World Health Organization

Health Financing Progress Matrix Country Training

Day 2 Session 1: HFPM Stage 2

22-24 June 2022
Victoria Falls, Zimbabwe

World Health Organization

KEY ISSUES IN STAGE 2

BRING QUANTITATIVE DATA TO STRENGTHEN THE ASSESSMENT

A CLOSER LOOK AT THE DESIRBALE ATTRIBUTES

CONDUCTING STAGE 2 OF THE HFPM

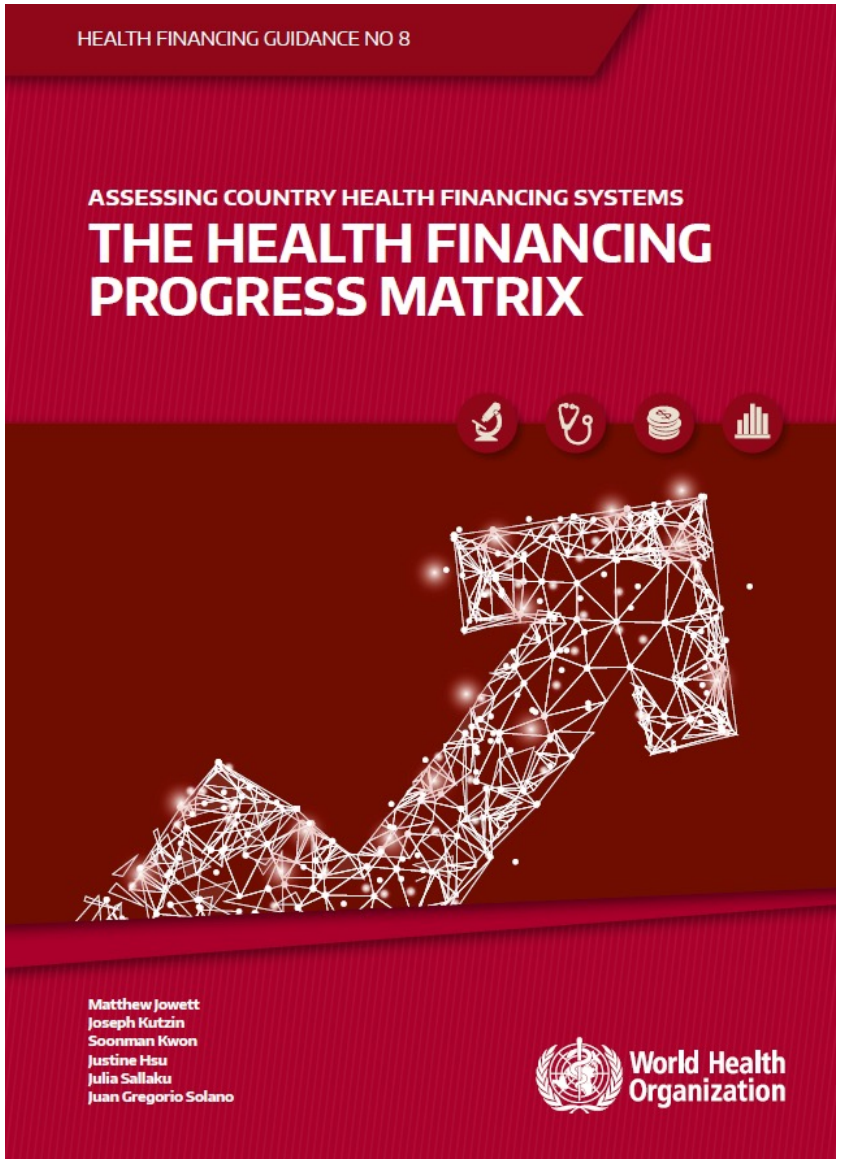
EACH QUESTION REPRESENTS A MINI MATURITY MODEL BUILT AROUND 4 PROGRESS LEVELS

33 QUESTIONS DISTRIBUTED ACROSS SEVEN ASSESSMENT AREAS & MAPPED TO ONE OR MORE DESIRABLE ATTRIBUTE

EACH QUESTION IS ALSO MAPPED TO ONE OR MORE OBJECTIVE / GOAL. **HERE LIES THE CAUSALITY**

EACH QUESTION IS MAPPED TO 1 OR MORE DESIRBALE ATTRIBUTE

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

https://www.who.int/publications/i/item/9789240017405

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MAPPING THE EVIDENCE

BY FUNCTION, INTERMEDIATE OBJECTIVES AND GOALS

KEY LINKS

New entry form

Full database

DOCUMENTS MAPPED

76

Total

DOCUMENT TYPE

Experimental

2

Quasi-experimental

7

Qualitative

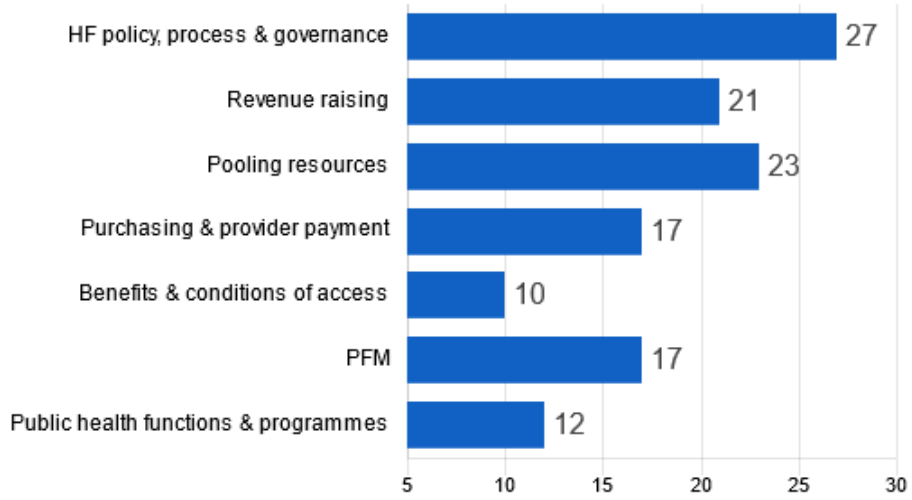
44

Mixed methods

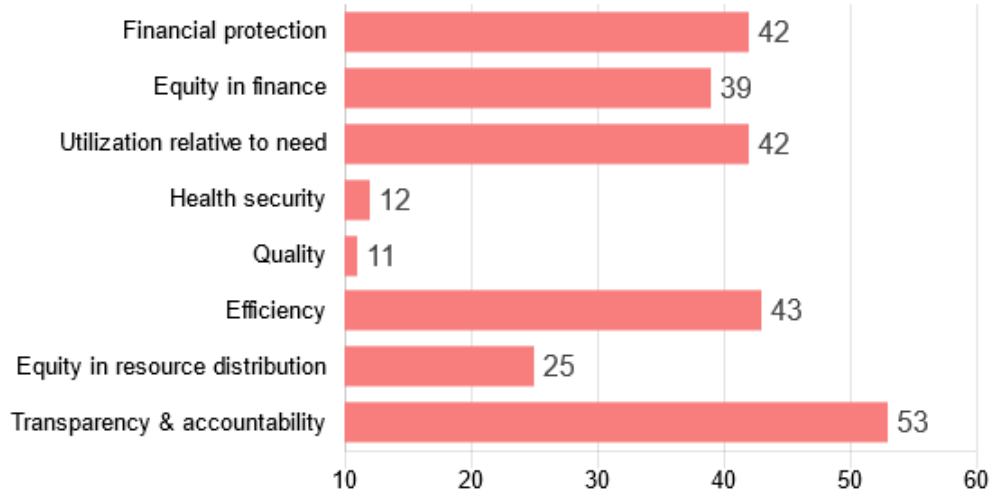
9

Other

HF FUNCTION



INTERMEDIATE OBJECTIVES & GOALS



REFERENCES

- HF policy, process & governance
- Revenue raising
- Pooling revenues
- Purchasing & provider payment

REFERENCES

- Benefits & conditions of access
- Public financial management
- Public health functions & program...

REFERENCES

- Financial protection
- Equity in finance
- Service use relative to need
- Health security

REFERENCES

- Quality
- Efficiency
- Equity in resource distribution
- Transparency & accountability

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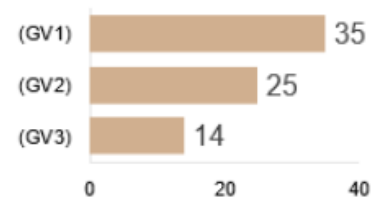
MAPPING THE EVIDENCE

BY DESIRABLE ATTRIBUTE

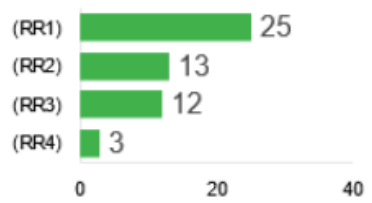
HF policy, process & governance



References

- (GV1) System v...
- (GV2) Accounta...
- (GV3) Evidence...

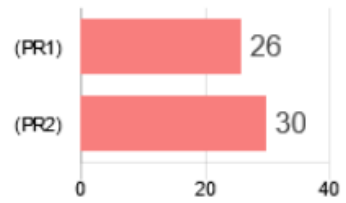
Revenue raising



References

- (RR1) Predominant
- (RR2) Predictability
- (RR3) Stability
- (RR4) Fiscal measures

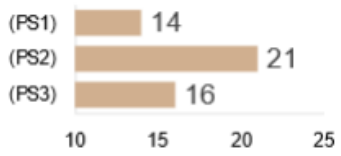
Pooling



References

- (PR1) Structure
- (PR2) Harmonize

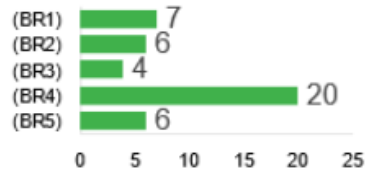
Purchasing & provider payment



References

- (PS1) Resource...
- (PS2) PPM & SD
- (PS3) PPM cos...

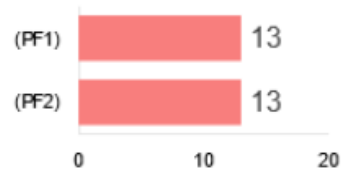
Benefits & conditions of access



References

- (BR1) Entitlements &...
- (BR2) Benefits universal
- (BR3) Benefit criteria
- (BR4) Benefits aligned
- (BR5) User charges li...

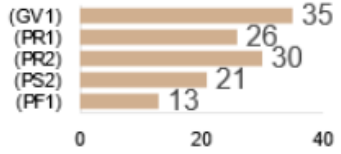
PFM



References

- (PF1) Budgets aligned priorities
- (PF2) Providers spending auth...

Public health functions & programmes



References

- (GV1) System v...
- (PR1) Structure
- (PR2) Harmonize
- (PS2) PPM & SD
- (PF1) Budgets ...

