WHO Symposium on Health Financing for UHC: Managing politics and assessing progress

World Health Organization

9th October 2018 @ the 5th Global Symposium on Health Systems Research

Opening comments

Dr. Agnes Soucat

Director, Department Health Systems Governance & Financing

WHO Geneva

Structure - morning

Tuesday 9th October 2018, ACC room 12		
08:15 – 08:45	**REGISTRATION AND COFFEE**	
08:45 – 09:00	**Opening & welcome**	**Agnes Soucat,** WHO Health Systems Governance and Financing
	SESSION 1	
09:00 – 09:20	**Guiding principles for the development & implementation of health financing policy**	**Joseph Kutzin,** WHO Health Financing
09:20 – 10:00	**Invited response and audience discussion**	**John Ataguba,** University of Cape Town
	SESSION 2	
10:00 – 10:45	• **Motivation for the development of Health Financing Progress Matrices** • **Overview of the structure of HF Progress Matrices** • **Open discussion**	**Matthew Jowett,** WHO Health Financing **Soonman Kwon,** Seoul National University (SNU) Moderator: **Joseph Kutzin,** WHO Health Financing
10:45 – 11:00	**COFFEE/TEA BREAK**	
11:00 – 12:20	• **Country perspectives on initial application of the matrices** • **Invited comments & open discussion**	**Thant Sin Htoo,** Director NIMU, Myanmar **Alfred Misana,** MoHCDGEC Tanzania **Midori de Habich**, former Minister of Health Peru Moderator: **Soonman Kwon,** SNU
12:20 – 12:30	**Wrap up, next steps**	**Matthew Jowett & Joseph Kutzin,** WHO Geneva
12:30 – 13:30	**LUNCH**	

http://www.who.int/health_financing/events/symposium-2018/en/

Structure – afternoon

World Health Organization

SESSION 3		
13:30 – 14:00	Political economy of health financing reform • **Motivation** • **Approach**	**Susan Sparkes,** WHO Health Financing **Jesse Bump,** Harvard T.H. Chan School of Public Health **Ece Ozcelik,** Harvard T.H. Chan School of Public Health Moderator: **Joseph Kutzin,** WHO Health Financing
14:00 – 15:00	Invited responses Open discussion	**Lucy Gilson,** University of Cape Town **Jeremy Shiffman,** Johns Hopkins University
15:00– 15:15	**COFFEE/TEA BREAK**	
SESSION 4		
15:15 – 15:45	Political economy factors and strategies to implement health financing reform Country Panel: Peru, Kenya and Thailand	**Midori de Habich,** former Minister of Health Peru **Wangari Ng'ang'a,** Government of Kenya **Walaiporn Patcharanarumol,** IHPP Moderator: **Grace Kabaniha,** WHO Health Financing
15:45 – 16.45	Group work & open discussion	Moderator: **Jesse Bump,** Harvard T.H. Chan School of Public Health
16:45 – 17:00	Wrap up, next steps	**Joseph Kutzin,** WHO Health Financing

Guiding principles for the development and implementation of health financing policy

Joseph Kutzin, Coordinator Health Financing, WHO Geneva

World Health Organization

Our health financing satellites at HSR Symposia

World Health Organization

- Beijing 2012: Does UHC = UHInsurance
  - (no)
- Cape Town 2014: Financing strategies to reach people in the informal sector
  - (maybe it's not primarily a financing issue)
- Vancouver 2016: Health programs and UHC
  - (putting the S in SDG)
- Liverpool 2018: more explicit guidance on design, and a recognition that strategies are not enough

Before we begin, the core assumption (even if it is to be progressively realized)

