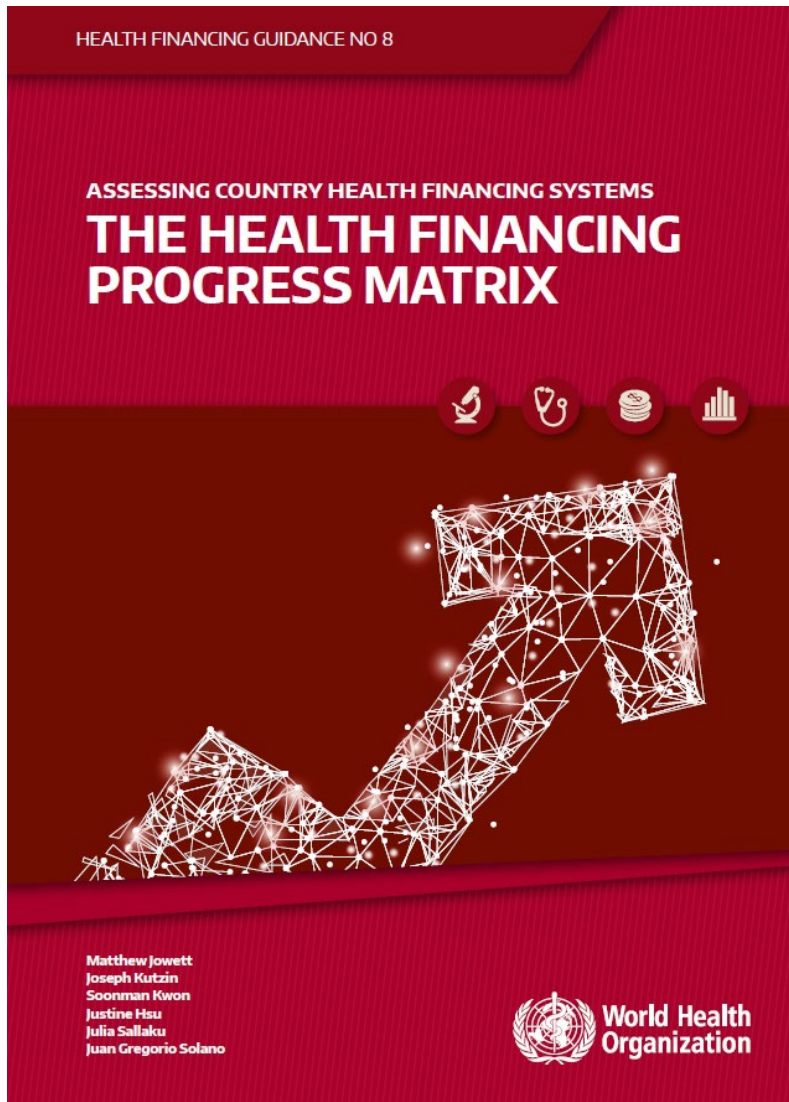


Demand for improved **tracking of country progress in health financing** closer to “real-time”; at least two-year lag on most quantitative indicators



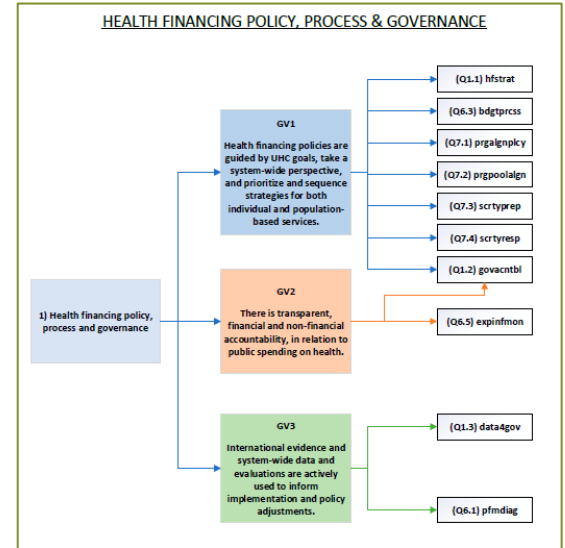
Based on and synthesis of 20-30 years of global evidence of **what works in health financing** to drive progress to UHC

LINKING HF POLICY WITH PERFORMANCE IN THE HFPM



ANNEXES 3, 4, 5
QUESTIONS BY
DESIRABLE
ATTRIBUTE

ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
1) HEALTH FINANCING POLICY, PROCESS & GOVERNANCE	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.	GV1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?	hfsrstr	Q11
			Are health financing agencies held accountable through appropriate governance arrangements and processes?	govacntbl	Q12
			Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?	bdgtprcss	Q6.3
			Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?	prgpalnply	Q7.1
			Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?	prgpoolaln	Q7.2
	There is transparent, financial and non-financial accountability, in relation to public spending on health.	GV2	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?	scrtyprep	Q7.3
			Are public financial management systems in place to enable a timely response to public health emergencies?	scrtypesp	Q7.4
			Are health financing agencies held accountable through appropriate governance arrangements and processes?	govacntbl	Q12
	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments.	GV3	Is health expenditure reporting comprehensive, timely, and publicly available?	expinfmon	Q6.5
			Is health financing information systematically used to monitor, evaluate and improve policy development and implementation?	data4gov	Q13
			Is there an up-to-date assessment of key public financial management bottlenecks in health?	pfmdiag	Q6.1



OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
EQUITY IN RESOURCE DISTRIBUTION	Q31	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q32	redistim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q33	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q34	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q35	vhspill	What is the role and scale of voluntary health insurance in financing health care?
	Q41	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q42	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q45	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q62	pfmallocty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q32	redistim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
EFFICIENCY	Q33	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q34	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q35	vhspill	What is the role and scale of voluntary health insurance in financing health care?
	Q42	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q44	pfmoeff	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q45	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q46	prvdauton	To what extent do providers have financial autonomy and are held accountable?
	Q61	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q64	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q71	prgpalnply	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q72	prgpoolaln	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
FINANCIAL PROTECTION	Q21	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q23	stable	How stable is the flow of public funds to health providers?
	Q24	prgrsv	To what extent are the different revenue sources raised in a progressive way?
	Q31	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q32	redistim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q33	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q34	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q35	vhspill	What is the role and scale of voluntary health insurance in financing health care?
	Q51	benepxct	Is there a set of explicitly defined benefits for the entire population?
	Q52	benundrtd	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
EQUITY IN FINANCE	Q54	copyvdgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q55	benrevlgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q43	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q23	stable	How stable is the flow of public funds to health providers?
	Q24	prgrsv	To what extent are the different revenue sources raised in a progressive way?
	Q33	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q35	vhspill	What is the role and scale of voluntary health insurance in financing health care?
	Q51	benepxct	Is there a set of explicitly defined benefits for the entire population?
	Q54	copyvdgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q43	ppmldrd	Do purchasing arrangements promote quality of care?
QUALITY	Q45	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q46	prvdauton	To what extent do providers have financial autonomy and are held accountable?
HEALTH SECURITY	Q32	redistim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q46	prvdauton	To what extent do providers have financial autonomy and are held accountable?
	Q62	pfmallocty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q71	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q74	scrtypesp	Are public financial management systems in place to enable a timely response to public health emergencies?



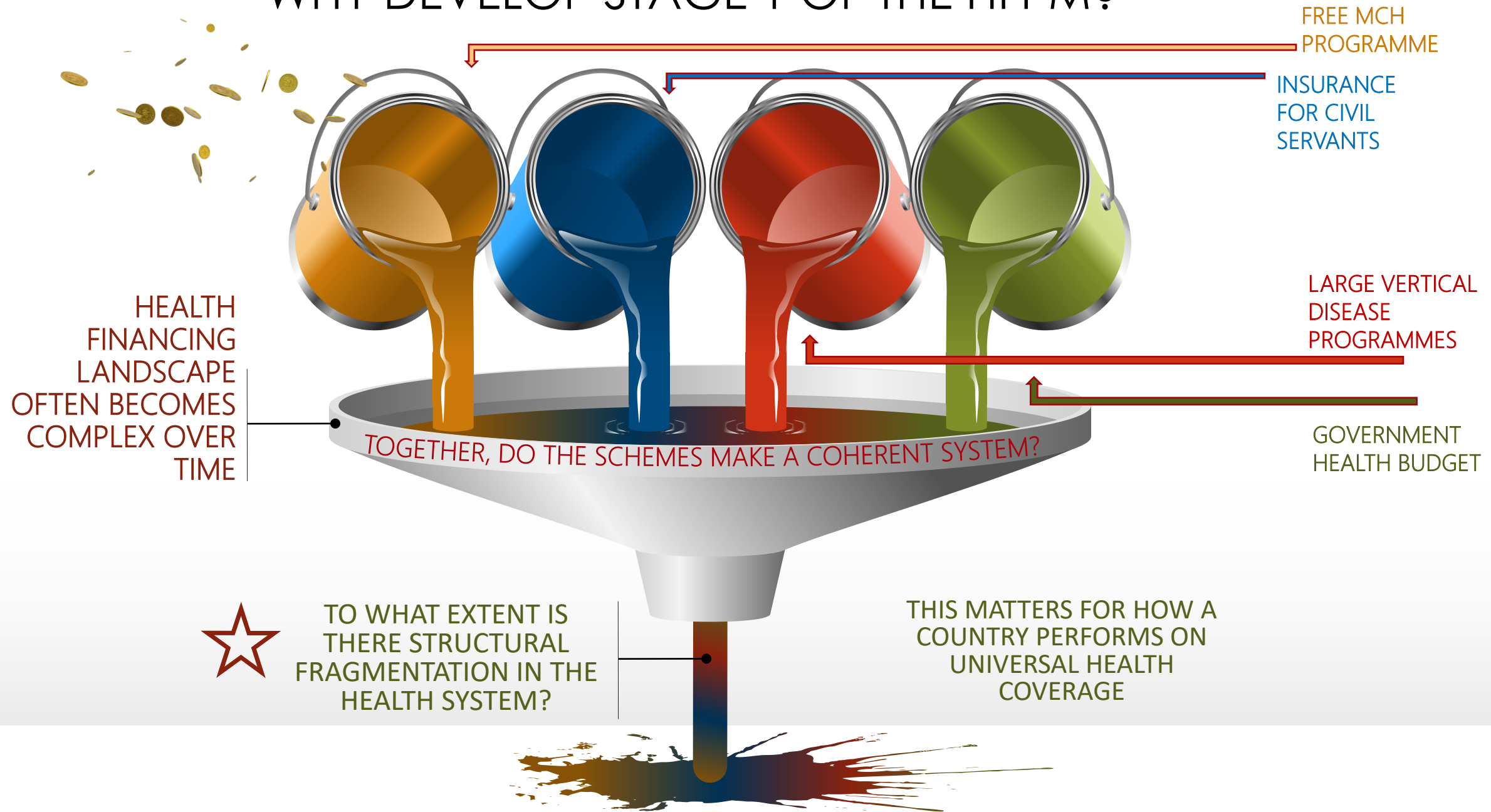
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Health Financing Progress Matrix Country Training