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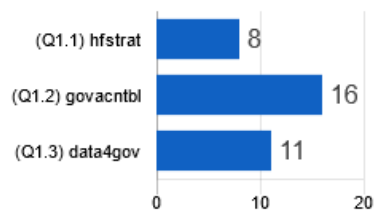
MAPPING THE EVIDENCE

BY ASSESSMENT QUESTION

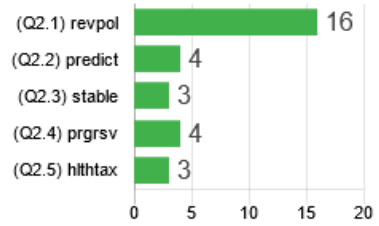
Health financing policy, process and governance



References

- Q1.1 (hfstrat)
- Q1.2 (govacntbl)
- Q1.3 (data4gov)

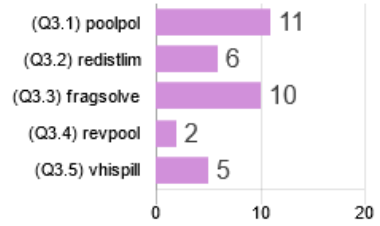
Revenue raising



References

- Q2.1 (revpol)
- Q2.2 (predict)
- Q2.3 (stable)
- Q2.4 (prgrsv)
- Q2.5 (hlthtax)

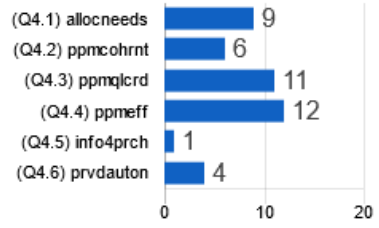
Pooling revenues



References

- Q3.1 (poolpol)
- Q3.2 (redistlim)
- Q3.3 (fragsolve)
- Q3.4 (revpool)
- Q3.5 (vhispill)

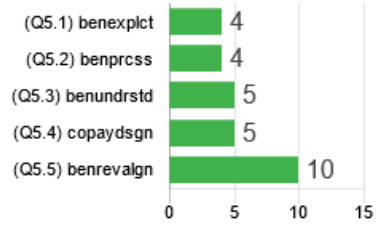
Purchasing and provider payment



References

- Q4.1 (allocnee…
- Q4.2 (ppmcoh…
- Q4.3 (ppmqlcrd)
- Q4.4 (ppmeff)
- Q4.5 (info4prch)
- Q4.6 (prvdauton)

Benefits and conditions of access



References

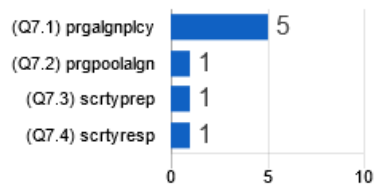
- Q5.1 (benexplct)
- Q5.2 (benprcss)
- Q5.3 (benundr…
- Q5.4 (copayds…
- Q5.5 (benreval…

PFM

References

- Q6.1 (pfmdiag)
- Q6.2 (pfmalloc…
- Q6.3 (bdgtprcss)
- Q6.4 (bdgtcntrl)
- Q6.5 (expinfm…

Public health functions and programmes



References

- Q7.1 (prgalgnp…
- Q7.2 (prgpoola…
- Q7.3 (scrtyprep)
- Q7.4 (scrtyresp)

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33 ASSESSMENT QUESTIONS

ANNEX 2
PAGES 17-18

ASSESSMENT AREA	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
1) HEALTH FINANCING POLICY, PROCESS & GOVERNANCE	Q1.1	hfstrat	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	govacntbl	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	data4gov	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) REVENUE RAISING	Q2.1	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	predict	How predictable is public funding for health in your country over a number of years?
	Q2.3	stable	How stable is the flow of public funds to health providers?
	Q2.4	prgrsv	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	hlthtax	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) POOLING REVENUES	Q3.1	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
4) PURCHASING & PROVIDER PAYMENT	Q4.1	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	ppmqlcrd	Do purchasing arrangements promote quality of care?
	Q4.4	ppmeff	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?

ASSESSMENT AREA	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
5) BENEFITS & CONDITIONS OF ACCESS	Q5.1	benexplct	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	benprcss	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	benundrstd	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	benrevalgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) PUBLIC FINANCIAL MANAGEMENT	Q6.1	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	bdgtprcss	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	expinfmon	Is health expenditure reporting comprehensive, timely, and publicly available?
7) PUBLIC HEALTH FUNCTIONS & PROGRAMMES	Q7.1	prgalgnplcy	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?

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EACH QUESTION ASSESSES PROGRESS TO ONE OR MORE DESIRABLE ATTRIBUTE

ANNEXES 3, 4, 5

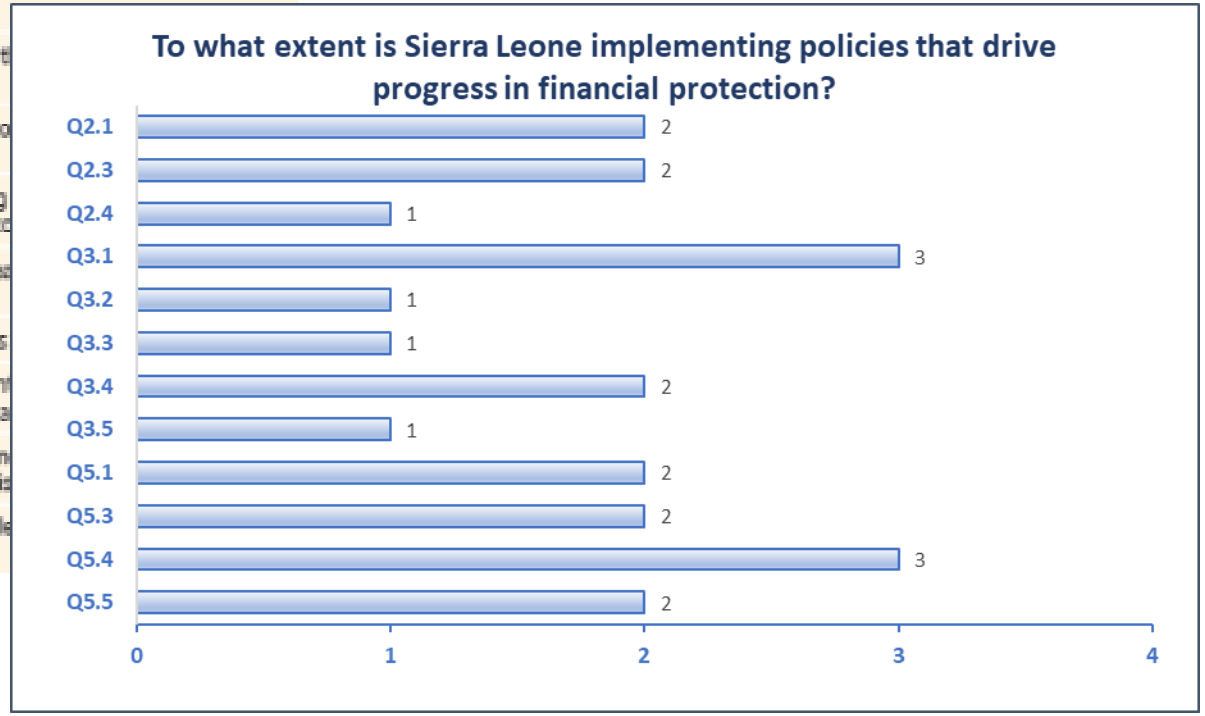
ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
3) POOLING REVENUES	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds	PR1	To what extent are the different revenue sources raised in a progressive way?	prgrsv	Q2.4
			Does your country's strategy for pooling revenues reflect international experience and evidence?	poolpol	Q3.1
			To what extent is the capacity of the health system to re-distribute prepaid funds limited?	redistlim	Q3.2
			Are multiple revenue sources and funding streams organised in a complementary manner, in support of a common set of benefits?	revpool	Q3.4
			What is the role and scale of voluntary health insurance in financing health care?	vhispill	Q3.5
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are public financial management systems in place to enable a timely response to public health emergencies?	scrtyresp	Q7.4
	Health system and financing functions are integrated or coordinated across schemes and programmes	PR2	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?	data4gov	Q1.3
			Does your country's strategy for pooling revenues reflect international experience and evidence?	poolpol	Q3.1
			What measures are in place to address problems arising from multiple fragmented pools?	fragsolve	Q3.3
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?	prgalgnplcy	Q7.1
			Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?	prgpoolalgn	Q7.2
			Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?	scrtyprep	Q7.3

ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
5) BENEFITS & CONDITIONS OF ACCESS	Entitlements and obligations are clearly understood by the population	BR1	Is there a set of explicitly defined benefits for the entire population?	benexplct	Q5.1
			To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?	benundrstd	Q5.3
			Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?	copaydsgn	Q5.4
	A set of priority health service benefits within a unified framework is implemented for the entire population	BR2	Is there a set of explicitly defined benefits for the entire population?	benexplct	Q5.1
	Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments	BR3	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?	benprcss	Q5.2
	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers	BR4	To what extent is the payment of providers driven by information on the health needs of the population they serve?	allocneeds	Q4.1
			Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?	benrevalgn	Q5.5
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
	Benefit design includes explicit limits on user charges and protects access for vulnerable groups	BR5	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?	copaydsgn	Q5.4

MAPPING CAUSALITY FROM POLICY TO PERFORMANCE

ANNEXE 6
e.g. p36

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
FINANCIAL PROTECTION	Q2.1	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	stable	How stable is the flow of public funds to health providers?
	Q2.4	prgrsv	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	redistlim	To what extent is the capacity of the healt prepaid funds limited?
	Q3.3	fragsolve	What measures are in place to address pro fragmented pools?
	Q3.4	revpool	Are multiple revenue sources and funding complementary manner, in support of a co
	Q3.5	vhispill	What is the role and scale of voluntary hea health care?
	Q5.1	benexplct	Is there a set of explicitly defined benefits
	Q5.3	benundrstd	To what extent are population entitlement defined explicitly and in easy-to-understa
	Q5.4	copaydsgn	Are user charges designed to ensure finan and have functioning protection mechanis
	Q5.5	benrevalgn	Are defined benefits aligned with available services, and purchasing mechanisms?