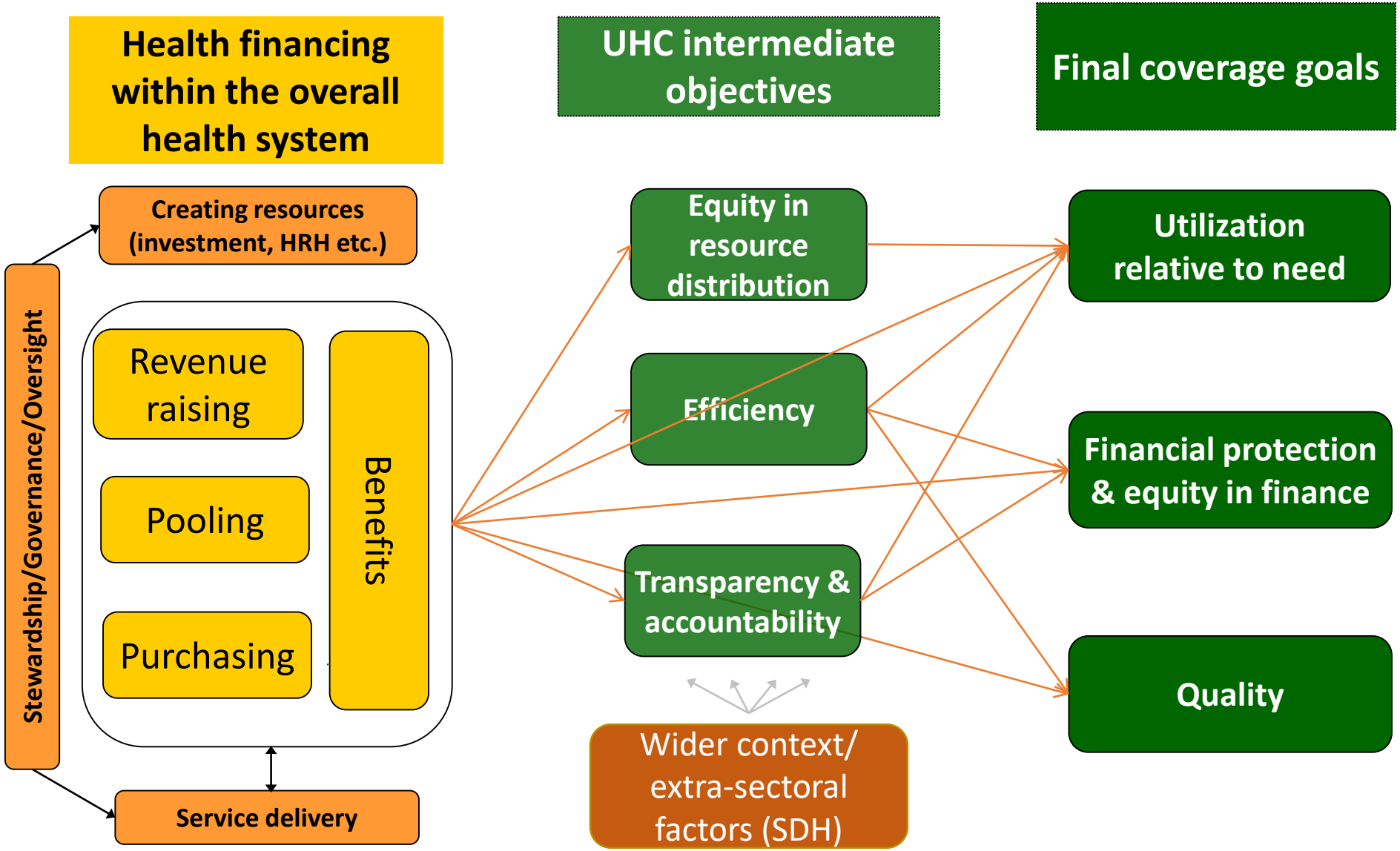
World Health Organization

- **ALL PEOPLE** are able to get the services they need, of good quality, without fear of financial hardship
    - ALL PEOPLE = $\sum_{i=1}^{N}$ PERSONS (i.e. non-discrimination, regardless of age, skin color, ethnic group, language, sex, citizenship status, religion, income, sexual preference...)
- The approaches we will talk about today takes this as a given…otherwise, we are talking about financing for something other than UHC

Assuming we accept this normative proposition…

- Operationalize UHC as a direction, not a destination
  - Reduce the gap between need and utilization (equity)
  - Improve quality
  - Improve financial protection
- Assessed at the level of the entire system and population (our “UHC unit of analysis”)

How can health financing arrangements influence progress towards UHC?



WHO diplomacy since WHR2010: "The path to UHC should be home-grown"

World Health Organization

- Even though broad UHC goals are shared by all…
  - Specific manifestations of problems vary, so how the goals should be operationalized will vary as well
  - Every country already has a health financing system, so starting point for each country is unique
  - Mix of fiscal and other contextual factors also unique

- But this should not be interpreted to mean that "anything goes" – we have learned a few things over past 30 years
  - Some "do's" and "don'ts" in health financing policy
  - Hypothesis: repeating mistakes made by others is not obligatory (my hope…not sure if it is evidence-based)

World Health Organization

a less diplomatic approach to health financing

Being more assertive

- "Guiding principles" or "signposts for change"
- Based on, to varying degrees, and in combination
  - Evidence
  - Theory
  - Common sense application of UHC "scheme to system" logic, combined with functional approach to health financing
- As principles/concepts, must be universal (i.e. applicable to all countries)

Remember that Beveridge and Bismarck are dead (and need to stay that way)

World Health Organization

- Labels like “social health insurance” or “tax-funded systems” are not helpful for understanding what a country is actually doing or the options available
- Sources are not systems
- Functional approach more useful

  - Disaggregated view of collection, pooling, purchasing, benefits, and wider governance arrangements
  - Relevant to countries at all income levels
  - And many countries are now overcoming their fragmented legacy and coordinating different funding sources, channeling general budget revenues into a distinct purchasing agency, etc.