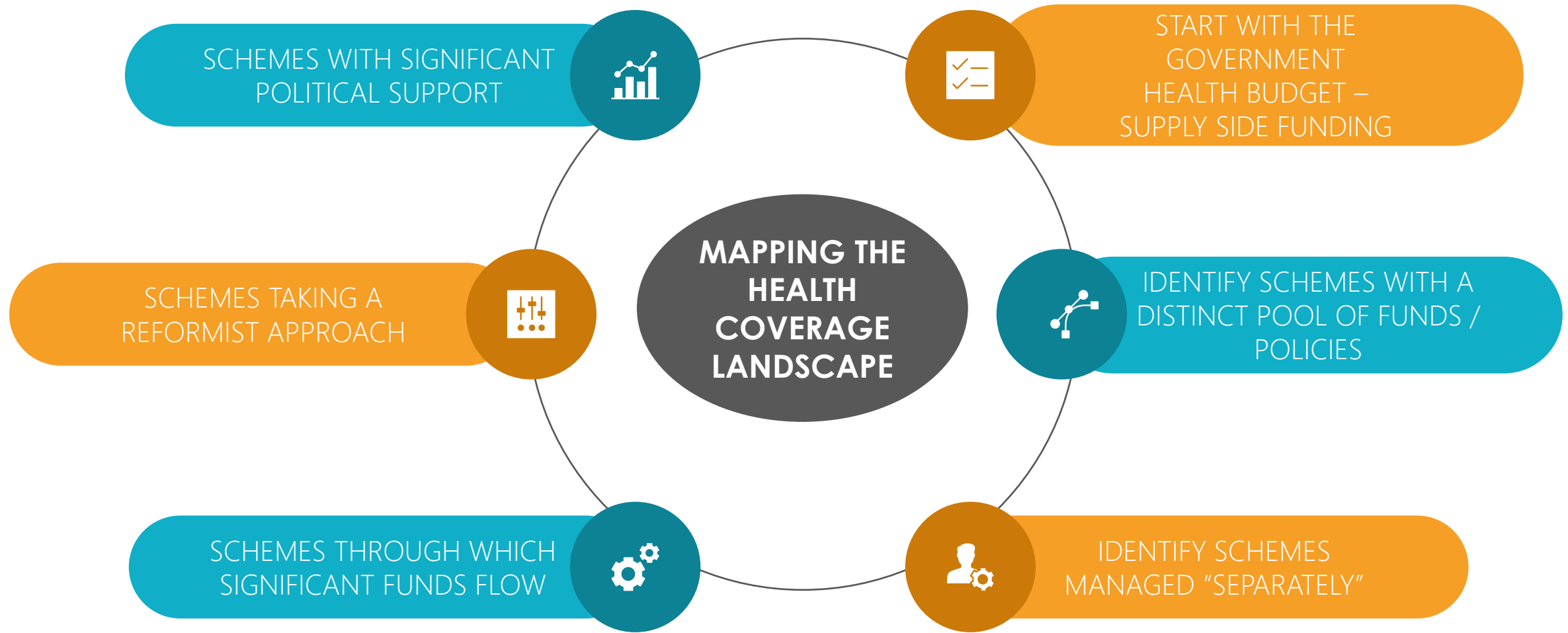
Session 2:
HFPM Stage 1 & NHA data integration

22-24 June 2022
Victoria Falls, Zimbabwe

WHY DEVELOP STAGE 1 OF THE HFPM?