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EACH QUESTION REPRESENTS A MATURITY MODEL

THE QUESTIONS

Each question raises issues about the situation in a country on a specific issue, which can support progress towards one or more "desired attribute(s)"

PROGRESS LEVELS

Each progress level reflects significant movement towards the desired situation: a mini "maturity model". Allows change relative to previous assessment(s) to be identified

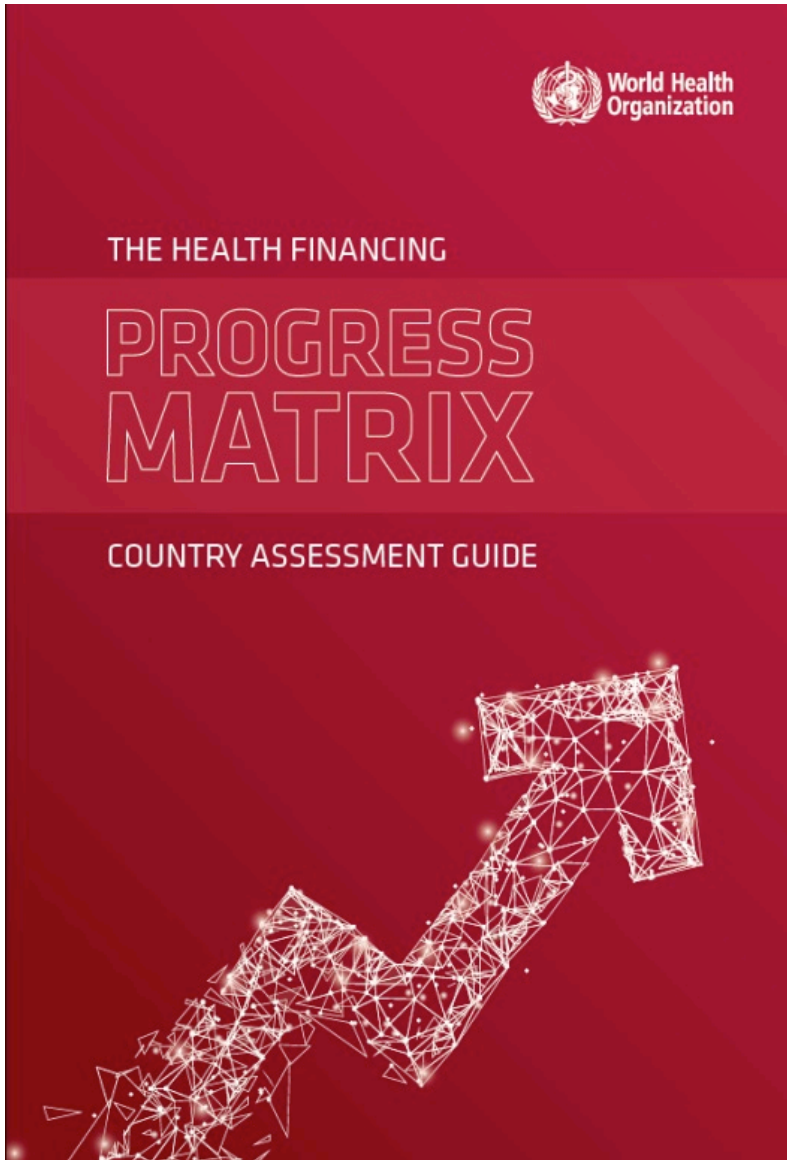
COUNTRY ASSESSMENT GUIDE

The CAS provides further background and explanation for each question; why it matters, what progress looks like, with illustrations / "for examples"

APPLYING RATINGS

Progress levels are yardsticks against which current situation in a country is assessed. Forms the basis of recommended directions for policy & implementation

COUNTRY ASSESSMENT GUIDE
(go to page 43-44)



Question 3.3 (fragsolve):
What measures are in place to address problems arising from multiple fragmented pools?

BACKGROUND TO THE QUESTION

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

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

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

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

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

LEVEL 1: EMERGING
There are no compensating measures to address inequity and inefficiency arising from fragmentation.

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

LEVEL 2: PROGRESSING
Some measures in place to address inequity and inefficiency arising from fragmentation.

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

LEVEL 3: ESTABLISHED
Substantial measures in place, though with room for improvement, to address inequity and inefficiency arising from fragmentation.

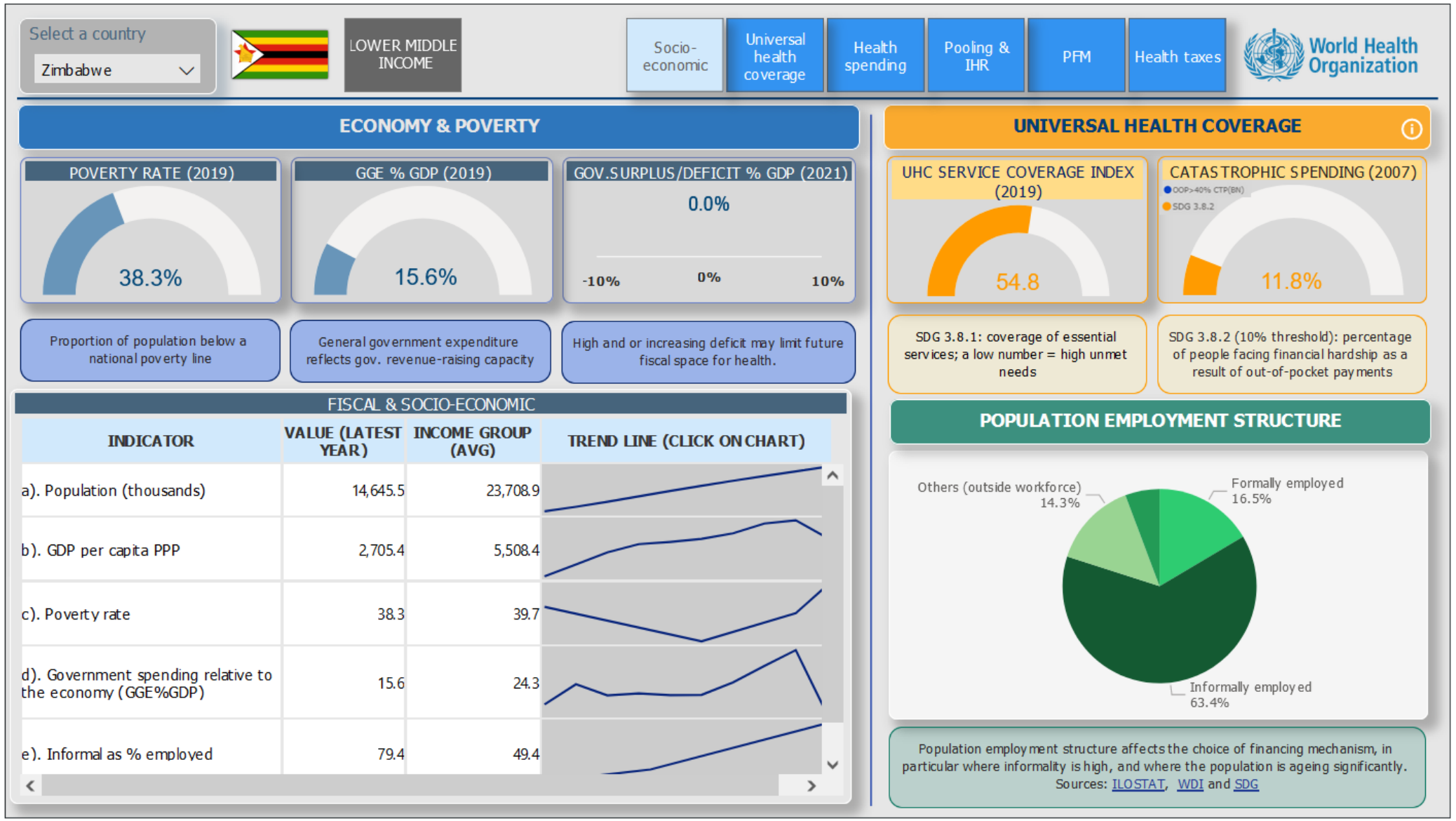
Examples of such "substantial measures" go beyond those of level 2, such as:

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

LEVEL 4: ADVANCED
Compensation measures fully implemented to enable equity and efficiency challenges arising from pool fragmentation to be fully addressed.