High-level principles to guide health financing reforms (it's not "anything goes")

World Health Organization

- Move towards predominant reliance on compulsory (i.e. public) funding sources

- Reduce fragmentation to enhance redistributional capacity and reduce administrative duplication
  - Pools should be large, cover populations with diverse health risks, and involve mandatory/automatic coverage

- Towards strategic purchasing to align funding and incentives with promised services, promote efficiency and accountability, and sustain progress

Time to say no to this……

- Expecting self-employed individuals to make regular contributions to pre-payment schemes (whether “social” or “micro”…)
  - When this doesn’t work in your country, it’s ok to be disappointed, but it’s not ok to be surprised

Pooling: directions for equity and efficiency

World Health Organization

- Consolidation/merger
  - Combine existing pools (Turkey)
- Compensation
  - Raise level of explicit entitlements for poor/informal (Thailand, Mexico, Burundi, Gabon, Peru), even if separate, to reduce gap in per capita funding levels
- Equalization
  - Central subsidies to poorer regions (China), and more generally, equalization grants in federal systems
- "As-if pooling" by sequencing pre-conditions
  - "Pool the data" first: harmonize information systems to enable inequities to be documented, and provide foundation for a future unified system (Korea, Kyrgyzstan)

Strategic purchasing of health services

World Health Organization

- Linking allocations to providers to data on their performance and/or the health needs of the populations they serve, while managing expenditure growth
- In practice, move away from the extremes of
  - Rigid, input-based line budgets
  - Completely unmanaged fee-for-service
- Reduce/eliminate obvious conflicts-of-interest (e.g. physician owners/investors in diagnostic centers)
- Best example: China vs Thailand in the 2000s
- Message: you can't just spend your way to UHC

Chinese Public Hospitals: “perfect alignment” of wrong incentives

Source of slide: Prof. Winnie Yip

- All staff of the hospital are investors in the CT scanner with objective to maximize its use

More granular signposts based on objectives for functions and policies (1)

- Revenue raising
  - Multi-year predictability as a basis for planning
  - Stability in flows to make efficiency possible

- Pooling
  - Aim for explicit complementarity of different sources (it doesn't happen automatically, and more isn't necessarily better)
  - Avoid scheme expenditures > scheme population coverage (beware distortionary spillover effects)

More granular signposts based on objectives for functions and policies (2)

- Purchasing
  - Avoid open-ended commitments/mechanisms
  - Some degree of provider autonomy over resource allocation
  - Towards unified/interoperable data platform on patient activity, even if multiple schemes (Kyrgyzstan and US State of Maryland vs Ghana)
  - Ongoing analysis of data to inform decision-making
  - Towards formula-based payment systems

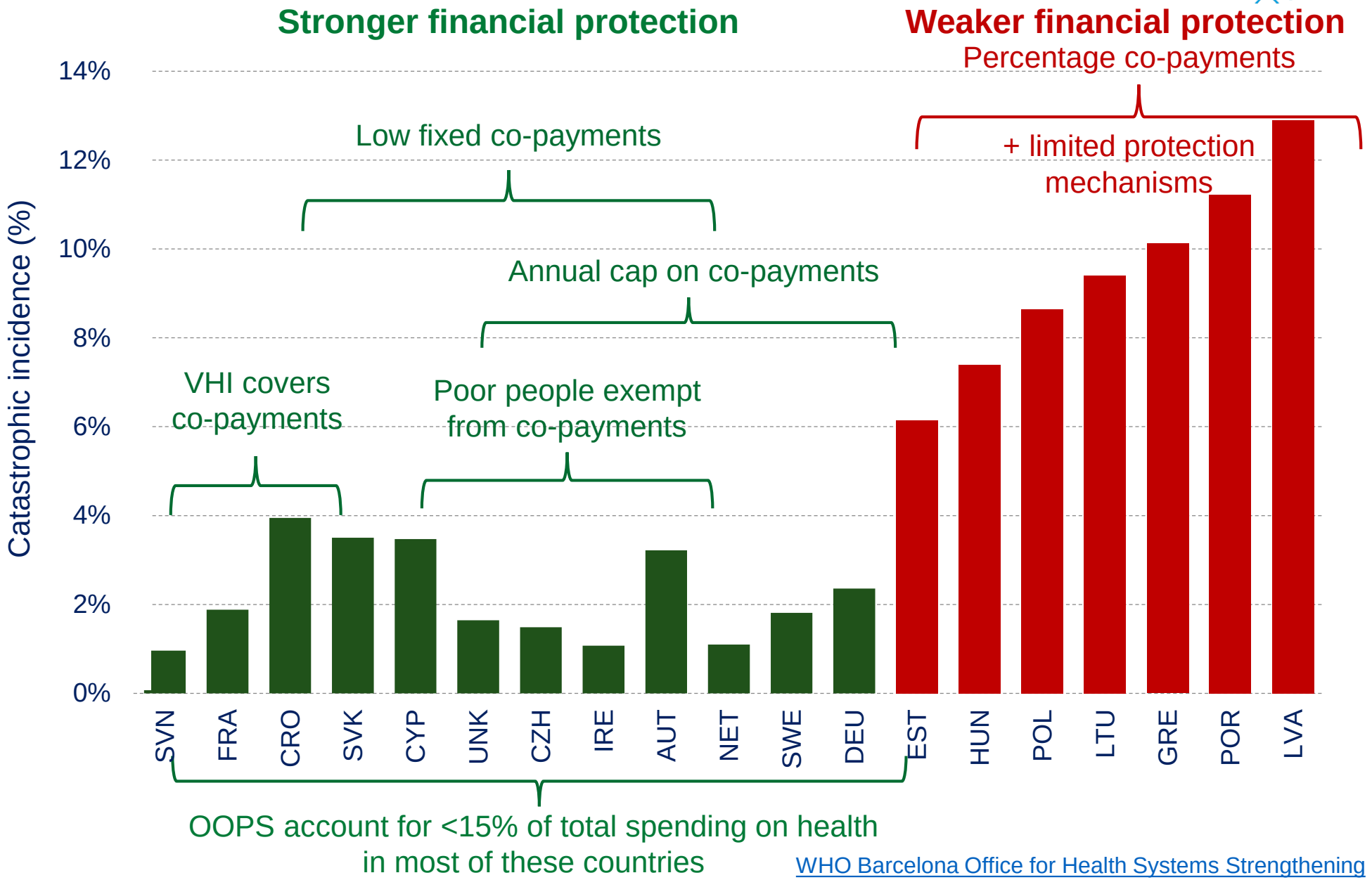
More granular signposts based on objectives for functions and policies (3)