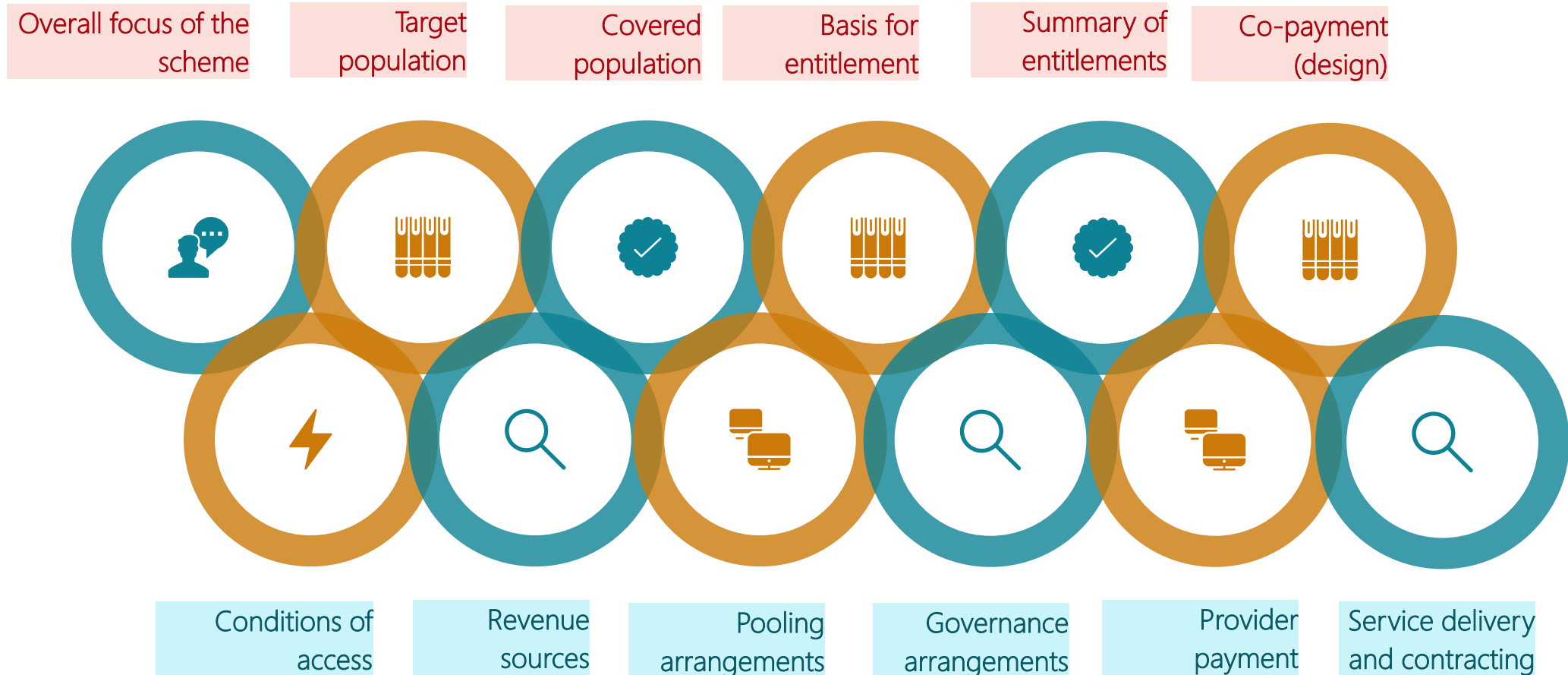


CRITERIA FOR INCLUSION IN STAGE 1





DESCRIBING THE KEY DESIGN ELEMENTS OF EACH SCHEME



DROP-DOWN CODING

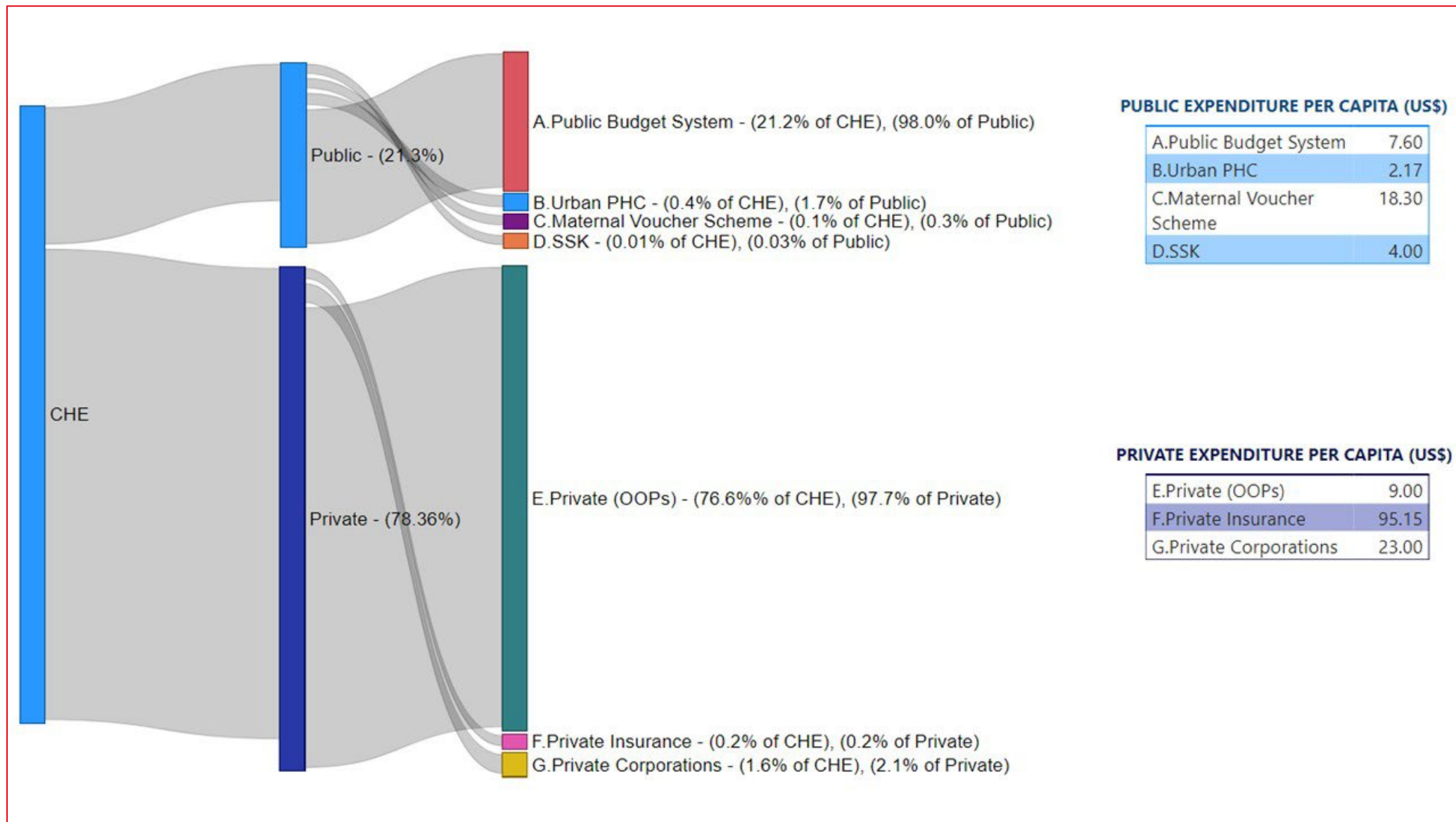
BANGLADESH STAGE 1

STAGE 1: HEALTH COVERAGE SCHEMES IN BANGLADESH: HEALTH FINANCING ARRANGEMENTS

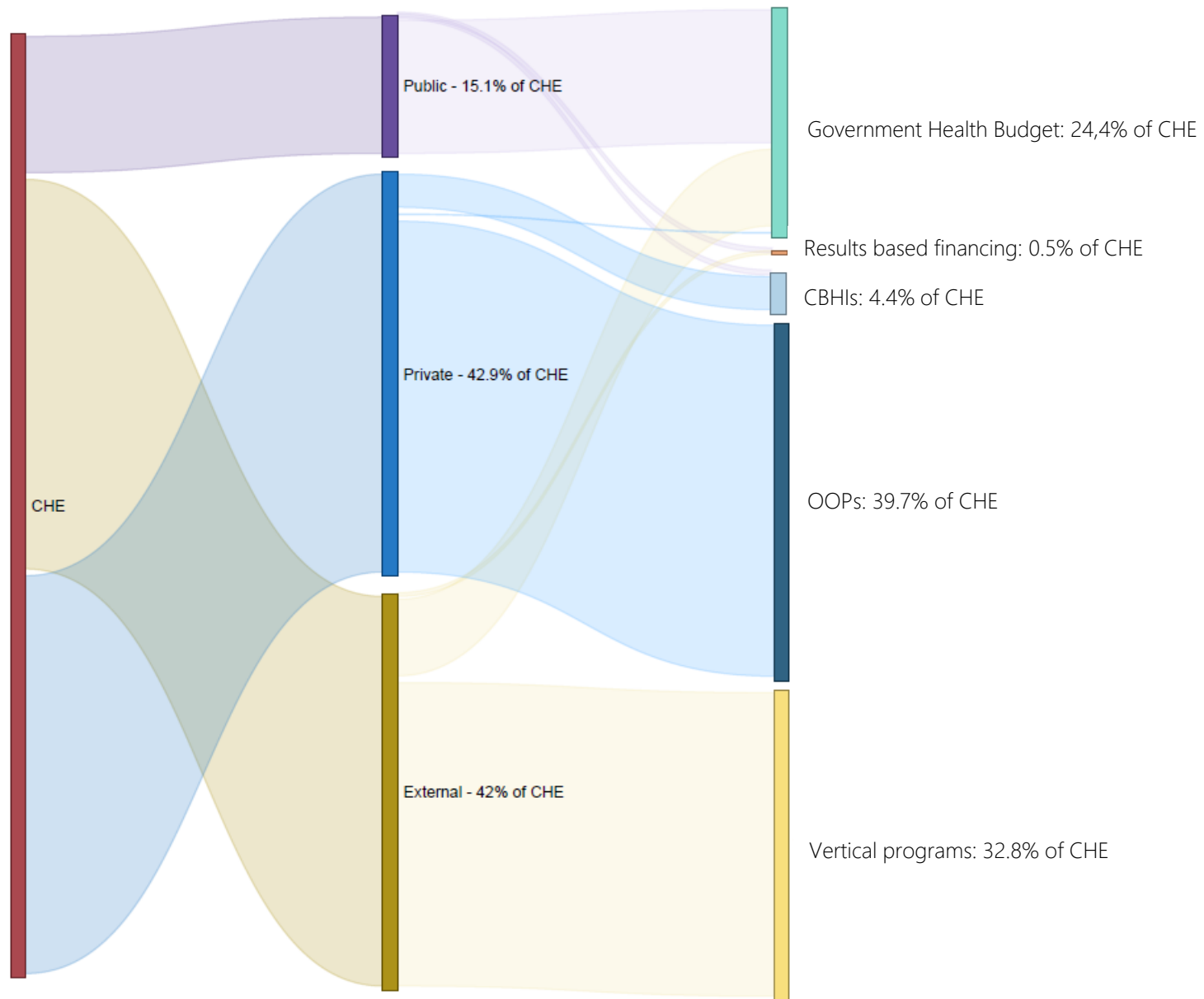
CRITERIA	PUBLIC SYSTEM	URBAN PRIMARY HEALTH CARE	MATERNAL VOUCHER SCHEME	SHASTHAYA SUROKKHA KARMOSHUCHI (SSK)	PRIVATE INSURANCE	CORPORATIONS, AUTONOMOUS BODIES AND PRIVATE COMPANIES	PRIVATE SECTOR
TARGET POPULATION Are all citizens covered, or a specific subgroup e.g. under 5s, salaried workers?	All citizens of Bangladesh are entitled to access public health facilities.	Urban citizens of Bangladesh in 10 city corporations and 4 municipalities, particularly targeting the poor, women and children.	Poor (as per defined poverty criteria) pregnant women of 55 sub-districts having no more than two children.	Households below poverty line in three sub-districts under a pilot scheme.	Any person can join a private insurance scheme. Sometimes employees join private insurance schemes under group insurance.	Employees of corporations, autonomous bodies and private companies	All citizens of Bangladesh are free to seek care from the private facilities (both for profit and for non-profit organizations).
POPULATION COVERED/ENROLLED Actual numbers relative to target pop.	Around 15.22% of population who need health services, receive those from public system.	10 million urban populations in the catchment areas.	201,000 pregnant women.	80,000 households in three sub-districts.	Less than 1% of population.	Less than 1% of population	Around 83.69 % population who need health services, receive those from the private sector.
BASIS FOR COVERAGE/ENROLMENT E.g. mandatory, automatic, voluntary	Automatic	Automatic	Conditional	Automatic	Mostly voluntary. In few cases, employees join mandatory private insurance schemes.	Automatic for employees (voluntary choice of particular enterprise/corporation)	Voluntary
BENEFITS / ENTITLEMENTS Is a list of services, or level of care defined? Do users have to make co-payments?	An 'Essential Service Package (ESP)' (mostly primary health care) comprised of 234 interventions has been developed and is being delivered through primary and secondary level facilities in both rural and urban areas. Besides, public facilities are delivering other non-ESP services through secondary and tertiary level hospitals. Services are being delivered through nominal user fees.	Essential services focusing maternal, neonatal, child and adolescent health, family planning services, reproductive health care, nutrition services, communicable and non-communicable disease control, behavior change and communication, diagnostic and emergency transportation services. Services are provided through user fees, however, the poor, ultra-poor and at-risk population receive services at free of cost.	Three antenatal visits, one visit for post natal care, safe delivery, treatment of complications including C-section; and blood and urinary laboratory tests at free of cost. Cash transfer for safe delivery, transportation reimbursement and incentives for newborn child.	Inpatient services for 78 diseases including necessary medicines, diagnostics and transport costs. Scheme cover benefits up to BDT 50,000 (USD 595) per household per year.	All types of primary, secondary and tertiary level services according to insurance policies. Users sometimes pay co-payment as per insurance policies.	All types of services. Services provided or financed by enterprises.	All type of primary, secondary and tertiary level services.
REVENUE SOURCES Where does the money come from? Budget allocations / transfers; pre-paid contributions.	• Budget allocations from government revenue (USD 1229 million or 94% of public spending on health went to this scheme in 2015) • External / donor funds	• Government revenue • External/development partners' loans and grants (USD 21.65 million or 1.7% of public spending on health went to this scheme in 2015) • User fees	• Government's development budget • Development Partners' fund.	• Government's budget	Funds for employers contribution and premium.	Funds from employers	Out of pocket payment. Is the main source of profit organizations. Most non-profit organizations receive external funds to provide subsidized services to service users.
POOLING ARRANGEMENTS Is the health budget allocated to regional authorities, is there a single or multiple "insurance" funds?	• Government budget and external funds are pooled centrally under a sector wide programme. • Procurement and purchasing mostly take place centrally. • Districts receive funds that cover salary-inputs and other inputs that are not procured or purchased centrally.	Single pool managed by the Ministry of Local Government and Rural Development Co-operatives (MOLGRDC).	Single pool managed by MOHFW.	• Government Pays BDT 1000 (USD 12) as premium on behalf of enrolled households. • Single pool managed by the MOHFW.	Separate insurance companies make their own pooling arrangements.	At individual enterprise level	No pooling mechanism.
PURCHASING ARRANGEMENTS Describe the management and governance arrangements?	• There is no purchaser-provider split. • Ministry of Health and Family Welfare is responsible for providing primary health services in rural areas and secondary and tertiary level services across the country.	• There is provider purchaser split. • A Project Management Unit under MOLGRDC play the role of purchaser. • MOLGRDC contract out NGOs through competitive bidding process to provide services. • The Health Department of the City Corporations and selected municipalities are the implementing agencies in their respective project areas through a Project Implementation Unit (PIU).	• MOHFW plays role of both purchaser and providers. In addition, MOHFW also purchase services from the private sector. • National Demand Side Financing (DSF) Committee chaired by Minister of MOHFW is responsible for the policy direction and DSF implementation committee chaired by secretary is responsible for the management of maternal voucher scheme.	There is no purchaser provider split. MOHFW is responsible for providing inpatient services through its facilities.	Users choose the providers by themselves. 2.2	Firms are responsible for making purchasing arrangement	Individual private organizations purchase for their organizations. Government regulates the private sector for ensuring quality and controlling prices, as well oversee the compliances of the facilities with the existing regulations.
PROVIDER PAYMENT E.g. inputs through budget line items; fee-for service, case payment, capitation, performance-based.	Input-based line item budgets.	Inputs based line item & fee for services	Inputs based line items for public providers and providers and admin staff receive pre-determined financial incentives per service category.	Simplified DRG to the hospitals for reimbursing investigation and medicine cost and health care providers receive fixed salary through line item budget.	Fee for services.	• fixed salary • Fee for services	Fee for service.
SERVICE DELIVERY & CONTRACTING Which providers are services purchased from? Public, private? Are contracts / services agreements used?	• Services are delivered mostly through public facilities. • Non-profit organizations are contracted out to provide services on TB, malaria and AIDS in both rural and urban areas.	MOLGRDC contract out the NGOs to provide primary health care.	• Services are delivered mostly through public facilities. • Beneficiaries as well may receive services from accredited NGOs and private clinics.	Services are delivered through public facilities.	In most cases, service users have freedom to purchase from any public and private facility and claim to insurance company.	Sometimes firms provide services through their own facilities. In other cases users choose the providers by themselves	Private providers are purchased. However, health personnel, particularly doctors from public system are contracted out to provide private services.
SIZE OF THE SCHEME IN MONETARY TERMS	HF.1.1.1 USD 1229 million or 21.2 % of total health expenditure (94% of public spending) (Bangladesh National Health Accounts 2015)	HF.1.1.1 USD 21.65 million or 0.4% of total health expenditure (1.7% public health spending) (Bangladesh National Health Accounts 2015)	HF.1.1.1 USD 3.66 million or 0.06% of total health expenditure (0.27% of public spending) (Administrative data 2015)	HF.1.1.1 USD 0.32 million or 0.0% of total health expenditure (HEU 2018)	HF.3.2.3 USD 9.0 million or 0.15% of Total health expenditure (Bangladesh National Health Accounts 2015)	HF.2.3 USD 95.15 million or 1.6% of total health expenditure (Bangladesh National Health Accounts 2015)	

BANGLADESH STAGE 1

with expenditure flows from NHA



HEALTH EXPENDITURE BY STAGE 1 COVERAGE SCHEMES - UGANDA



PAKISTAN STAGE 1

Identifying fragmentation

CRITERIA	PUBLIC SYSTEM (Federal and State budgets)	PRIME MINISTER NATIONAL HEALTH PROGRAM	SEHAT SAHULAT PROGRAM (KHYBER PAKHTUNKHWA SOCIAL HEALTH PROTECTION INITIATIVE)	SOCIAL HEALTH PROTECTION INITIATIVE GILGIT BALTISTAN	EMPLOYEES SOCIAL SECURITY INSTITUTION (ESSI)	Armed Forces
Benefits / entitlements covered	Vaccinations Public health programs <u>Subsidised care</u> - primary, secondary and tertiary, depending on the level of facility (basic health unit, rural health center, district headquarter 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 <i>Priority diseases</i> 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. <i>Additional benefits</i> 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 240,000/household/year 2. Tertiary care (priority disease): PKR 300,000/household/year <i>Priority diseases</i> 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) b. Radiotherapy (Day care or hospitalization) c. Medical and Surgical management requiring hospitalization 5. HCV & HBV Complications 6. Organ failure management 7. <u>Cerebro-Vascular Accidents</u> (CVA) <i>Additional benefits</i>	Cashless indoor healthcare 1. Secondary care: PKR 25,000/person/household/ year & 175,000/household/year 2. Tertiary care not provided and no priority diseases <i>Additional benefits</i> 1. Ambulance/transportation: PKR 1000.00 2. Medication: Five days medicine at time of discharge. 3. Day-care surgeries are covered <i>Limit beyond coverage:</i> Nil	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