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

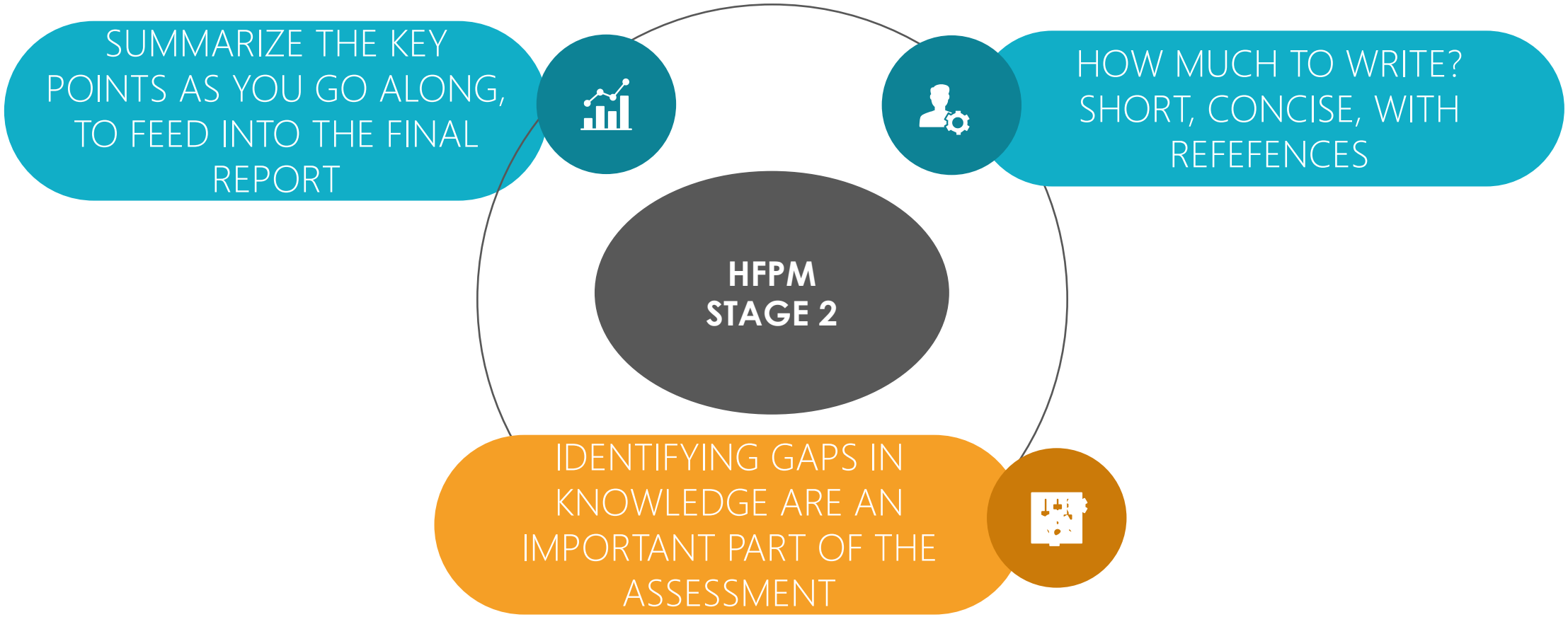
DASHBOARD OF QUANTITATIVE INDICATORS



See examples of supporting metrics in Q2.4 and Q2.5 in Country Assessment Guide

WEB LINK TO DASHBOARD

ADDITIONAL POINTS



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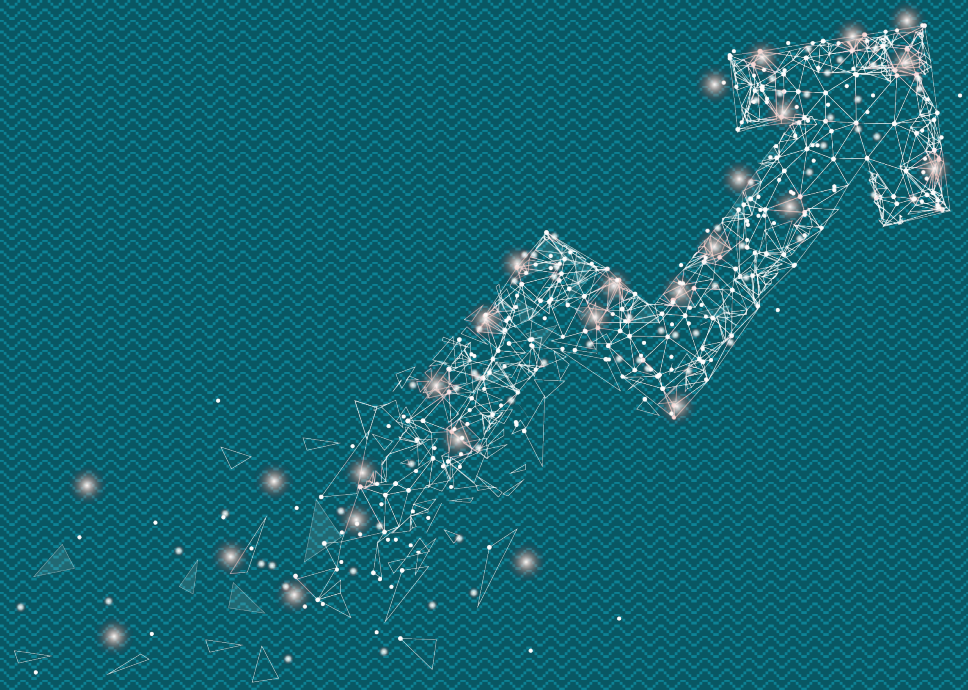


Thank You

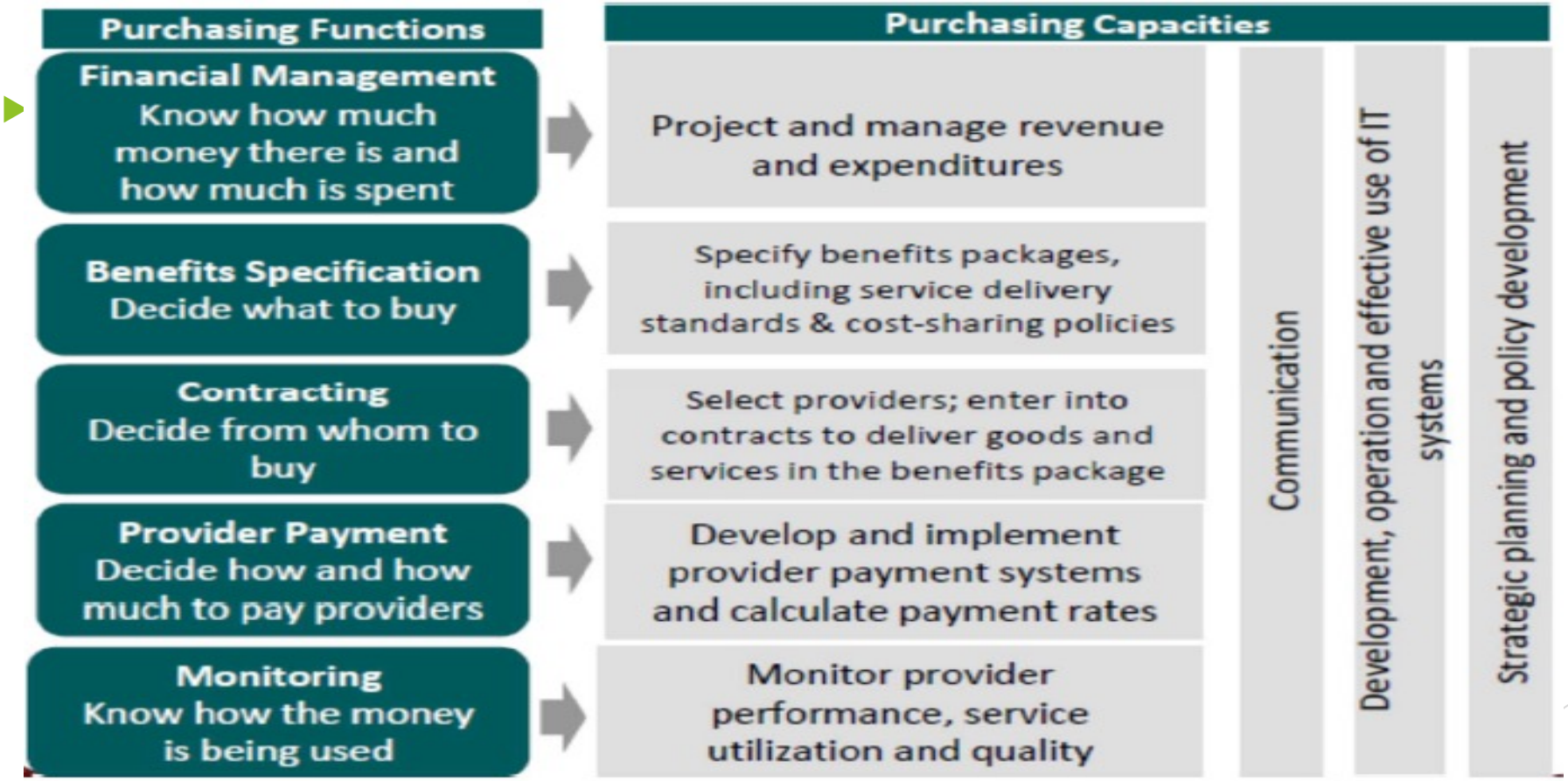
Data or Information for HPFM assessment

(Lesson from Implementing Strategic Purchasing in Tanzania)

Health financing

Tanzania

What is SPARC?



Data sources

- Government documents
- Key informant interview with program implementers
- Those implementing different elements within bigger schemes

Purchasing Functions in Tanzania's Health Financing Schemes

	Tax-Financed Schemes	National Health Insurance Fund (NHIF)	Social Health Insurance Benefit (SHIB)	Improved Community Health Fund (iCHF)	Private Insurance
% of Total Health Expenditure (2015/16)*	54%	8%			
Main Purchaser(s)	Ministry of Finance and Planning (MOF)	National Health Insurance Fund (NHIF)	National Social Security Fund (NSSF)	Regional Administrative Secretary	Private insurers
Governance	MOF has a designated officer but is mostly interested in disbursing funds and less so on service delivery objectives.	NHIF has a clear mandate anchored in legislation and reports to a management board.	NSSF has a clear mandate anchored in legislation and reports to a management board.	Mandate is defined by the parent ministry (President's Office, regional administration, and local government).	Private insurers are governed by legislation and report to the Tanzania Insurance Regulatory Authority.
Financial Management	Budget overruns occur. Deficits are financed through reallocation of funds per Section 40(1) of the 2014 Budget Act. Accounting officers request approval for reallocation of funds from the Minister of Finance.	Budget overruns occur when premiums collected are insufficient to cover claims. Deficits are covered using reserves accumulated from the previous years' surpluses.	Budget overruns occur. The NSSF Act allows for supplementary budget by approval of the Minister of Labour and Employment.	Budget overruns are not allowed. A budget-neutral capitation formula prevents deficits.	Budget overruns occur when claims exceed premiums collected. Deficits are covered by profits from the insurance company's other lines of business.
Benefits Specification	Explicit guidance from the National Package of Essential Health Interventions for primary care and hospital care; no exclusions and no defined process for revisions	Explicit benefit package of primary care and hospital care, with exclusions; revisions are based on enrollee feedback via public consultations	Explicit benefit package of primary care and hospital care, with exclusions; revisions are based on enrollee feedback via public consultations	Not explicit; uses broad intervention categories for primary and hospital care with no specific exclusions; no clear process for revisions	Explicit benefit package of primary and hospital care with exclusions; no clear process for revisions
Contracting Arrangements	Loose agreements with public providers and some private nonprofit facilities	All public facilities included; selective contracting with private providers	Selective contracting with public and private providers	All public facilities included; selective contracting with private nonprofit providers	Selective contracting with private providers
Provider Payment	Line-item budgets, salaries, and allocation to health facilities based on a capitation formula	Fee-for-service	Capitation; enrollees select their preferred providers and fee-for-service payments are made for referrals	Capitation; enrollees select their preferred provider	Fee-for-service

Key message concerning data for HFPM stage one 1

- There is sufficient data at the moment when it comes to describing the financing landscape
- i.e expenditure data like NHA or MTEF data sources which provides a good snapshot of financing landscape
- These are useful information in showing the size of each scheme in total financing
- WHO has also provided background indicators for each country Health Systems Governance and Financing (who.int) for describing the landcape

Why do we have good quantitative data

- ***"Perhaps because initially the health economists were so much focused on numbers only! They did not think that qualitative data can play a key role in making assessment or measuring progress.***
- Due to that they put pressure on governments to produce quantitative data to aid assessments
- Thus why we have such data as NHA and MTEF and they have become routine data collected by governments

- ***Problem arise*** *when qualitative is data is needed for making an assessment*.

Different perspectives

- Differences in definition of issues between technical people and purchasing schemes

- **i.e Reviewing the benefit package**

"A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and a transparent process for revision is specified."

- The NHIF definition of reviewing benefit package is different .
- Cost is the driver of benefit package review for sustainability of scheme and not according to the need. So after evaluation of the sustainability of the fund, decision is then made can be made to review benefit and whether to include a certain service or not.

- Need alignment between what assessors know and what purchasers/scheme owners think.