World Health Organization

- Benefit design
  - Clarify the entitlements and obligations of the population, and communicate these in layman's terms, especially for first contact (e.g. by level of care)
  - Align promised benefits with provider payment
  - Don't pay for harmful or unnecessary services or inputs (e.g. Human Growth Hormone in Iran)
  - Establish mandatory analysis of cost-effectiveness and budget impact of proposed additions to promised services
  - If co-payments/user fees, design for understanding and to protect against financial risk (absolute rather than percent)

New evidence on co-payment design

World Health Organization



WHO Barcelona Office for Health Systems Strengthening

Simple & people-centred co-payment design works best

World Health Organization

1
Replace percentage co-payments with low fixed co-payments

2
Exempt poor people and regular service users

3
Cap all co-payments per person (not just for medicines)

Feasible everywhere

Requires more administrative capacity

- Source: WHO Barcelona Office for Health Systems Strengthening (2018)

Contextualizing guidance for LMICs => PFM matters!

- In contexts of high informality, moving towards compulsory sources means more reliance on general government budget revenues
- To purchase services strategically from budget revenues, need to be able to "match" to priority services and populations
  - Most public financial management (PFM) systems only allow to pay for buildings and inputs
  - So addressing budget structure, formulation, use, and reporting are absolutely central to the UHC agenda

World Health Organization

Final reflections

Today's fun

- Morning
  - Transforming these principles and signposts into a (yuk) "tool" to both assess and encourage progress with health financing reforms: the progress matrix
- Afternoon
  - Trying to take on an explicit weakness in (our's and other's) technical approaches by incorporating political economy considerations to enable countries to move from strategies to (good) implementation