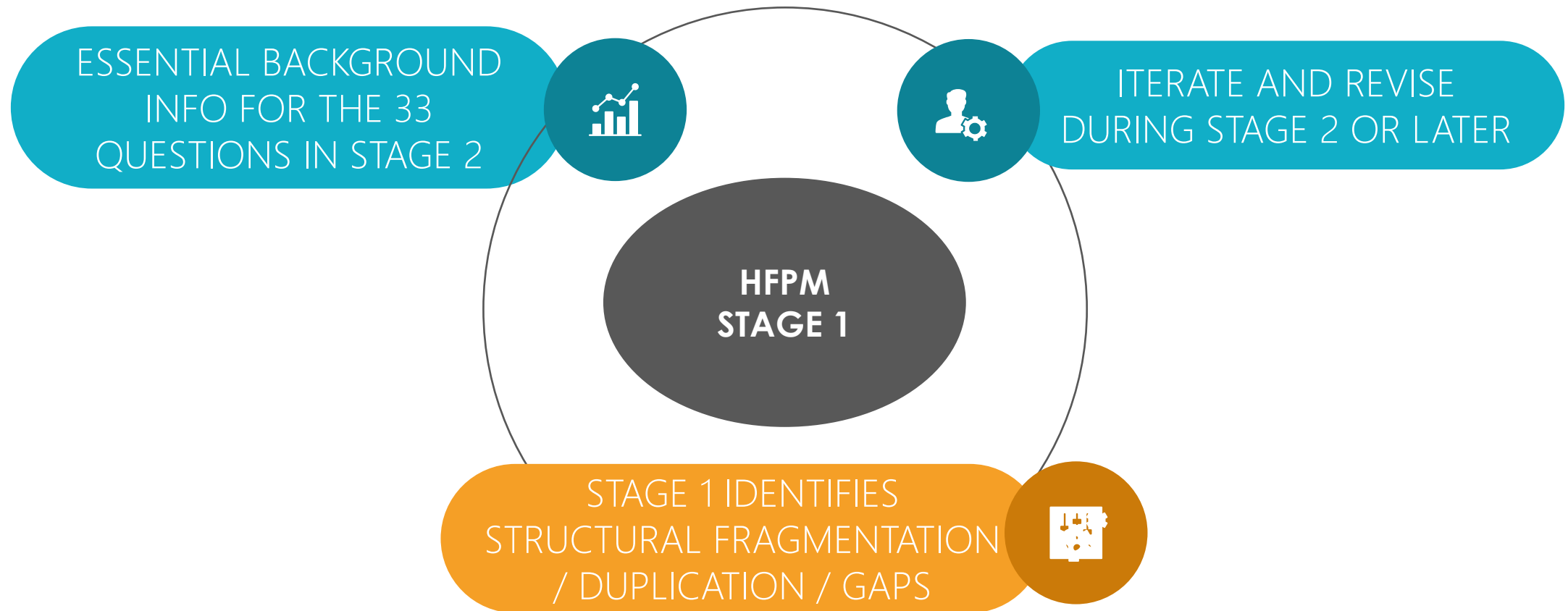
KEY DESIGN FEATURE	National Social Security Fund (NSSF)	Health Equity Fund (HEF)	Government of Cambodia Health Budget	Vertical health services for HIV/AIDS, TB, and malaria
YEAR ESTABLISHED	2008	Before 2000	Not applicable	Select an option
A) FOCUS OF THE SCHEME	Focus on private sector employees and some civil servants (e.g. retired or veterans)	Demand-side financing mechanism designed to increase financial protection for the poor	<p>Provide health services to Cambodians through the HEF scheme, and to invest in public health infrastructure.</p> <p>In 2017, the government spent 1.4 percent of GDP or 6.1 percent of the government's general expenditure on health, which is one of the lowest general government health spending shares in the region.</p> <p>The growth in government expenditure on health in the past has been largely driven by economic growth. However, Cambodia's strong economic growth is not being translated into commensurate public investments in health.</p>	<p>Highly dependent on donor-funding and not all of is channeled through the government budget but finances health providers (like CSOs).</p> <p>Includes PHC services such as nutrition, HIV/AIDS, TB, Malaria.</p>
CODE A1	Employment status (salaried)	Low income (below poverty line)	Population sub-group (e.g. under 5s)	Universal (all citizens)
B) TARGET POPULATION	<p>About 10 percent of the total population: employees in private sector enterprises (1.3 million); employees in public sector, public pensioners, and veterans (315,000)</p> <p>In 2018, coverage for retired or veteran civil servants was added to the scheme</p>	<p>Poorest 1/5th of the population; About 15 percent of the total population, including: IDPoor (2.5 million); poor persons identified in hospital; coverage of vulnerable households, including the elderly, disabled, children under five is under consideration</p>	Through HEF, the government budget targets the poorest 1/5th of the population.	Cambodian citizens (target populations may vary by donor depending on their target consumers of interest, target geographies, etc.)

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."

FINAL POINTS





World Health
Organization

Health Financing Progress Matrix Country Training

Session 2:
Sierra Leone Presentation

22-24 June 2022
Victoria Falls, Zimbabwe

HFPM

Sierra Leone's Experiences

Dr Abdul Jibril Njai

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

KEY DESIGN FEATURE	GOSL HEALTH BUDGET	FHC INITIATIVE	VERTICAL DISEASE PROGRAMS
A) FOCUS OF THE SCHEME	Provide Essential Health services to all the people of Sierra Leone	To reduce high burden of maternal and child mortality by providing free essential services to all the target population	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.
B) TARGET POPULATION	General Population	Under 5 children, Pregnant and Lactating women	People infected with the diseases
C) POPULATION COVERED	Not clear	Target population of Pregnant and lactating women and under 5 children	People diagnosed with the diseases

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



World Health
Organization

Health Financing Progress Matrix Country Training

Session 2: Georgia Presentation

22-24 June 2022
Victoria Falls, Zimbabwe



THE HEALTH FINANCING

PROGRESS MATRIX

COUNTRY ASSESSMENT GUIDE

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

Rationale
Largest programme (both in budgetary volume and scope)

Rationale
Relevant today, could become challenging financially

Rationale
Controversial, donor-state mixed budget

Rationale
Changes through history, source of inefficiencies

KEY DESIGN FEATURE	Universal Health Care Programme (UHCP)	COVID-19 Management Programme	Hepatitis C Elimination Programme	Private insurance
YEAR ESTABLISHED	2013	2020	2015	Not applicable
A) FOCUS OF THE SCHEME	<p>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.</p> <p>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.</p>	<p>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.</p>	<p>What are we missing here?</p> 	<p>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.</p> <p>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.</p>

Thought process: budgetary information

	2021 budget	%
Healthcare budget	1 498 582 000	
Total Universal Health Coverage Program (UHCP)	800 000 000	53%
Total vertical programmes* (includes only program costs)	651 235 000	43%
<i>diabetes program</i>	16 000 000	2,5%
<i>maternal and child health programme</i>	8 000 000	1,2%
<i>immunization</i>	27 958 000	4,3%
<i>TB care</i>	17 159 000	2,6%
<i>mental health care</i>	28 900 000	4,4%
<i>HIV</i>	14 060 000	2,2%
<i>hepatitis C</i>	7 000 000	1,1%
<i>cancer and other screening programmes</i>	2 800 000	0,4%
<i>Rural Doctors Programme</i>	25 000 000	3,8%
<i>Medicines financed under the medicines program (in 2019)</i>	7 204 329	1,3%

*Total of 23 programmes, not all listed here

Stage 1: second draft

Rationale
Largest programme (both in budgetary volume and scope)

Rationale
Relevant today, could become challenging financially

Rationale
Now we encompass all programs and services

Rationale
Changes through history, source of inefficiencies

KEY DESIGN FEATURE	Universal Health Care Programme (UHCP)	COVID-19 Management Programme	Vertical (priority) programmes	Private insurance
YEAR ESTABLISHED	2013	2020	Not applicable	Not applicable
A) FOCUS OF THE SCHEME	<p>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.</p> <p>UHCP has undergone several cycles of major policy changes, related to population entitlement, services covered, co-payment mechanisms and purchasing arrangements. The information on the scheme below is based on the most recent (September 2021) information.</p>	<p>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.</p>	<p>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.</p> <p>Following is a list of vertical programs in 2021:</p> <ul style="list-style-type: none"> • Early disease detection and screening 	<p>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.</p> <p>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.</p>

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





This work is driven by AU Member States through AWA and the AU Assembly

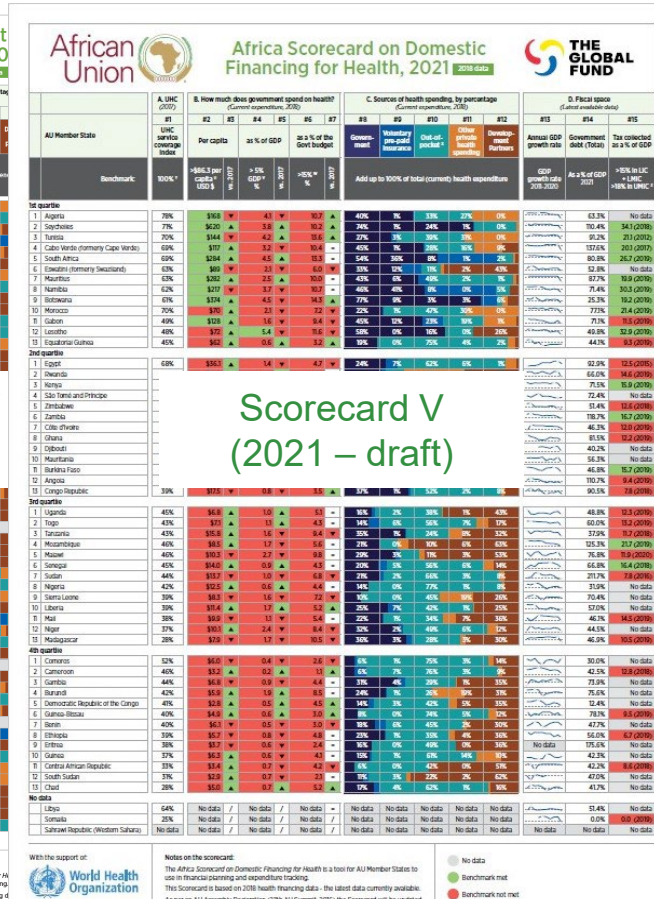
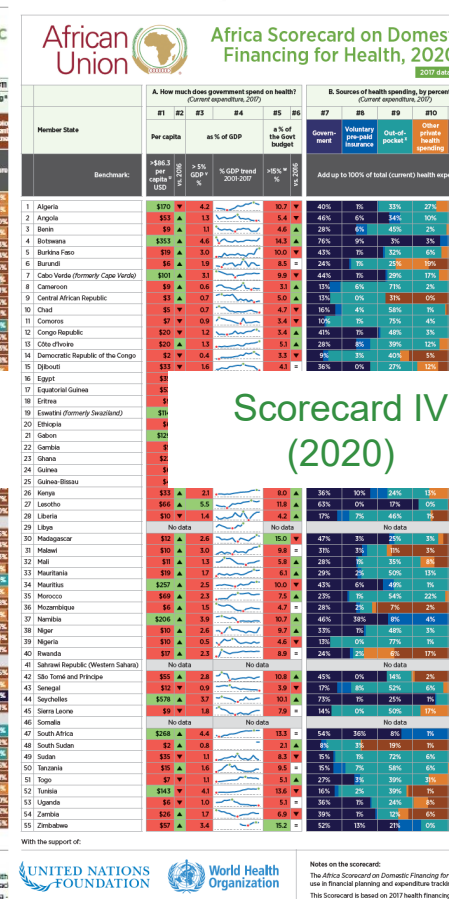
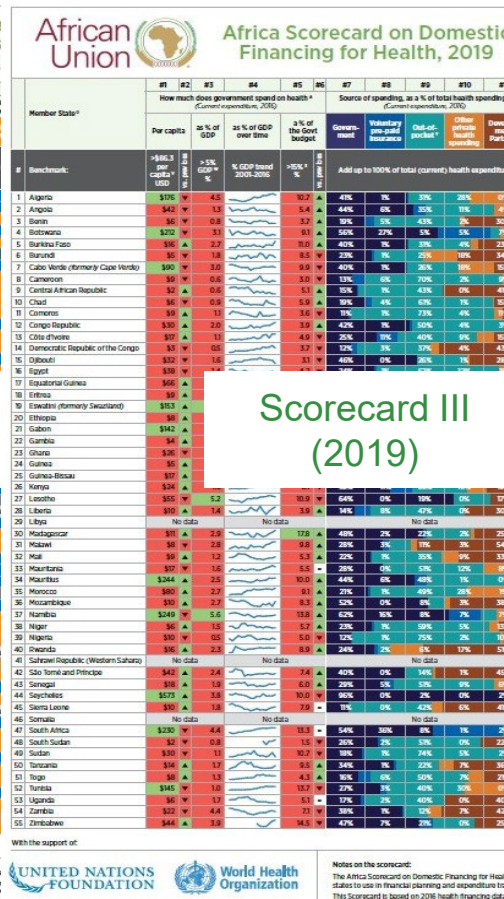
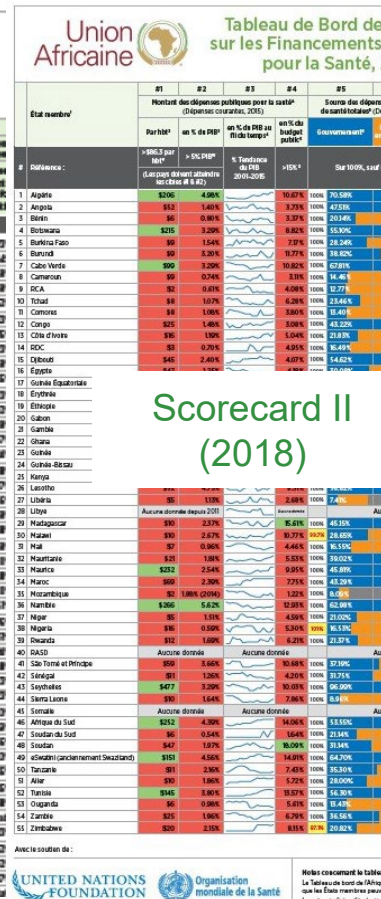
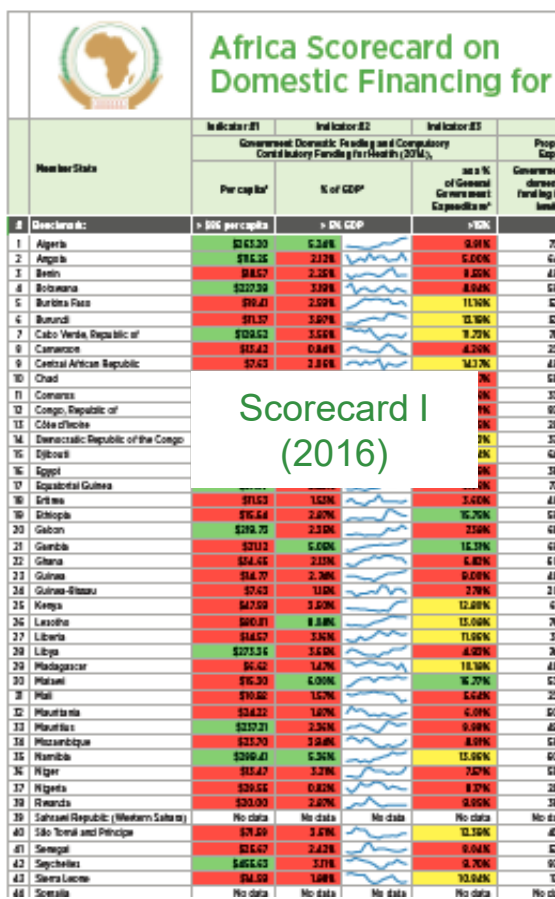
“The African Union should monitor and evaluate the implementation of the 15% Abuja target”

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



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)



President Kagame presented ALM to HoS, AU Assembly adopted *ALM Declaration*

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.