Areas where we found no good information for assessing progress

- NHIF has some form of periodic assessment but we could not find any such assessment to other schemes included in the assessment
- DHIS 2 data – shows utilisation of service but does not show which scheme or payment modality the patients uses to enable analysis
- Health and Management Information system –some schemes have and some does not have
- Routine analysis for making purchasing decisions – NHIF carry out Prices assessment to inform pricing exercise
- Weak provider monitoring

What data is in what document

- NHA – Tell how big is the scheme can help categorise the schemes
- Data availability according to functions of Health Financing –
- Benefits- Acts documents and Scheme Websites
- Service delivery standards – Use of Standard treatment guideline issued by th MOH
- Medicine list – National Essential Medicine list used.
- Governance – Data from legal documents like acts which defines mandate of the scheme what it can and what it cannot

Design of schemes matters to aid future assessments

- The monitoring and evaluation mechanisms of purchasing schemes should be embedded in during design
- Periodic reporting should improve within the system with action points well clearly defined to enable implementers to take action
- It is important to understand what design feature lead to outcome and maximise efforts
- The progress assessment should be used as feedback tool to implementers in communicating what works and what does not work during the implementation cycle of program so that they keep refining things as they continue implementation
- So the HPFM should be implemented as a cycle

Reflections for policy makers

- How do we make the HPFM tool used by policy makers as something for them to see areas where they can improve implementation of different programes

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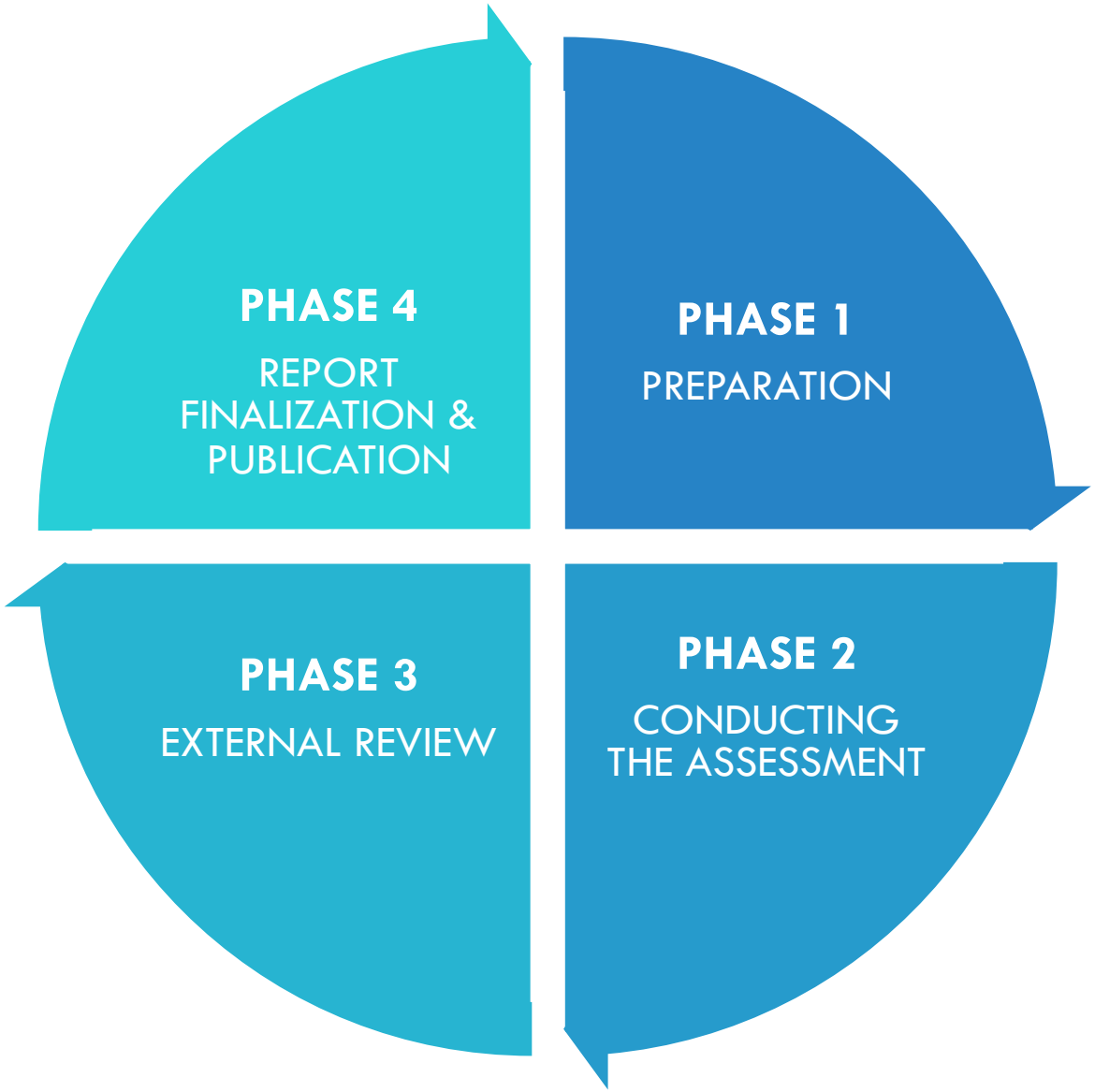
Health Financing Progress Matrix Country Training

Day 2 Session 1: Implementation phases

22-24 June 2022
Victoria Falls, Zimbabwe

HFPM: four phases of implementation

World Health Organization

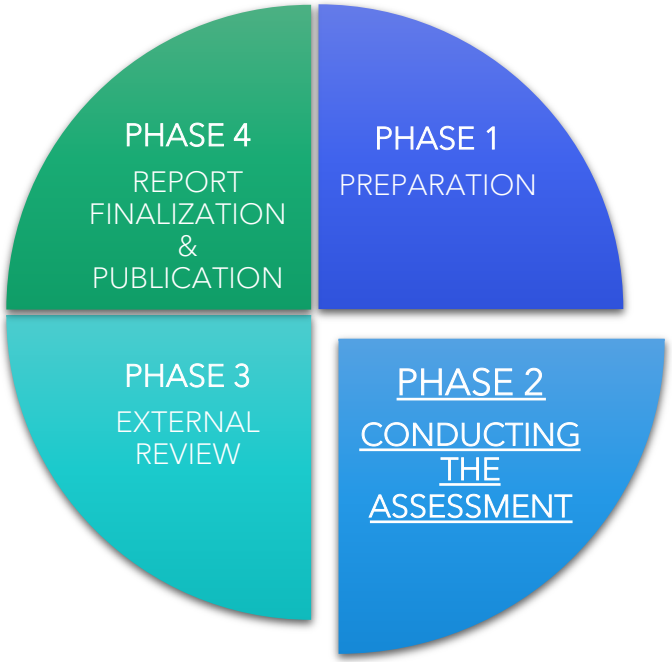


1.1
Initial briefings & HFPM overview with MoH

1.2
Identification of PI and core team.
Also Oversight Team.

1.3
Training and in-depth briefing of PI & core team.
Training course developed

1.4
Timeline & milestones developed to align with country processes



Explicit capacity-building objective

2.1
HFPM
Launch Event

2.2
Data / info compilation and template completion

2.3
Review / feedback by Oversight Team

2.4
Assessment considered ready for external review

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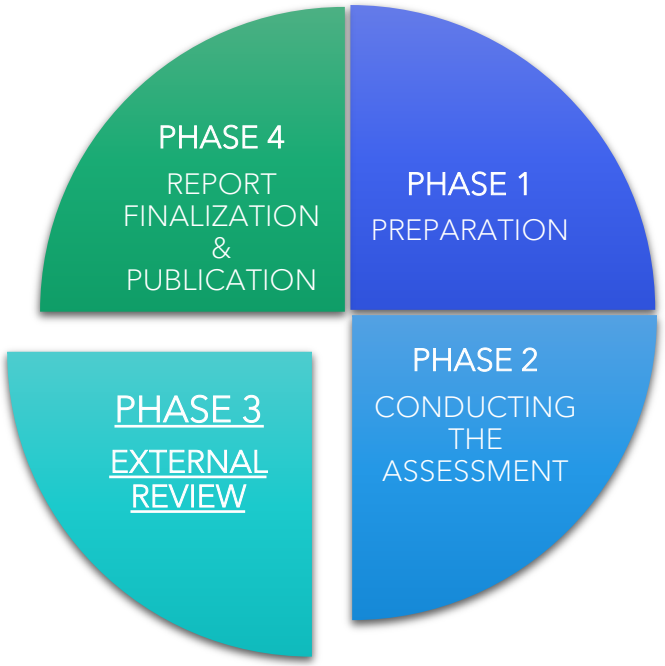

3.1
Two experts independently review and discuss areas of divergence on rating scale

3.2
External reviewer comments discussed with PI and country team

3.3
Final adjustments to assessment based on consensus score

3.4
Cross-country validation review

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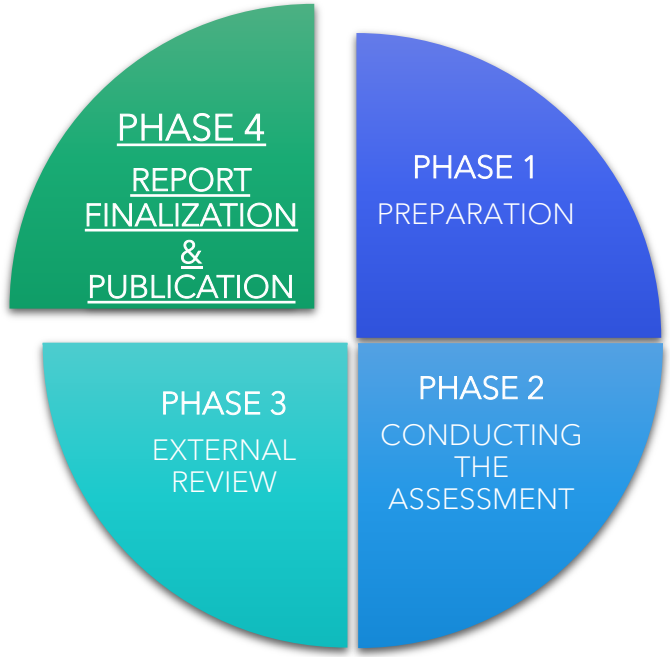


4.1
Draft report prepared: key findings & recommendat-ions

4.2
Final report prepared following review & agreement

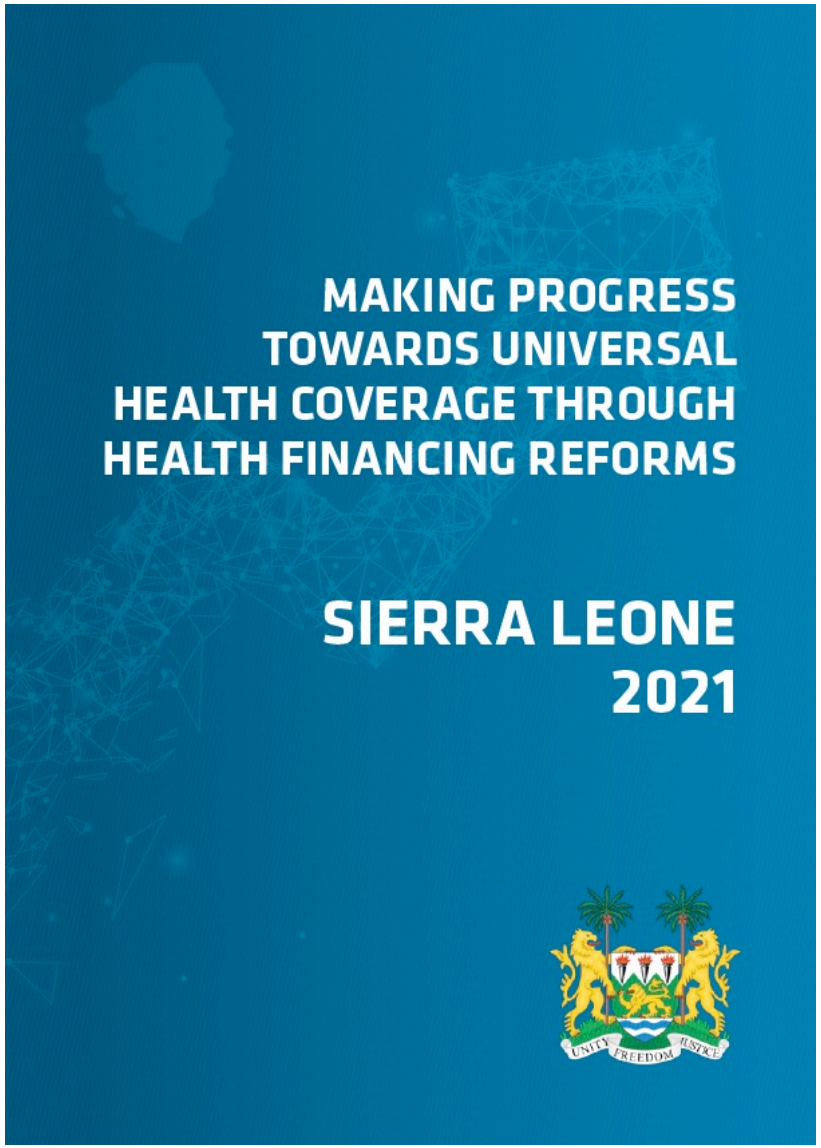
4.3
Publication of HFPM report
(at least three options)

4.4
Event to disseminate findings with key stakeholders

Country assessment report – SIERRA LEONE

World Health Organization

BLOG



FOREWORD

The Health Financing Progress Matrix is a tool developed by the WHO Department of Health Systems Governance & Financing. It assesses the country's health financing system against a set of evidence-based benchmarks that were identified as being key in order to make progress towards Universal Health Care (UHC). The matrix signals the direction in which the various aspects of health financing system need to develop.