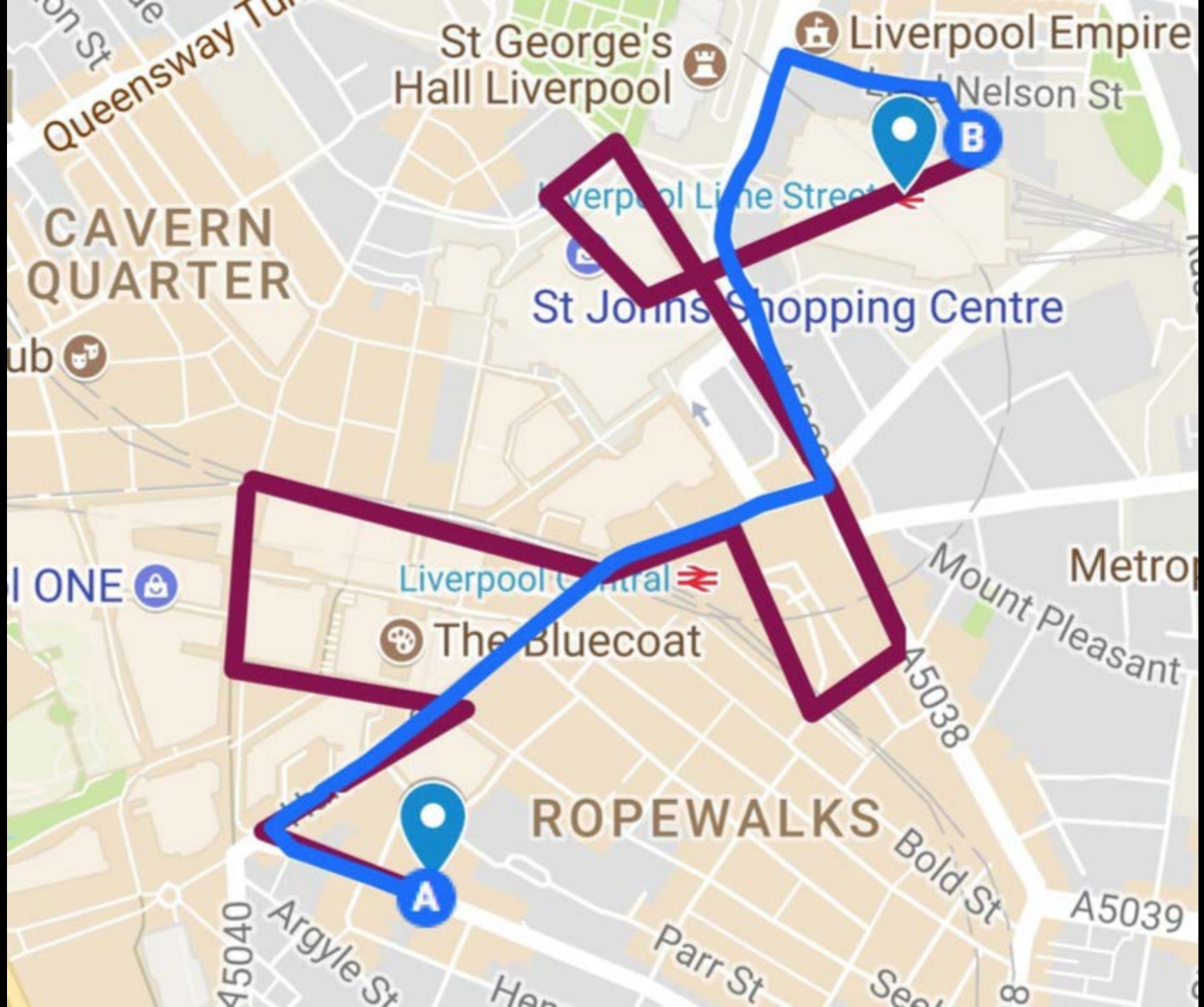
Looking forward to our discussions

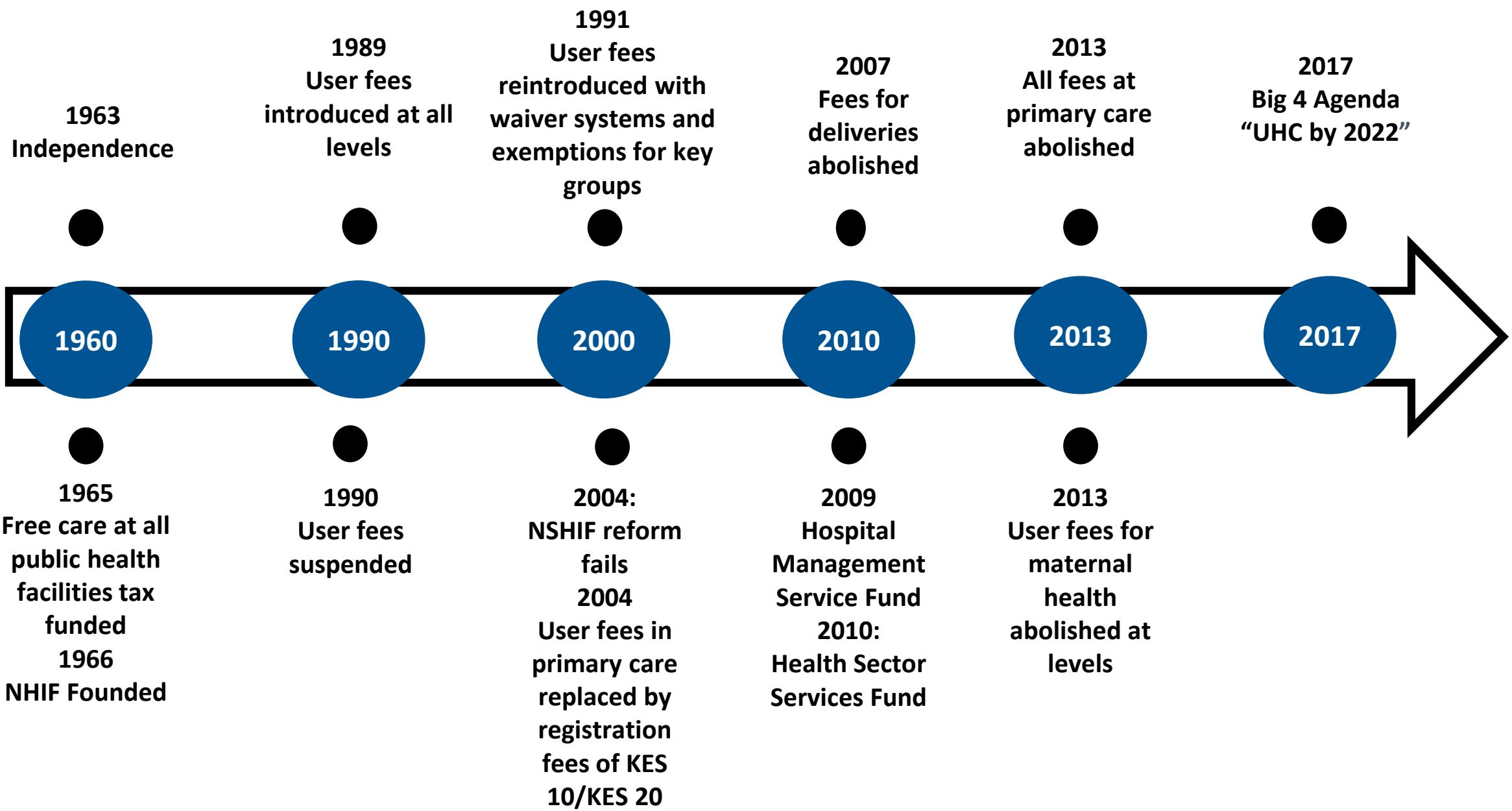
- What do you think of the principles and guideposts?
  - Relevance to policy design and implementation?
  - Testable hypotheses for researchers?