President Kagame presented ALM to HoS, AU Assembly adopted *ALM Declaration*

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.





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

<div>African Union</div> <div></div>		<div>Africa Scorecard on Domestic Financing for Health, 2021</div> <div>2018 data</div>							<div> THE GLOBAL FUND</div>							
		A. UHC (2017)	B. How much does government spend on health? (Current expenditure, 2018)						C. Sources of health spending, by percentage (Current expenditure, 2018)					D. Fiscal space (Latest available data)		
		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14	#15
AU Member State		UHC service coverage Index	Per capita		as % of GDP		as a % of the Govt budget		Government	Voluntary pre-paid Insurance	Out-of-pocket ^x	Other private health spending	Development Partners	Annual GDP growth rate	Government debt (Total)	Tax collected as a % of GDP
Benchmark:		100% ^y	>\$86.3 per capita ^u USD \$	vs. 2017	> 5% GDP ^v %	vs. 2017	>15% ^w %	vs. 2017	Add up to 100% of total (current) health expenditure					GDP growth rate 2011-2020	As a % of GDP 2021	>15% in LIC + LMIC >18% in UMIC ^z
1st quartile																
1	Algeria	78%	\$168	▼	4.1	▼	10.7	▲	40%	1%	33%	27%	0%		63.3%	No data
2	Seychelles	71%	\$620	▲	3.8	▲	10.2	▲	74%	1%	24%	1%	0%		110.4%	34.1 (2018)
3	Tunisia	70%	\$144	▼	4.2	▲	13.6	▲	27%	3%	39%	31%	0%		91.2%	21.1 (2012)
4	Cabo Verde (formerly Cape Verde)	69%	\$117	▲	3.2	▼	10.4	=	45%	1%	28%	16%	9%		137.6%	20.1 (2017)
5	South Africa	69%	\$284	▲	4.5	▲	13.3	=	54%	36%	8%	1%	2%		80.8%	26.7 (2019)
6	Eswatini (formerly Swaziland)	63%	\$89	▼	2.1	▼	6.0	▼	33%	12%	11%	2%	43%		52.8%	No data
7	Mauritius	63%	\$282	▲	2.5	▲	10.0	=	43%	6%	49%	2%	1%		87.7%	19.9 (2019)
8	Namibia	62%	\$217	▼	3.7	▼	10.7	=	46%	41%	8%	0%	5%		71.4%	30.3 (2019)
9	Botswana	61%	\$374	▲	4.5	▼	14.3	▲	77%	9%	3%	3%	6%		25.3%	19.2 (2019)
10	Morocco	70%	\$70	▲	2.1	▼	7.2	▼	22%	1%	47%	30%	0%		77.1%	21.4 (2019)
11	Gabon	49%	\$128	▲	1.6	▼	9.4	▼	45%	12%	23%	19%	1%		71.1%	11.5 (2019)
12	Lesotho	48%	\$72	▲	5.4	▼	11.6	▼	58%	0%	16%	0%	26%		49.8%	32.9 (2019)
13	Equatorial Guinea	45%	\$62	▲	0.6	▲	3.2	▲	19%	0%	75%	4%	2%		44.1%	9.3 (2019)
2nd quartile																
1	Egypt	68%	\$36.1	▲	1.4	▼	4.7	▼	24%	7%	62%	6%	1%		92.9%	12.5 (2015)
2	Rwanda	57%	\$18.4	▲	2.4	▲	8.9	=	22%	2%	11%	35%	31%		66.0%	14.6 (2019)

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

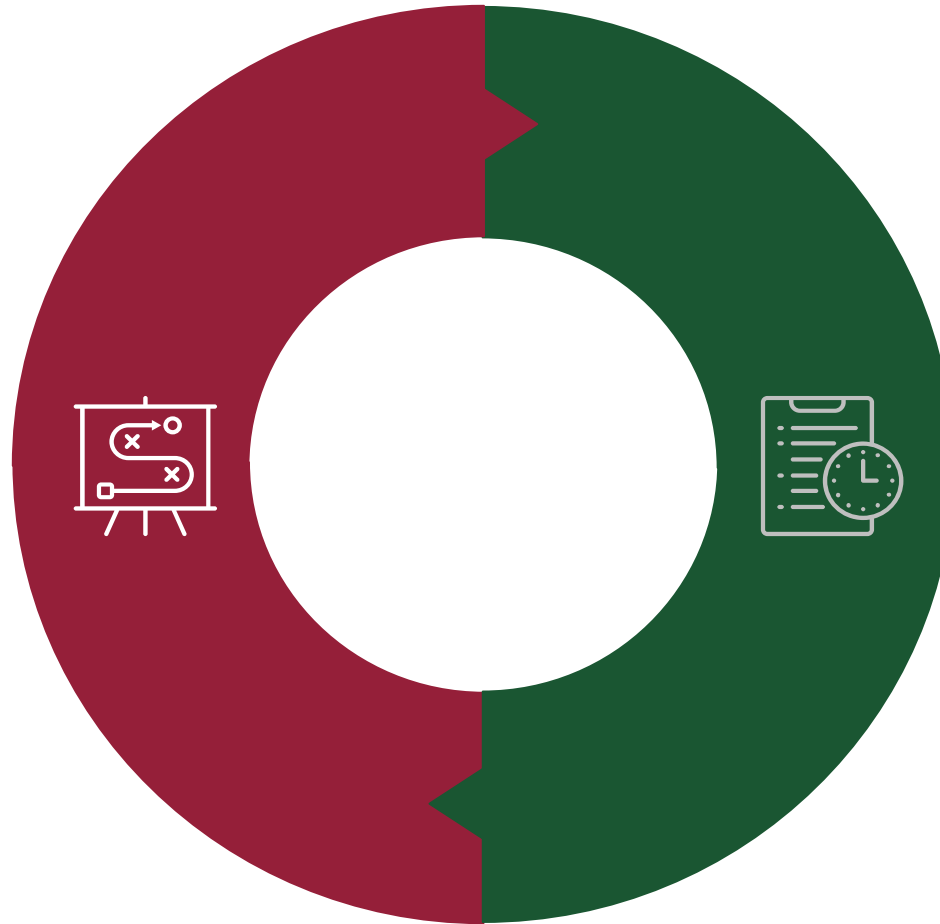


Tracker facilitates a structured dialogue between MoH & MoF officials to identify challenges, set priorities and work through fixing them together.

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.



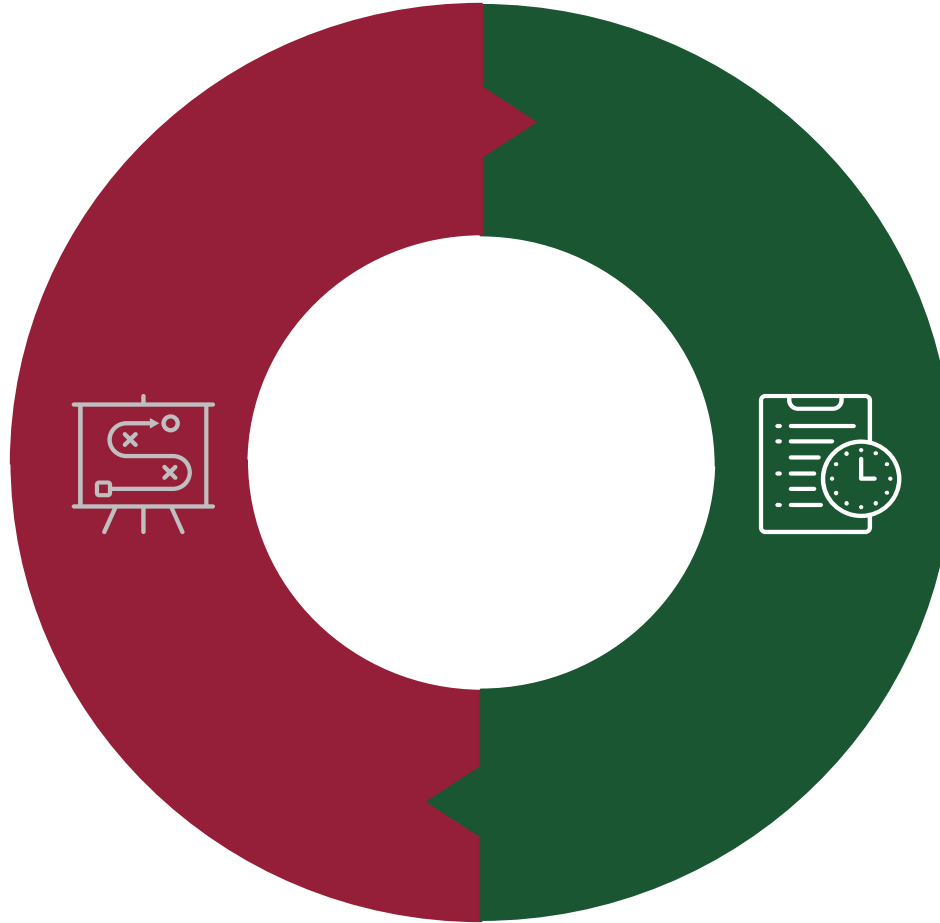
Tracker: Part 2

- A **Resource Pack** of what to do next in the areas identified after conducting the Tracker (Part 1).

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).

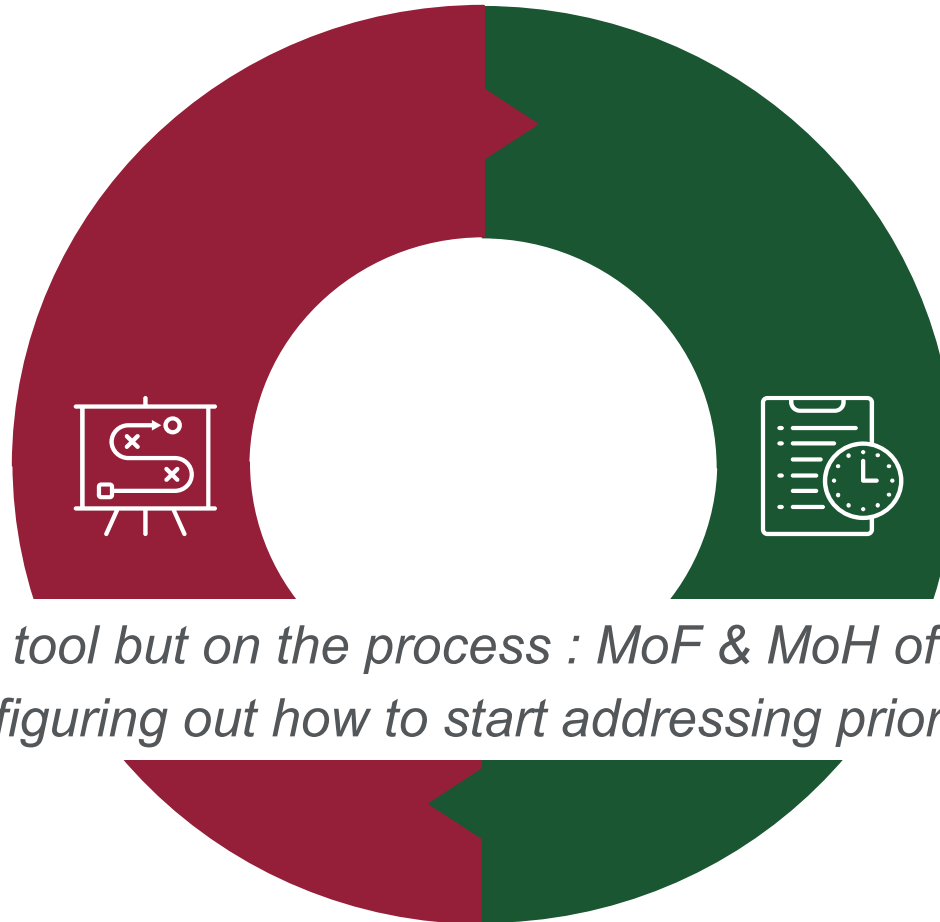
The Tracker has 2 parts

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.*

TO WILL BE CHOSEN.