Sierra Leone has launched the UHC roadmap at the end of 2019, which outlines the next few years of work. In order to setup the health financing system as a solid foundation for progress towards Universal Health Care, the Ministry of Health and Sanitation set out to assess progress so far with the Health Financing Progress Matrix. This made Sierra Leone only the second country in West Africa to finalize this process, and the first to do so without external consultants. The process was fully led and guided by the Principal Health Economist, drawing on a team of health financing experts and enthusiasts within the country. The report was drafted using a consultative approach, and the recommendations were reviewed by several outside experts from both within and outside of the country. This assures a solid evidence-based, while customization to our Sierra Leonean needs is guaranteed.

The findings of the report are clear: there is space to grow. The matrix helped us identify where our biggest growth areas are – in pooling resources and how we purchase services from providers and pay them for it. The MoHS is cognizant that the health financing landscape is a fragmented one, with several pools. The Government remains the biggest pooling agency and aims to build upon that strength and prepare for a Social Health Insurance Scheme. Together with our development partners, we are also looking at how to strengthening provider payment mechanisms, within the current legal framework.

The Health Financing Progress Matrix also showed that we have already done substantive work in Public Financial Management. Our budget information are available online, an annual execution statements are also published. We are in the middle of migrating the internal payment system from paper-based to online, which will further direct us towards Universal Health Care.

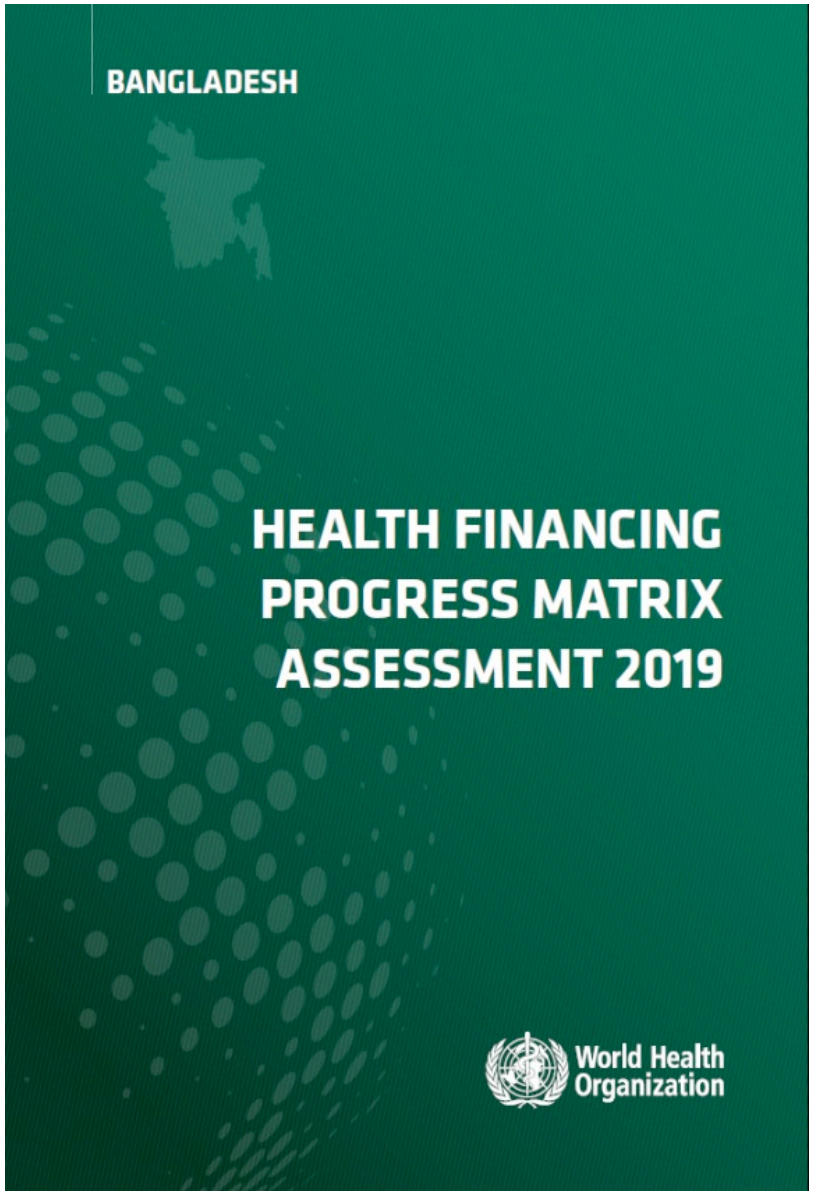
The Ministry of Health and Sanitation is thankful to its staff, development partners and other health stakeholders, especially in the health financing space, that contributed to various efforts in shaping this report. The Government of Sierra Leone is fully committed realization of recommendations coming out of this assessment and we look forward to working across the health sector with our partners and stakeholders to ensure every Sierra Leonean will be benefitting from Universal Health Care as soon as possible.

Austin Demby

Dr Austin Demby
Minister of Health and Sanitation
December 2021

https://portal.mohs.gov.sl/download/33/publications/1652/sierra-leone-health-financing-progress-matrix-report_web.pdf

Country assessment report - BANGLADESH



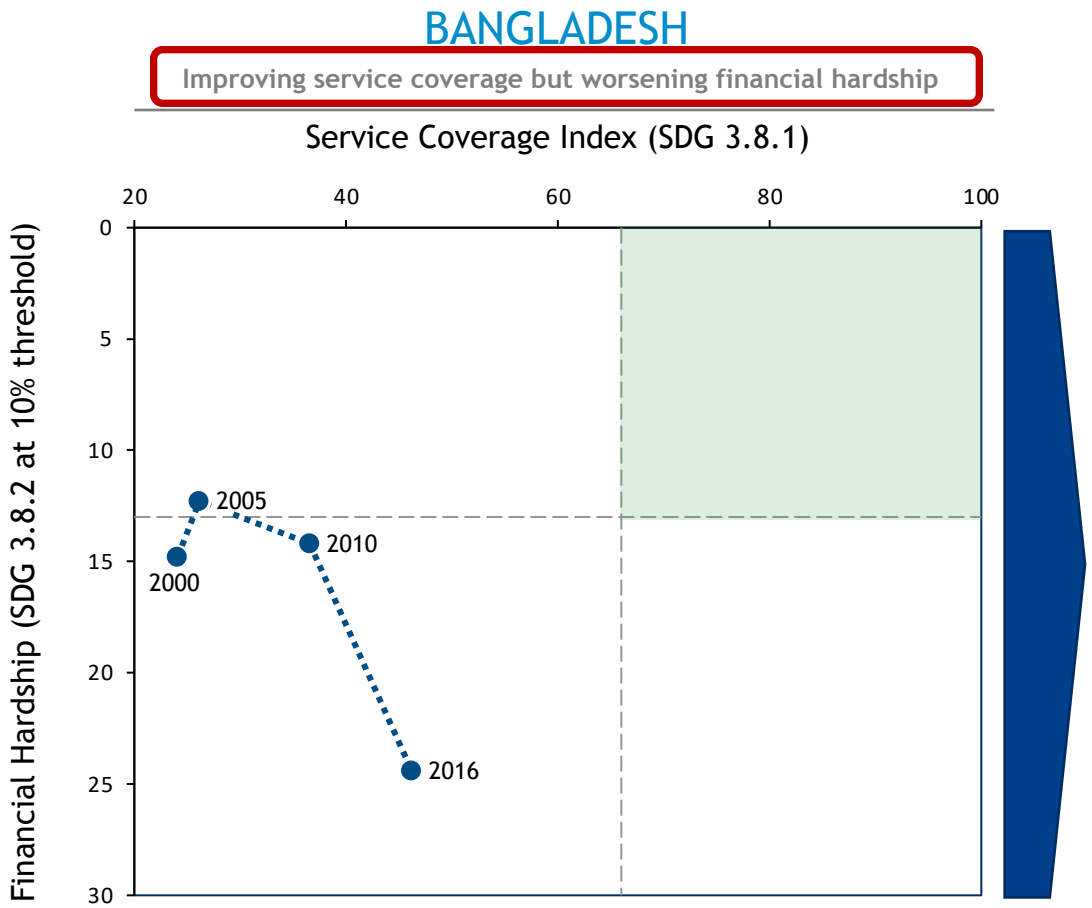
BANGLADESH

HEALTH FINANCING PROGRESS MATRIX COUNTRY ASSESSMENT 2019

DATE COMPLETED:	2019
STAGE / STATUS:	External review completed: for presentation to Ministry of Health