- THANK YOU

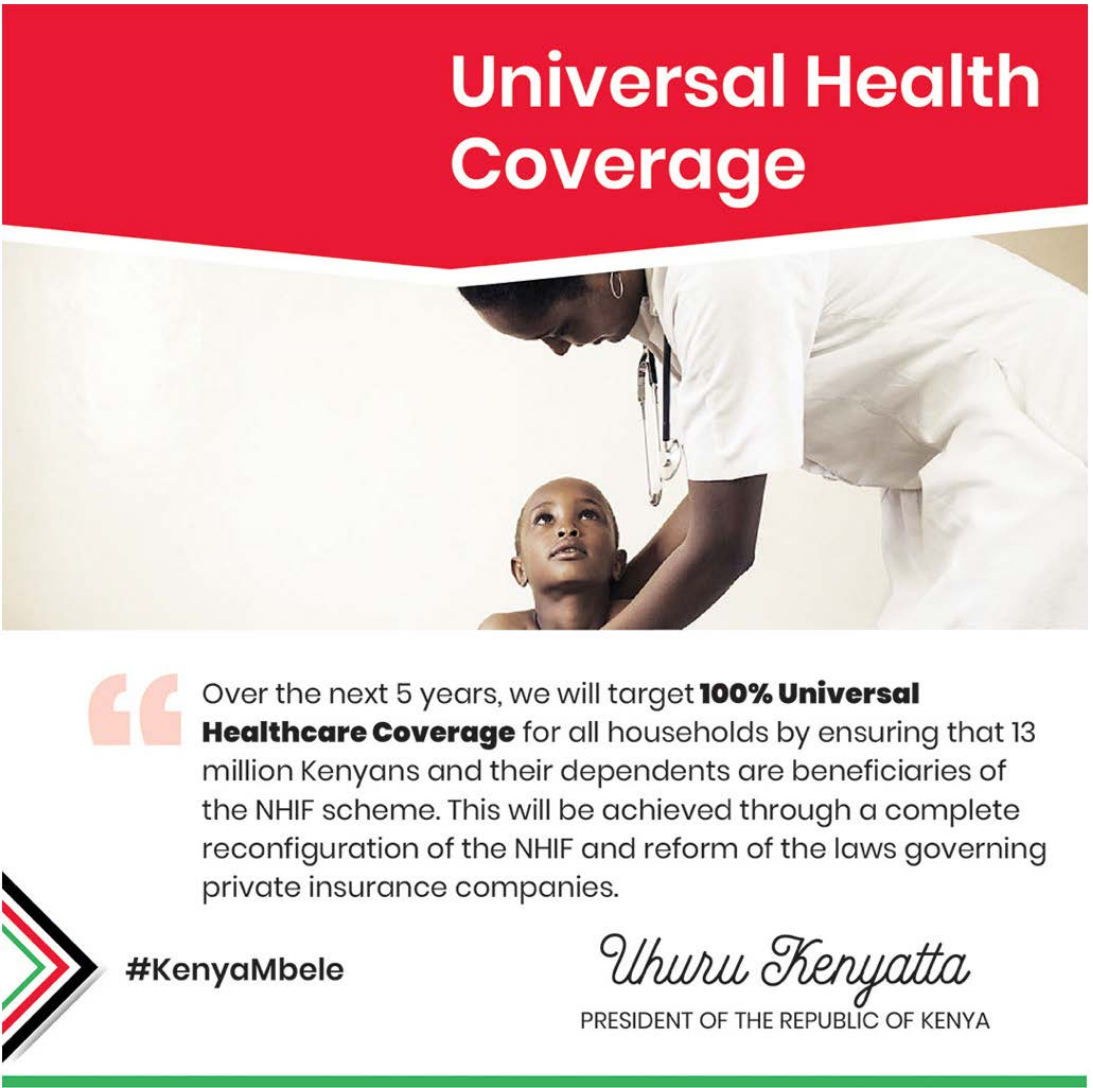
Health financing guiding principles and guideposts: some reflections