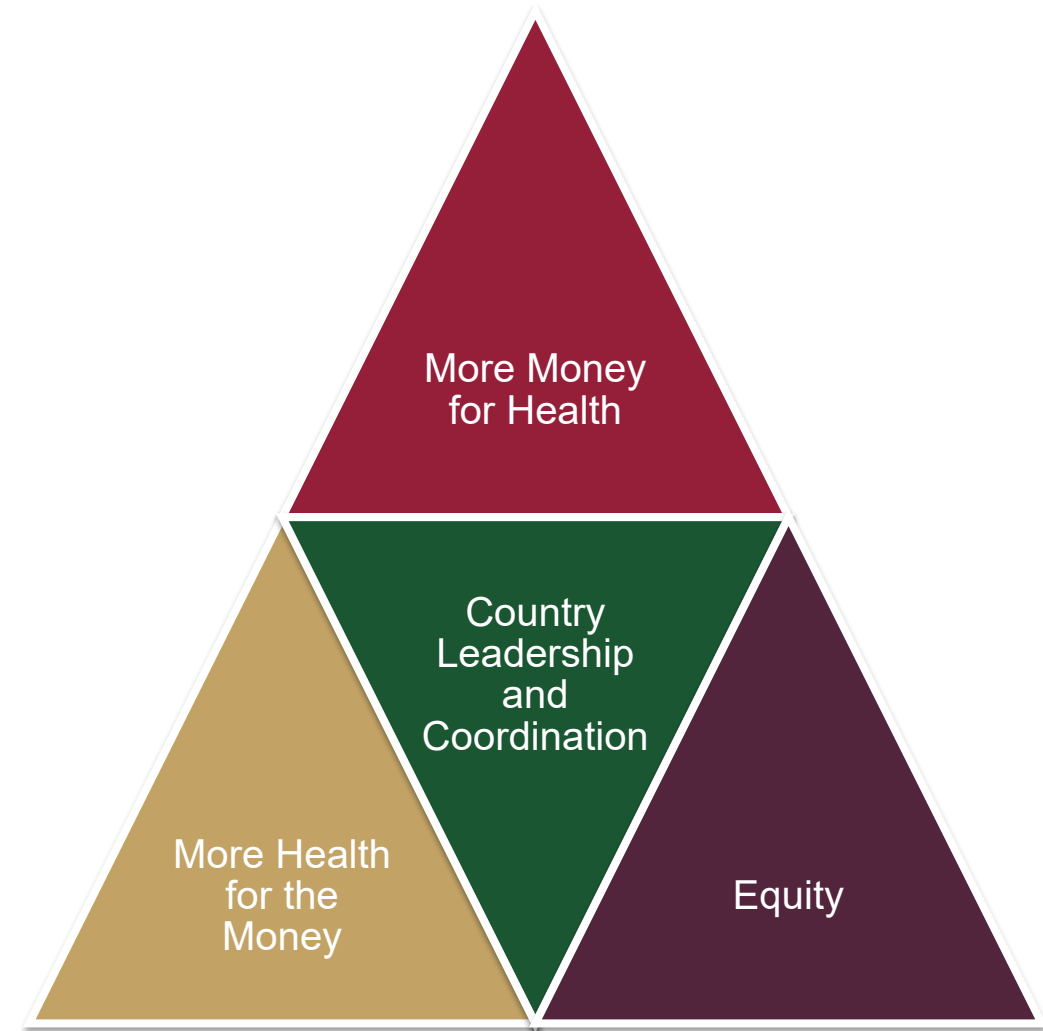


Tracker: Part 2

- 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
3. **Spend:** Health financial management
4. **Efficiency:** Tackle main areas of inefficiency within govt health spending
5. **Effectiveness:** Investing in the right priorities
6. **Measurement & Monitoring:** 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**

Where can government
realise the biggest return
on effort?

More money for health	1	Raise	Change in tax effort (year on year) [Tax collected / tax capacity]		Trends in tax-to-GDP ratio (year on year changes)
	2	Allocate	Increased prioritisation of health spending as public expenditure grows (elasticity of GGHE-D to GGE)		
	3	Spend	Ministry of Health budget utilisation / execution rate		PEFA indicator: "Predictability of in-year resource allocation"
More health for the money	4	Efficiency	Percentage of government domestic health expenditure (GGHE-D) spent on salaries / wages	Is the country participating in a pooled procurement initiative to access medicines and commodities at the best pricing available to them?	Proportion (%) of pharmaceutical [public] procurement volume (\$%) that is generic
	5	Effectiveness	Percentage of total [public] health spending allocated to Primary Health Care (PHC)		Percentage of government health expenditure that goes to medicines
	6	Measurement & Monitoring	Does the country use a priority setting mechanism to allocate health resources (e.g. a transparent and open priority setting process)? If yes, is do they use this priority setting process for: (i) determining which medicines appear on their Essential Medicines List and (ii) determining a Minimum Benefits Package		Is provider performance monitored? If yes, is performance monitoring linked to purchasing decisions?
Equity	7	Equity in Service Coverage	Access to 'X' services by wealth quintile (e.g. RMNCH)		RMNCH Coverage Index
	8	Equity in Access	Are Benefit Incidence Analysis (BIA) of public spending in health carried out routinely with a view to identifying areas for improvement		Global Health Equity Analysis of Resource Pools
	9	Financial Protection	Medical Impoverishment (proportion of population pushed below poverty line by OOP spending)		Year 1: "What are the key drivers of OOP spending?". Year 2 onwards: Measure the change in these key drivers of OOPs.
Country Leadership	10	Country Leadership	In line with the AU <i>ALM Declaration</i> 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?		Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	11	Governance & Coordination	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?		Worldwide Governance Indicators (WGI) project indicator: "Government effectiveness index"
	12	Data Systems	Is health financing information systematically used to monitor, evaluate, and improve policy development and implementation?		World Bank: Statistical Capacity Indicator (SCI) score

INDICATORS

The Tracker pilot will test 23 questions.

The purpose of the pilot is to select 12-15 final questions.

EXAMPLE: SOUTH AFRICA: High-level analysis – Identify 2-3 priority ‘action areas’

Objective	Identified ‘Action areas’ and summary high-level analysis	Is this Objective a priority? List all shortlisted ‘action areas’
More money for health		NO
More health for the money	<p>Efficiency: Wages / salaries consume significant portion of the budget. Opportunities for pooled procurement; Proportion of generic medicines procurement not measured / publicly reported.</p> <p>Effectiveness: 47% allocated to Primary Health Care</p> <p>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.</p>	<p>YES</p> <ul style="list-style-type: none"> • Efficiency • Effectiveness
Equity	<p>Equity in Service Coverage: No data.</p> <ul style="list-style-type: none"> • 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	<p>Governance & Coordination</p> <p>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.</p> <ul style="list-style-type: none"> • Establish regular / standing MoF & MoH meeting <p>MoF & MoH could begin this collaboration by jointly chairing the development partner coordination forum</p> <ul style="list-style-type: none"> • Opportunity for MoF & MoH to jointly chair the development partner coordination forum <p>Much room for improvement on the "Government effectiveness index"</p>	<p>YES</p> <ul style="list-style-type: none"> • 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



AFRICAN DEVELOPMENT BANK GROUP
GROUPE DE LA BANQUE AFRICAINE
DE DEVELOPPEMENT



State of Africa's Healthcare Systems

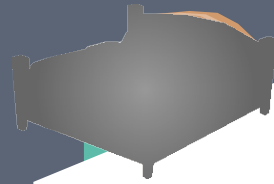
The Strategy focuses on areas that match the African Development Bank Group's comparative advantage, including health infrastructure and building in flexibility to respond to the needs of Bank regional member countries.

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 **2.1 per 1,000 people** in Latin America and **6.1 per 1,000 people** in Europe.



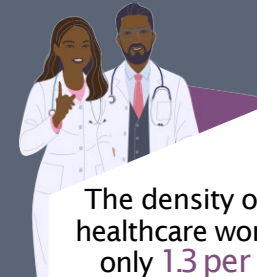
Thirty-one percent of Africa's population lives more than **2 hours** away from the nearest health facility.



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 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

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.

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.

Primary healthcare infrastructure for under-served populations

THE FOCUS WILL BE ON THREE CATEGORIES OF HEALTH INFRASTRUCTURE

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. Jsagie Ehanire, Minister of Health of Nigeria



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



One
Plan

- **Government-led** realistic and costed plan with stakeholder participation and joint ownership.
- **Development partners commit** to aligning with plan and participating in country platform.

One
Budget

- **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).

One
M&E

- **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

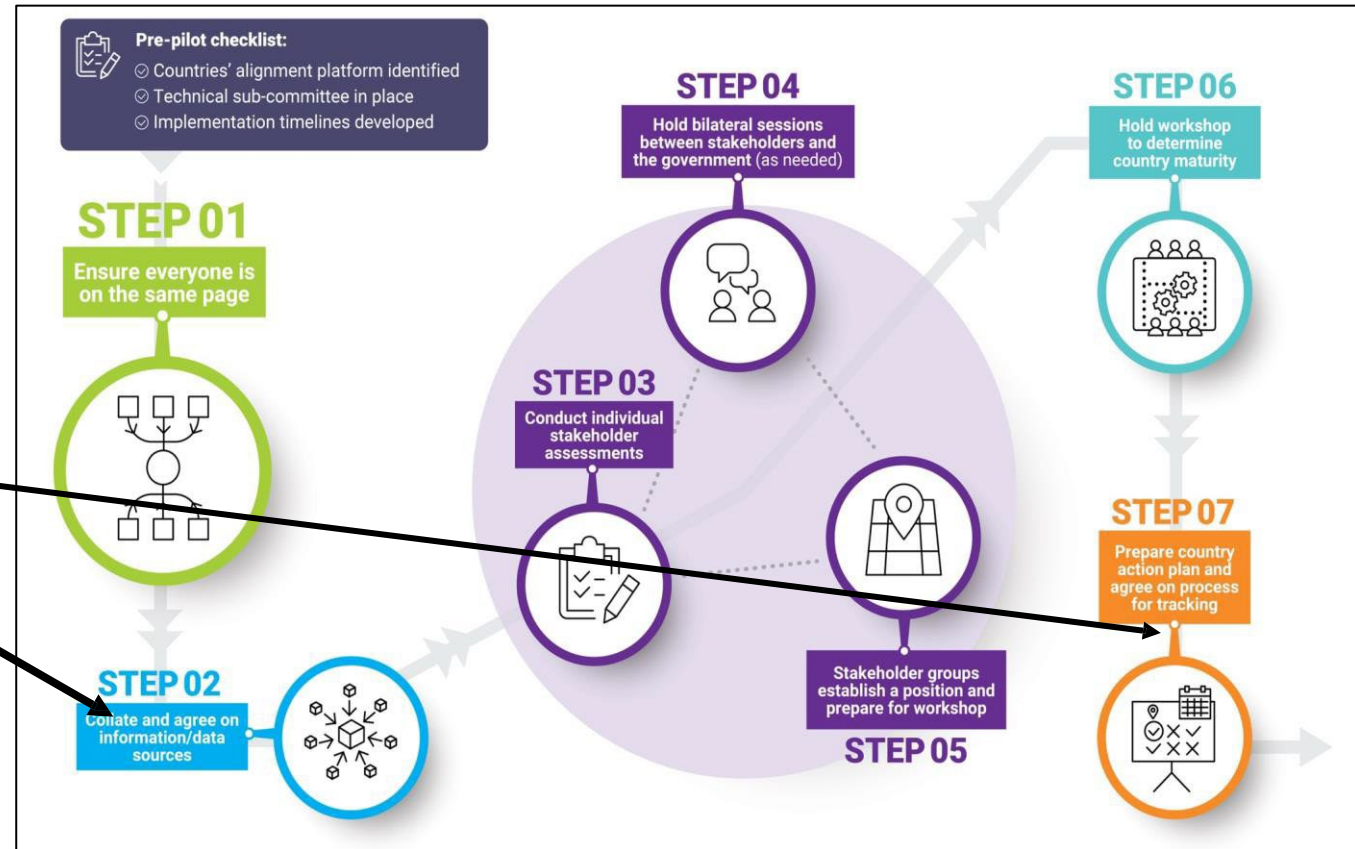
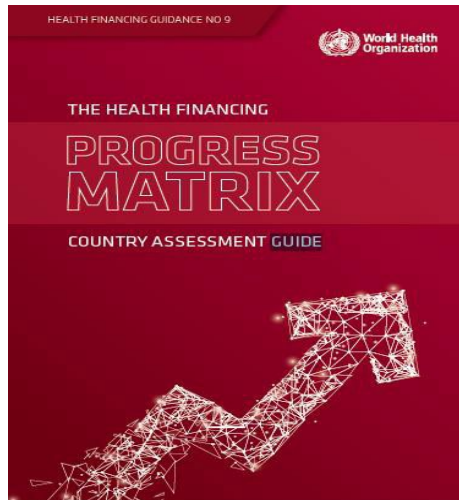
1. HFPM key input into alignment diagnostic and plan