ASSESSMENT AREA		STATUS
POLICY PROCESS	A number of strategic interventions in the Health Care financing Strategy should be reviewed and possibly reconsidered in light of global evidence on health financing. For example, the proposal to establish a number of health insurance schemes targeting different population groups may lead to greater fragmentation in the health system. The draft Social Health Protection Law should also be reviewed as part of this process. While the processes used to develop the health financing strategy have been highly inclusive, it is recommended that a governance mechanism is established, ideally bringing together MOHFW, MOF and other relevant ministries, to hold health financing policy dialogue on a more systematic basis. Finally, in addition to establishing key indicators as part of annual monitoring , for example using the WHO Health Financing Policy Matrix, deeper diagnostic analysis on key policy areas, notably revenue raising and purchasing of health services, should be conducted every 3-4 years.	ESTABLISHED
REVENUE RAISING	The Government of Bangladesh has clear policy statements about the importance of public funding for health services, to ensure a strong foundation for equitable access to health services, and financial protection for patients. Priority to health in the budget remains low, however, and targets set for increased allocations are probably unrealistic, even in the medium term. Even without increased allocations to health, ensing the timely release of funds would help to improve the resilience of front-line services. Targeting budget funds towards the poor, through the SSK, is an innovative use of public funging and has potential to improve access, but needs to move to scale and also to avoid the unintended consquences of drawing more patients to hospitals for primary-care sensitive conditions. Increasing revenues through health insurance for garment workers may yield limited resources and a close look at global evidence is recommended given the potential instabilty of such schemes; plans for earmarked revenues have promise. The use of MTBF is excellent although greater accuracy in forecasts would support planners and implementers.	LATENT
POOLING REVENUES	The government has laid out plans to introduce health insurance schemes e.g. for civil services and garment workers, with the objectives of increasing pre-paid revenues and increasing coverage for these respective population groups. A closer look at the global evidence is recommended to ensure that the establishment of such schemes, whilst increasing the total level of pooled pre-paid funds in the health system, do not create greater fragmentation in the health system and generate greater inequities as a result. Many countries have struggled to progress towards UHC due to the very different benefits , without a clear strategy which prevents this.	PROGRESSING
PURCHASING SERVICES	In the public sector, the current approach to purchasing health services in Bangladesh is driven by the budget structure i.e. input-based line-items; no adjustment is currently made for population health needs, although analytical work has been conducted which proposes a needs-driven formula. Adjusting allocations to sub-national levels by population health needs will help to direct public funds to areas of greatest health needs and support progress to UHC. Under this system, there are no explicit incentives for providers to drive up efficiency in service delivery nor some of the autonomy which would facilite this; with respect to quality of care, whilst there are no specific incentives through the way services are purchased, introducing such measuers could strengthen the various quality improvement initiatives. Establishing patient encounter forms would be a useful measure, as would further experimenting with payment methods as used in SSK and the MVS. Central procurement of medicines together with a focus on generics keeps publicly procured medicines low price, which is extremely positive, although greater price regulation in the wider market would help to immprove financial protection.	LATENT
BENEFITS AND ENTITLEMENTS	Bangladesh is ahead of many countries in having an established universal essential service package, developed using several evidence-based critiera and through an inclusive stakeholder process. To improve this further, a process to regularly review the criteria and process used should be established. The SSK was less inclusive in terms of process, and evidence suggests that entitlments need to be more clearly communicated to the population. Perhaps the greatest area for policy consideration is the alignment between the ESP, available public revenues, and the incentives generated through provider payment.	PROGRESSING
PUBLIC FINANCIAL MANAGEMENT	A number of commendable processes have been established in Bangladesh, including a Medium Term Budget Framework, and a budgetary process which includes all key stakeholders (MoF, MoH, external funders) both at inception and mid-term review. Greater training and in some cases delegation of budgetary authority should be considered a priority, including increasing the level of operational funds available at the facility level. The findings and recommendations of the diagnostic analysis of public financial management barriers in the health sector should be carefully reviewed and an implementation plan prepared and discussed. Gradually introducing elements of flexibility in the way funds can be used should be considered in order to support improved efficiency in service delivery.	PROGRESSING
GOVERNANCE	The highly consultative nature of policy making in thehealth sector Bangldesh is commendable, with all key stakholders involved. Similarly, the attention given to transparency through the availability of health budget and other key documents online, and through dissemination events, is welcomed. Areas which Bangladesh might look at to further improve governance in the health system is the strengthening of capacity to plan, monitor and report on budgets at all levels of the system, which would in turn strengthen accountability for performance.	PROGRESSING

Bangladesh has not been able to reduce financial hardship due to weak implementation of health financing policies



HFPM ASSESSMENT 2020 FINDINGS

- Strategies outlined to expand population coverage risk creating greater fragmentation and inequity in the health system
- Poor predictability of budget allocations and low budget execution
- Essential Service Package exists but funds do not flow to ensure delivery

- Reconsider plans to establish new, separate insurance schemes for specific groups eg. garment workers
- Establish budgetary mechanisms to ensure flow of adequate funds to frontline providers focused on ESP
- Address low budget execution and link improvements with increased budget allocations

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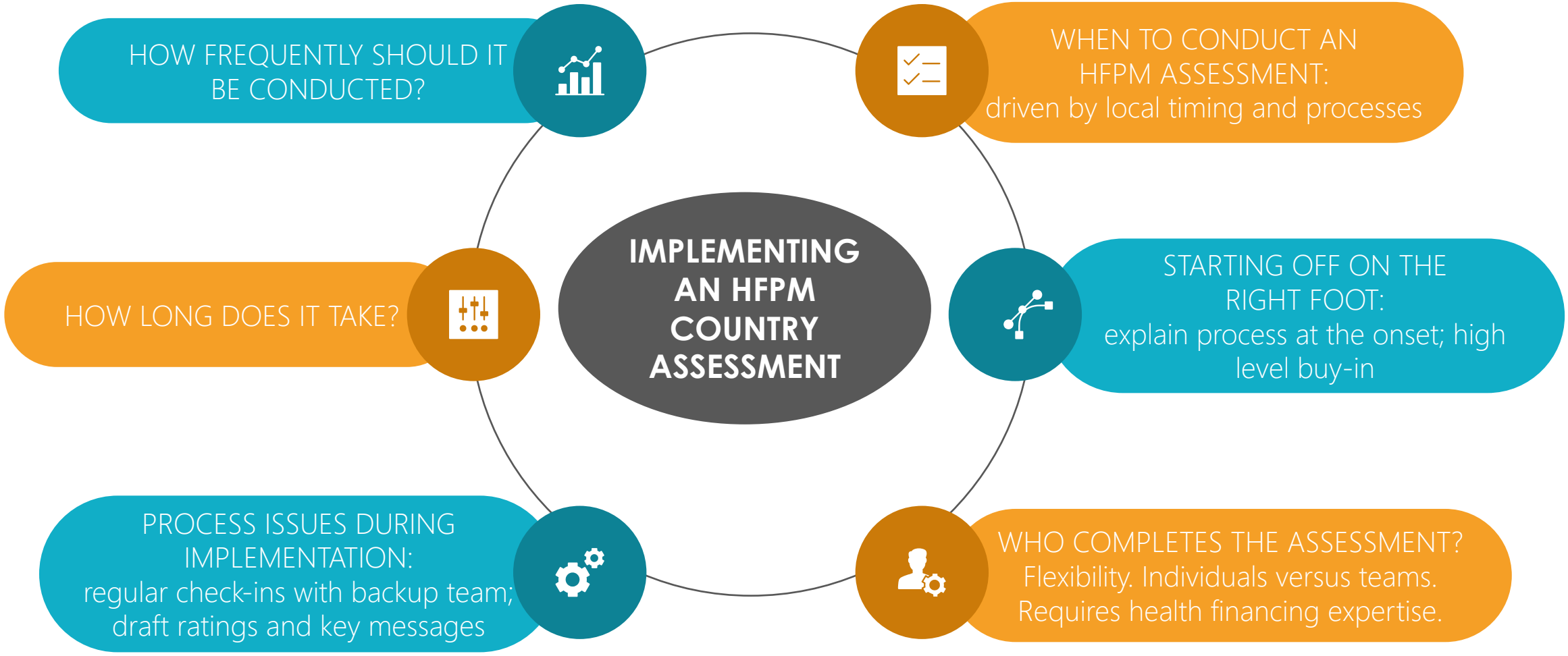
ADDITIONAL ISSUES & REMINDER OF KEY CONSIDERATIONS



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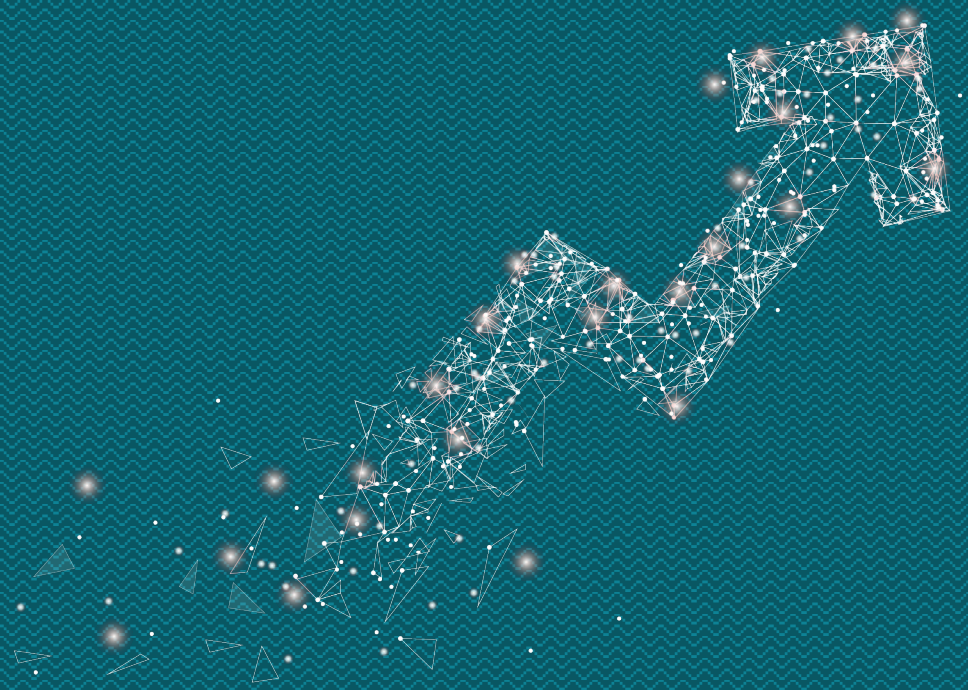


Thank You

Implementation of the Health Financing Progress Matrix

Experience from Ethiopia

Overview of the HFPM implementation in Ethiopia

Purpose

- Support progress towards UHC through **systematic assessment** of the health financing system over time
- To build **consensus** around the health financing situation.
- Identify strengths and weaknesses, inform **revised Health Care Financing Strategy** and **future policy dialogues.**

Implementation

- The work led by the **Ministry of Health's Partnership and Cooperation Directorate (PCD)** with the support from WHO and partners.
- One of the pilot countries for the first version of the HFPM
- Piloted the second version of the HFPM Q2-3 2021