Kenneth Munge, KEMRI Wellcome Trust Research Program


St George's Hall Liverpool
Liverpool Empire
Nelson St
B
CAVERN QUARTER
St Johns Shopping Centre
ONE
Liverpool Central
The Bluecoat
Mount Pleasant
A5038
ROPEWALKS
Bold St
A5039
A
Argyle St
Parr St


1963
Independence
1989
User fees introduced at all levels
1991
User fees reintroduced with waiver systems and exemptions for key groups
2007
Fees for deliveries abolished
2013
All fees at primary care abolished
2017
Big 4 Agenda "UHC by 2022"
1960
1990
2000
2010
2013
2017
1965
Free care at all public health facilities tax funded
1966
NHIF Founded
1990
User fees suspended
2004:
NSHIF reform fails
2004
User fees in primary care replaced by registration fees of KES 10/KES 20
2009
Hospital Management Service Fund
2010:
Health Sector Services Fund
2013
User fees for maternal health abolished at levels

What does UHC really mean? A question of framing? By whom?



"…the words that the President used were affordable healthcare, which is significantly different from universal healthcare… " [which is different from…]

Source: Ndemo B. Daily Nation (Online)
https://www.nation.co.ke/oped/blogs/dot9/ndemo/2274486-4323102-6lt9alz/index.html

So ignoring that we may be talking about financing something other than UHC…

Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)

Improve stability (i.e. regular budget execution) in the flow of public (and external) funds

Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)

Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries

Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)

Improve stability (i.e. regular budget execution) in the flow of public (and external) funds

Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)

Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries

Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)

Improve stability (i.e. regular budget execution) in the flow of public (and external) funds

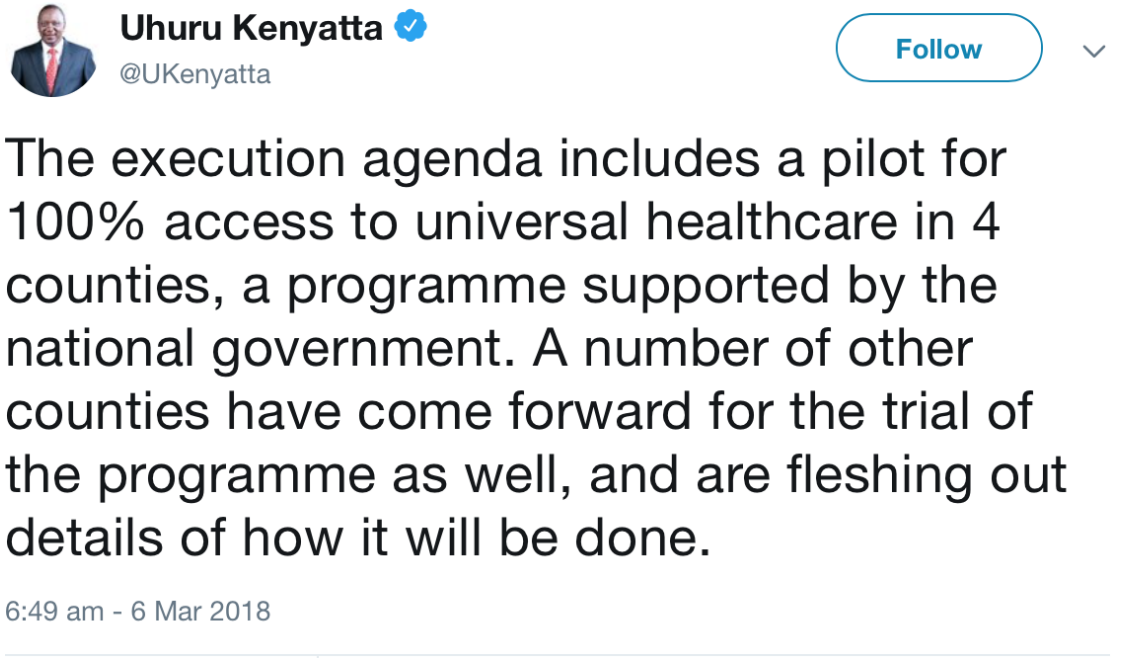
Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)

Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries

Predominant reliance on public/compulsory funding sources

"I turn to the third element of the Big Four. It is universal healthcare…**by providing medical insurance cover** for every Kenyan within the next five years."