HFPM (and other) assessments



Use existing assessments

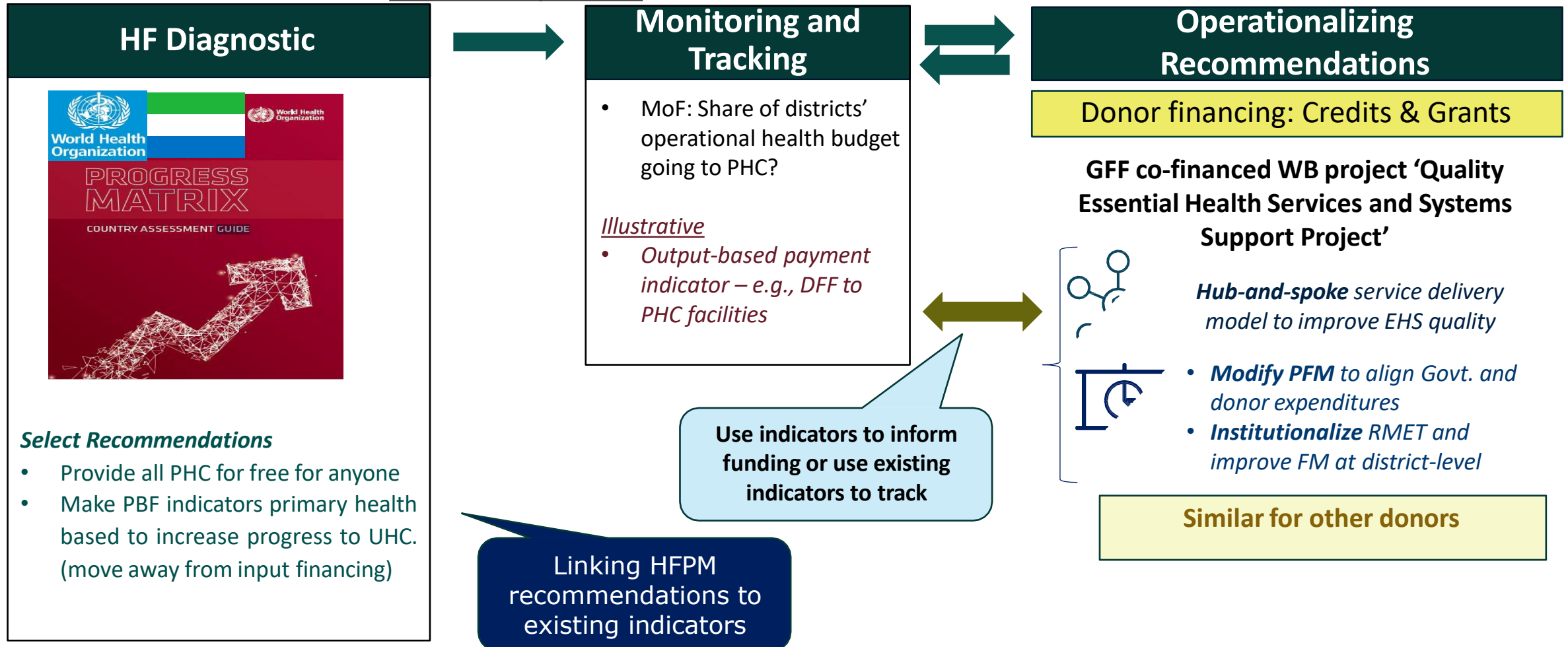
**Alignment framework:
Diagnostic, maturity rating and plan**



HFPM concretely informs, and monitors alignment

2. Contributes to DP instrument alignment, one M&E

Translate recommendations to indicators based on Government priorities



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



CONTEXT

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

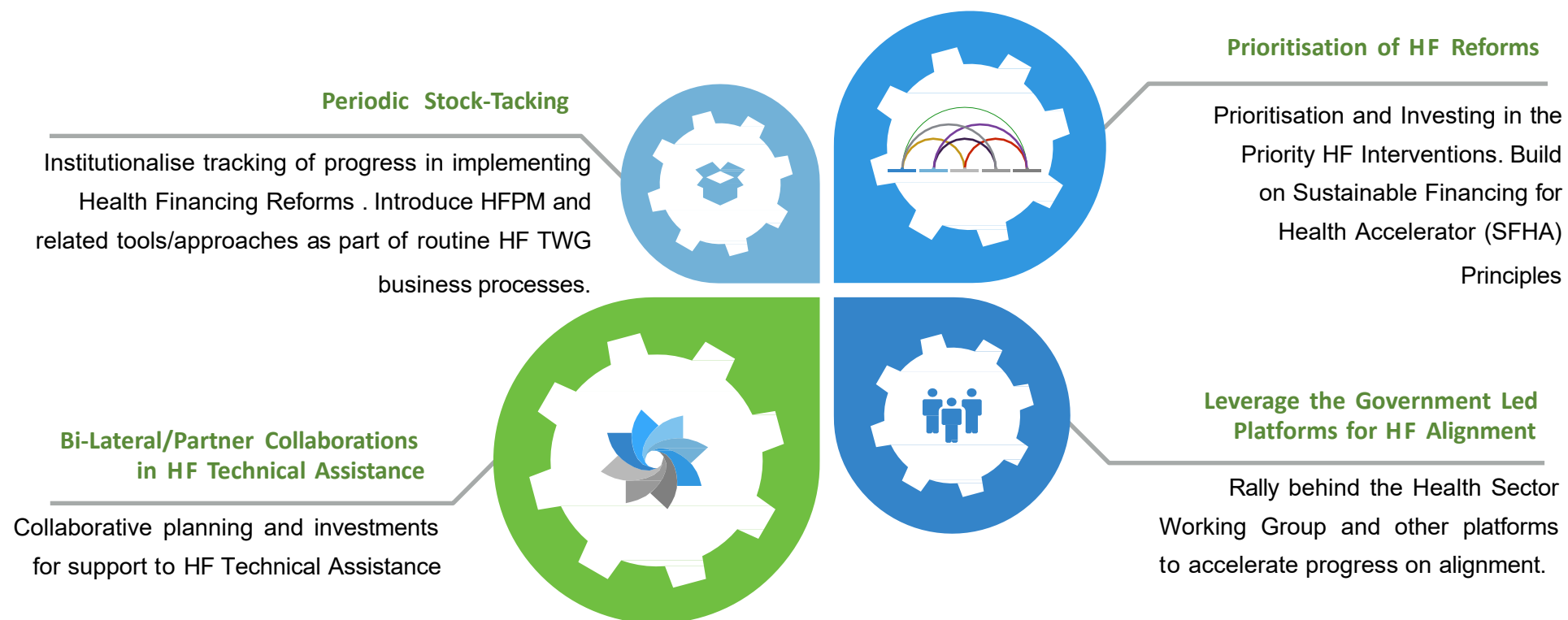
- Institutionalizing RBF (including PFM Alignment)
- Integrated Service Delivery Models
- Resource Allocation Formula and EHB Package Building on Evidence

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!





World Health
Organization

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)