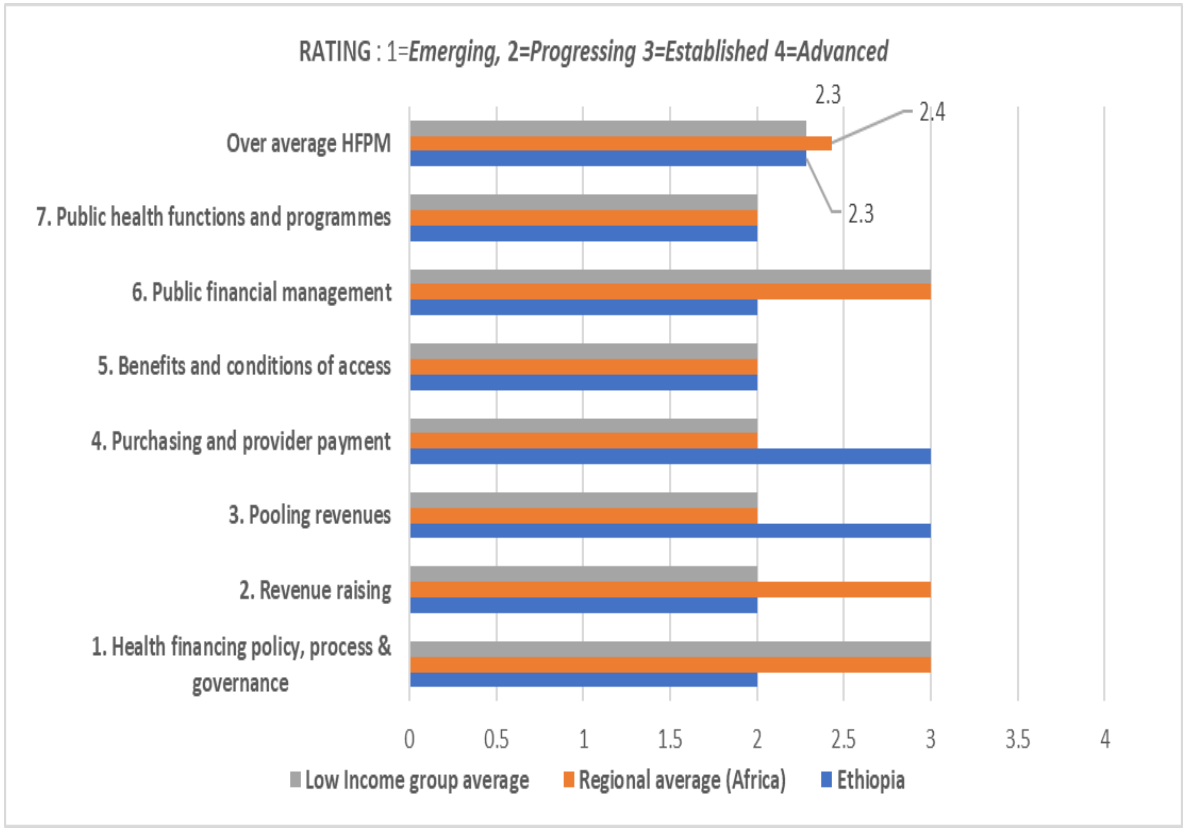
World Health Organization

Results of the HFPM assessment – Stage 1 and 2

Main coverage arrangements

1. Cost-sharing, cost-recovery and exempted services
2. Fee-waiver for indigent households
3. Community Based Health Insurance (CBHI)

Social Health Insurance,
Private insurance
Government health budget



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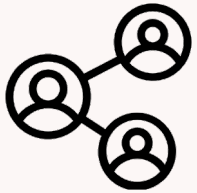
Results of the HFPM assessment – Stage 2

Revenue raising	Pooling revenues	Purchasing
		
▪ Limited move towards reliance on public revenue sources.	▪ High level of fragmentation and limited risk pooling between Community Based Health Insurance (CBHI) schemes.	• Inadequate incentives to improve quality and efficiency. • Predominantly passive rather than active or strategic purchasing.

Stakeholder involvement

- Workshop organized to **validate preliminary result** and discuss their implication in Ethiopia.
- Bringing together **different institutions:** Ministry of Health, Ministry of Finance, the Health Insurance Agency, local universities, donors and implementing partners.
- Split into groups to discuss Stage 1 and Stage 2.

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Challenges and lessons learnt

The different levels can be a distraction – facilitators need to manage discussion

Importance of involving stakeholders – given the complex nature health financing issues

For **large & decentralized countries –** difficult to arrive at overall, system-level conclusions

World Health Organization

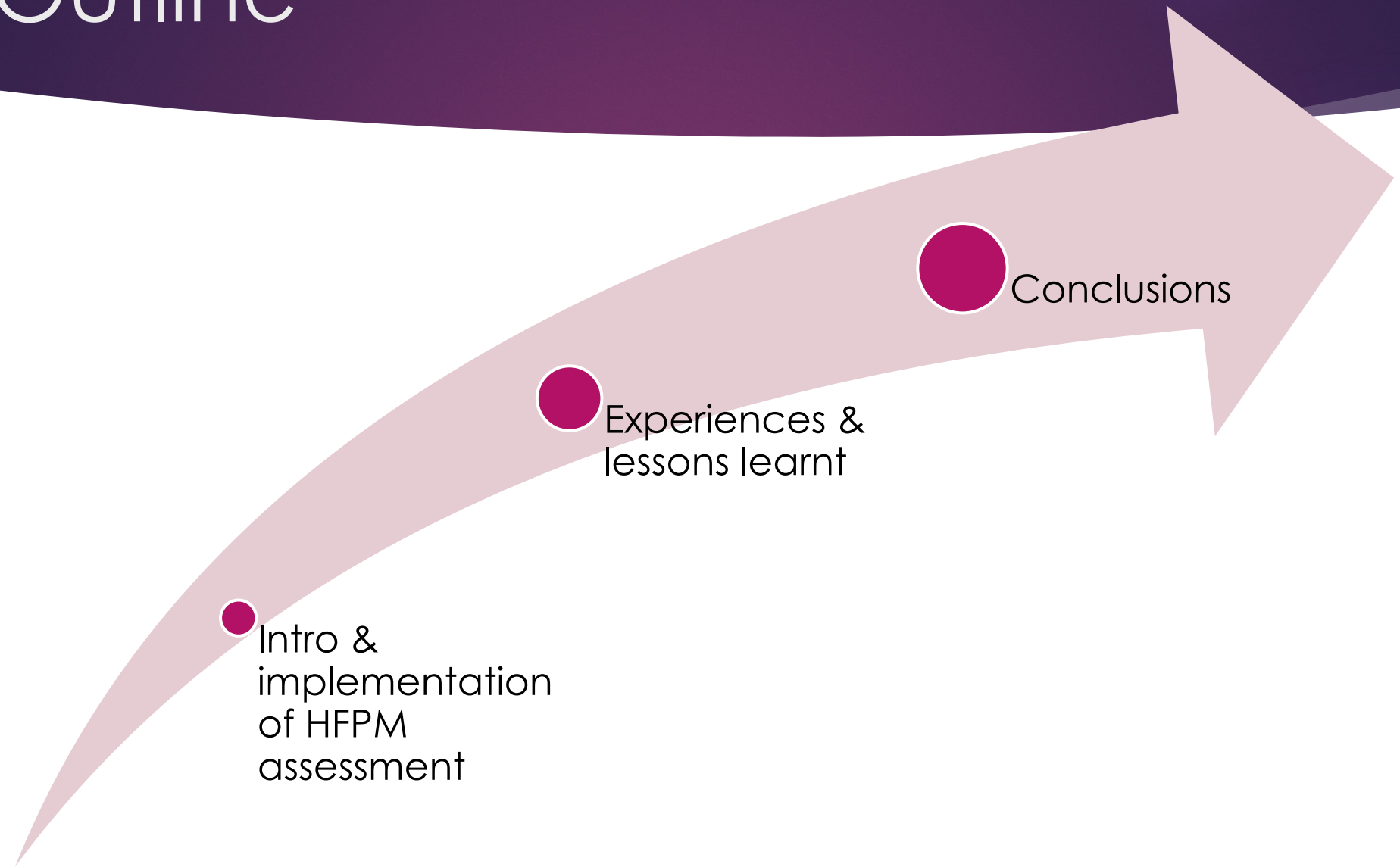
Way forward

- Publication/dissemination of the HFPM based on Version 2 for the public.
- MOH wants to institutionalize the HFPM process and use it to inform future Health Sector Strategic Plans.
- Continue involving stakeholders in the process.

Using the HFPM: Experiences from Uganda

ELIZABETH EKIRAPA KIRACHO
MAKSPH

Outline


Conclusions
Experiences & lessons learnt
Intro & implementation of HFPM assessment

Background

- Uganda is currently evaluating its HFS (2015 – 2020)
- Update the HFPM for Uganda
- Objectives of the HFS

Background – Objectives of the HFS

- To enable equitable, efficient and sustainable mobilization of adequate resources
- To establish and roll out a Social Health Protection system
- To increase effective pooling and strengthen strategic purchasing mechanisms that ensure the attainment of equitable and efficient resource allocation and delivery of quality health services by 2025.
- To develop new and strengthen existing institutional arrangements that will ensure effective accountability and transparency in resource management and use.
- To strengthen mechanisms for harmonized and effective partnerships in financing and delivery of health services.
- To strengthen systems for timely generation and production of health financing and expenditure information to guide policy and decision making.

Resource mobilization interventions

- Increasing government allocation to health
- Improving efficiency for existing resources
- Improving the predictability of external resources
- Increasing the contribution of prepayment to the health sector
- Innovative health financing mechanisms

Interventions - Pooling

Harmonization and alignment of DAH to sector priorities
Pooling DAH and government resources
Establishment of the Health Fund (for pooling JAF & NHIS)
Pooling of health insurance schemes

Interventions - Purchasing

Building capacity for purchasing in the health sector
Results-based financing
Input-based payment
Process-based provider payments (such as contracting, reimbursements, etc.)
Delivery of the benefit package

Introduction

- HFS strategy has been implemented by diff stakeholders.
- What progress has been made?
- What are the obstacles/ challenges?
- What strategies are required to achieve key health financing goals

Introduction

Implementation

- **Initial completion** of the HFPM by a technical team from academia, MOH and WHO.
- **Obtain consensus** - with a team of diverse stakeholders.
- **Validate** - External review team.
- **Currently** matrix completed by technical team.

Experiences and lessons learnt

1.HFPM provides **in depth outline of key areas** that are of importance in advancing health financing .

2. Enables you **identify gaps in the strategy** eg – Public financial management, policy and governance process, benefits & conditions of acess

3. Enables you to **develop relevant milestones/assess achievement** of key milestones… *poorly identified milestones do not allow you to assess progress satisfactorily*

Experiences and lessons learnt

4.HFPM ranking process - **stepwise progress-** assess progress **more objectively** and present progress in a **simple clear manner.**

5.The HFPM tool and findings are only as useful as the information entered – **"gabbage in gabbage out"**

6.When completed well and regularly - allows you to make a good assessment of the **progress made over time –** *if initial findings* were not assessed appropriately , you cant assess progress adequately.

Experiences and lessons learnt

7.

7.HFPM process should also **collect qualitative data** that can enable you to explain the findings observed.

8.HFPM process allows you to **identify specific relevant strategic actions** that need to be taken by the country to make progress in HF based on the findings

9.HFPM findings makes it easier for you to **advocate for required changes** because it makes progress achieved and the gaps clear.

10. A few sections focus mainly on countries with insurance and does not have adequate provision for countries which do not predominantly use insurance.. *Benefits& conditions of access No 4- user fees.. Informal fees . Pooling section- Govt funding*

Conclusion

- HFPM assessment allows you **to appreciate key actions** that need to be taken to advance health financing functions - more effective implementation and evaluation of HF
- The assessment needs to be done by a **technically competent team**.
- The HFPM can inform development, **implementation and evaluation of HFS.**