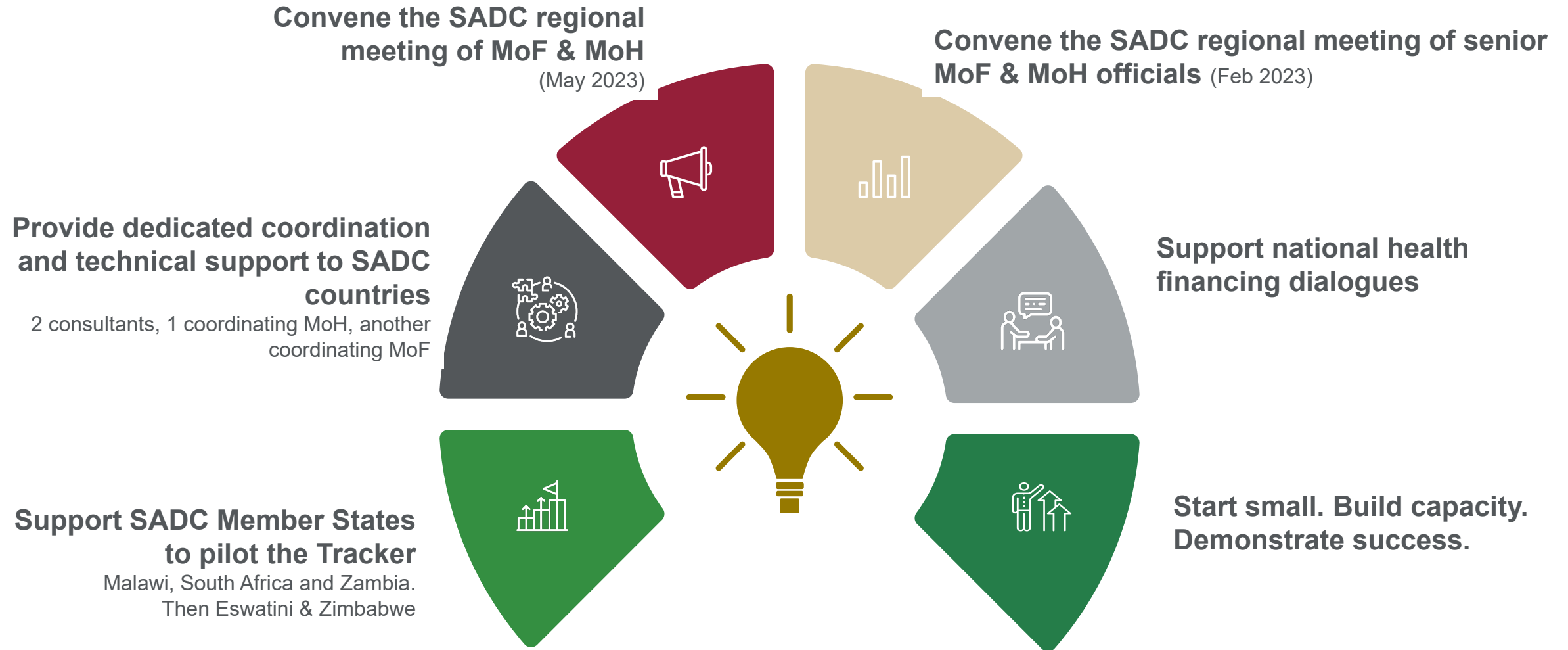
- Eswatini, Mauritius, Zambia



Hubs

- SADC health financing Hub launch in August 2022

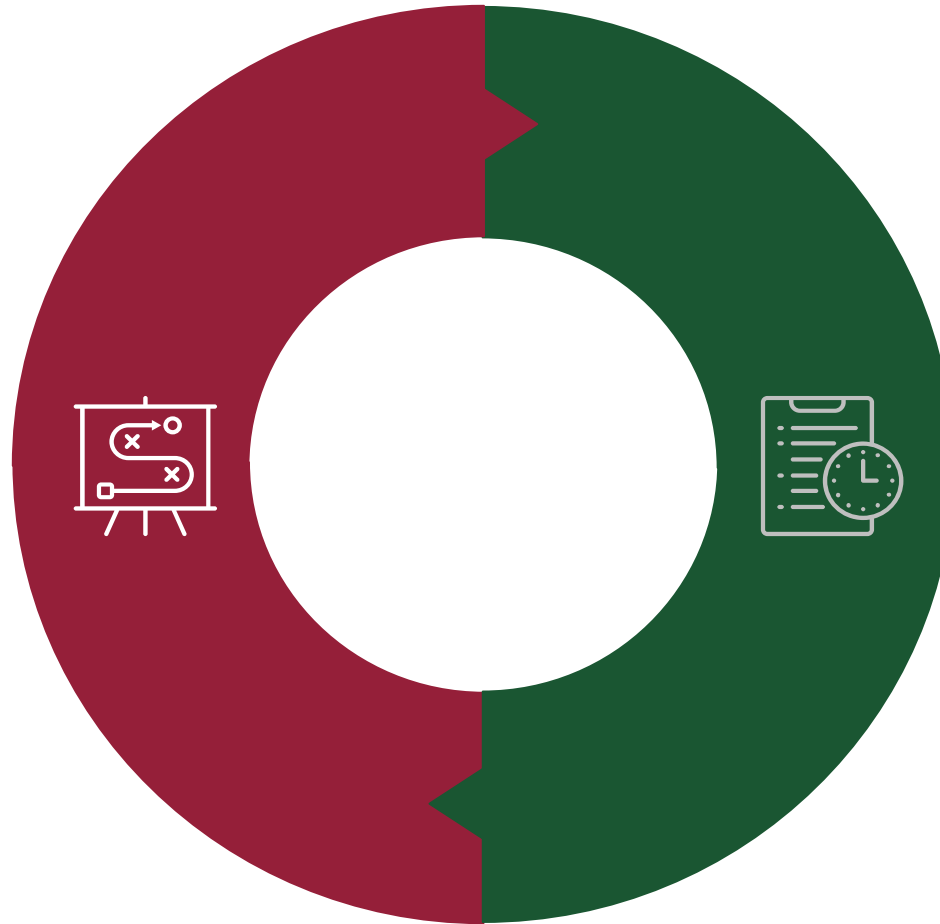
What will SADC Hub do in year 1



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.



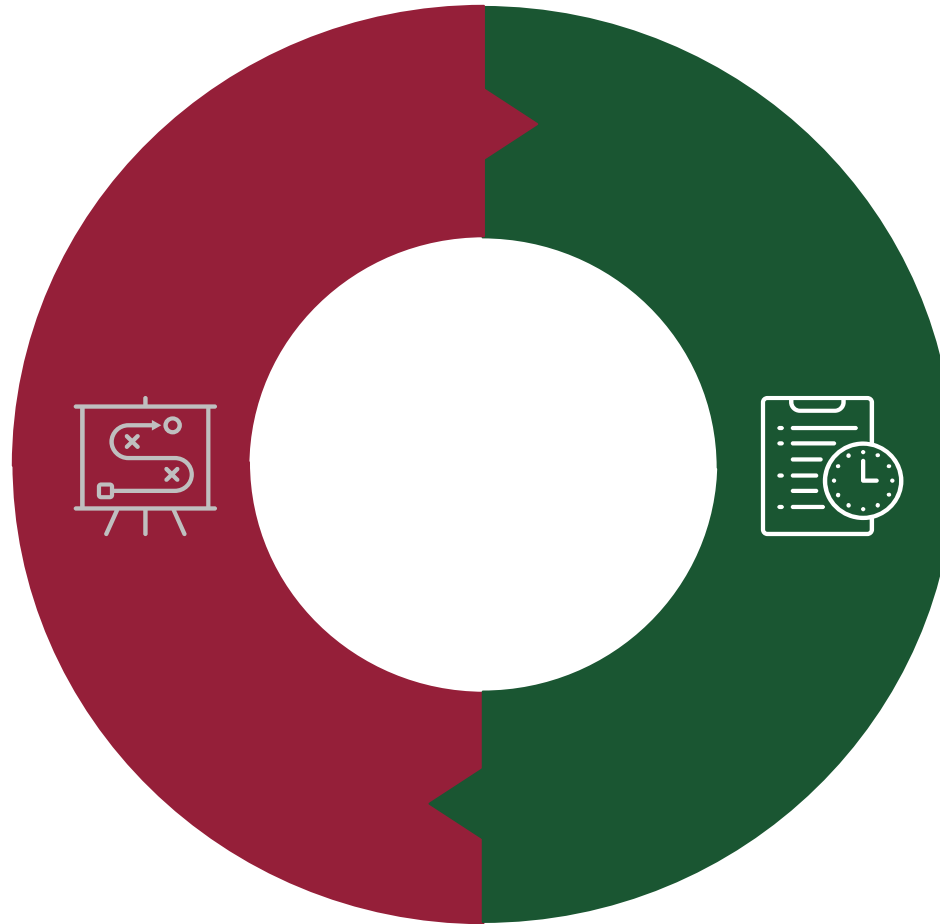
Tracker: Part 2

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

The Tracker has 2 parts

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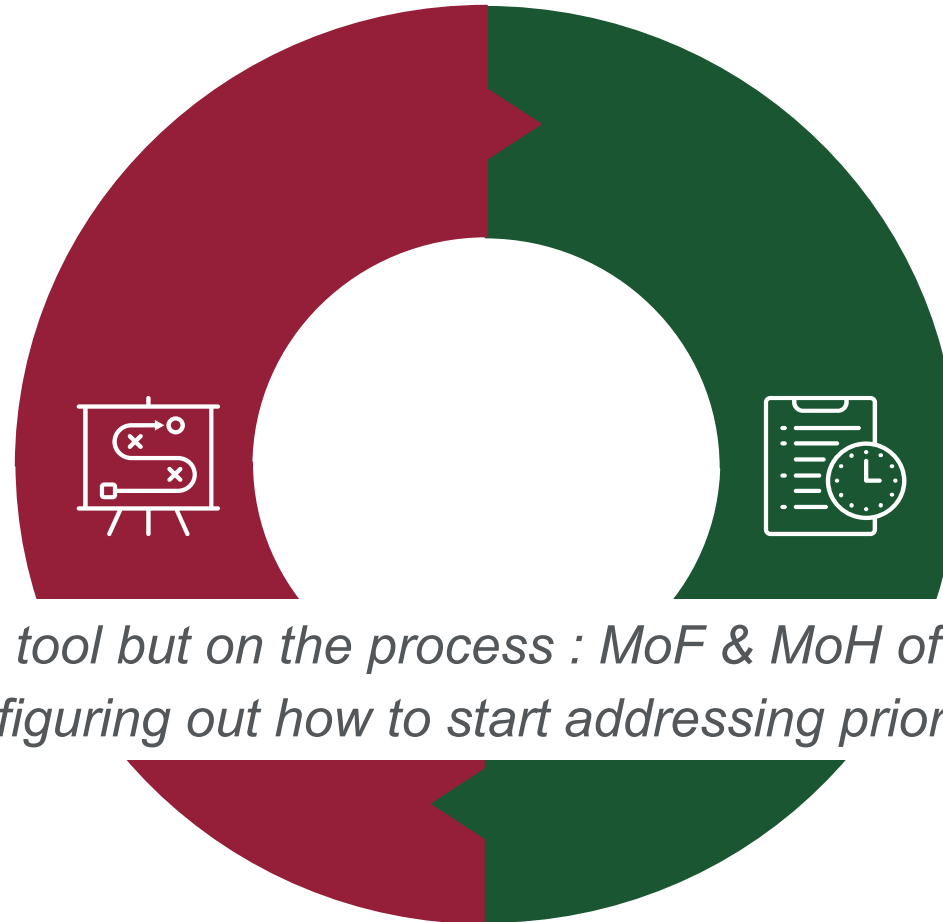
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Tracker: Part 2

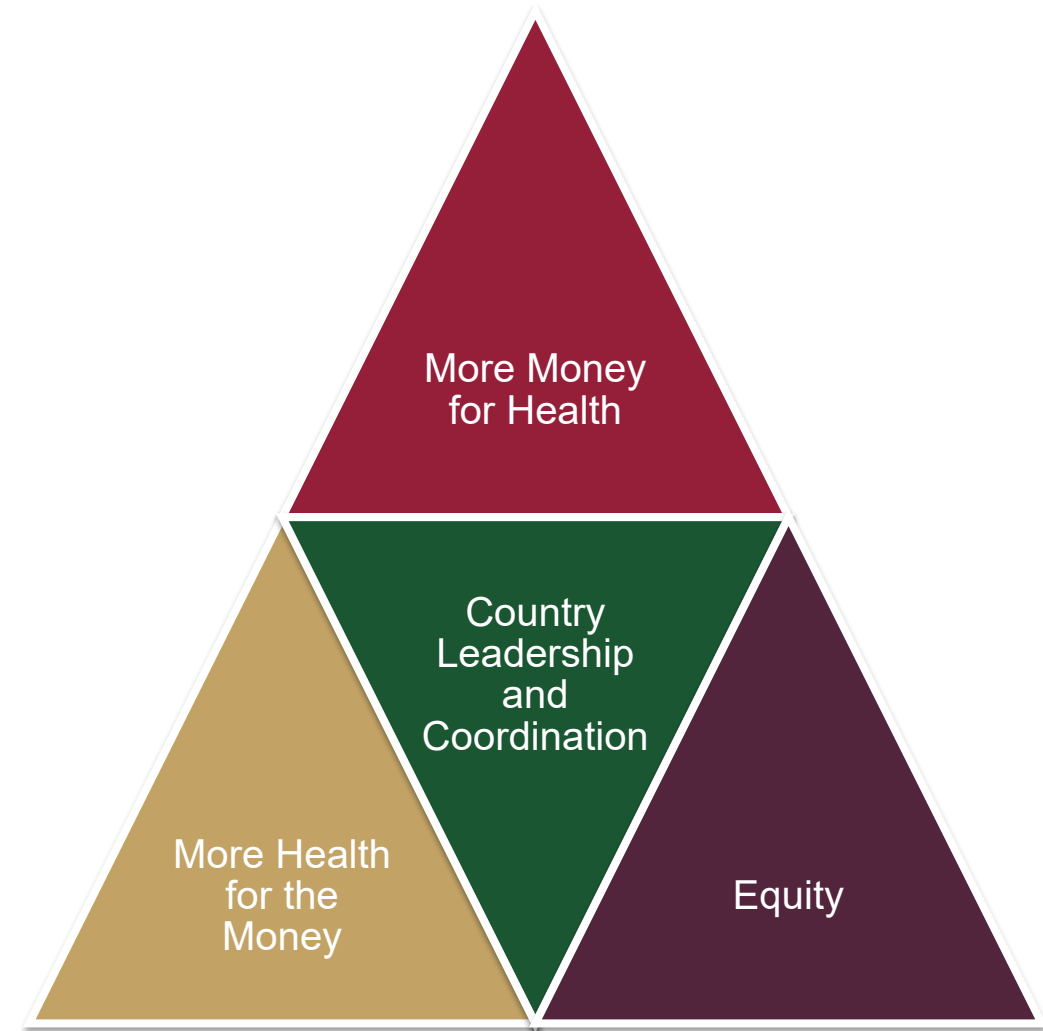
- A **Resource Pack** of what to do next in the areas identified after conducting the Tracker (Part I).

- *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.*

TO WILL BE CHOSEN.

Objectives: What areas does the Tracker suggest the country should focus on?

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
3. **Spend:** Health financial management
4. **Efficiency:** Tackle main areas of inefficiency within govt health spending
5. **Effectiveness:** Investing in the right priorities
6. **Measurement & Monitoring:** 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**

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**