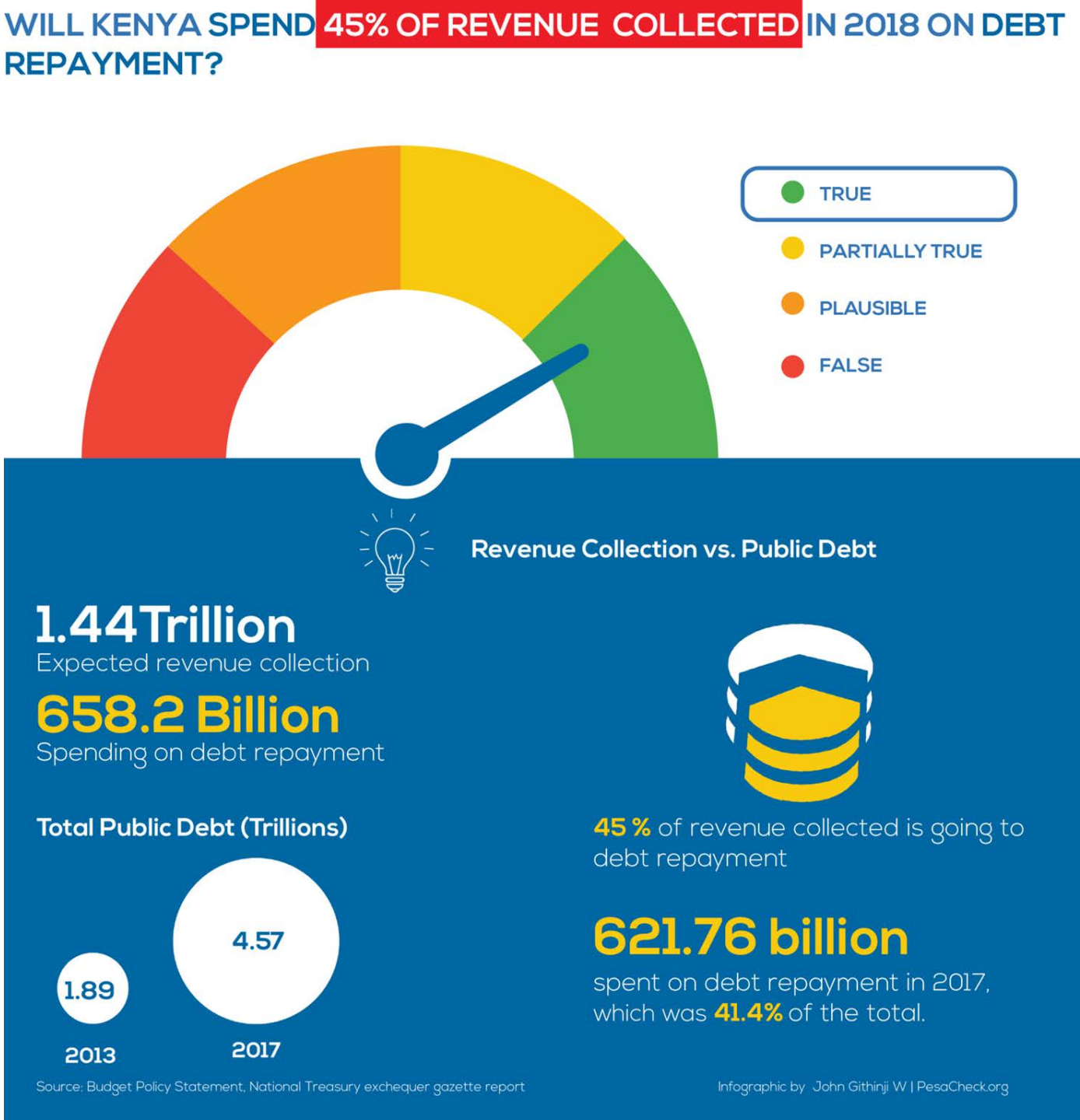
Source: Speech by His Excellency Hon. Uhuru Kenyatta, CGH, President and Commander in Chief of the Defence Forces of the Republic of Kenya during the 2017 Jamhuri Day celebrations at the Moi International Sports Centre, Kasarani on 12th December, 2017



…suggests we can't really ignore that we're talking about financing something other than UHC

Insurance Coverage as Percentage of Population		
Data Source	Any insurance	NHIF
KHHEUS 2003	9.7%	No data
KDHS 2009	8.17%	1.56%
KHHEUS 2007	10.0%	8%
KHHEUS 2013	17.1%	15%
KDHS 2014	19.59%	15.80%
KHHEUS 2018*	19.10%	No data

Source: Data (above): Kazungu and Barasa 2018; Image (right): https://pesacheck.org/how-much-will-kenya-spend-on-debt-repayment-in-2018-4bde15937409



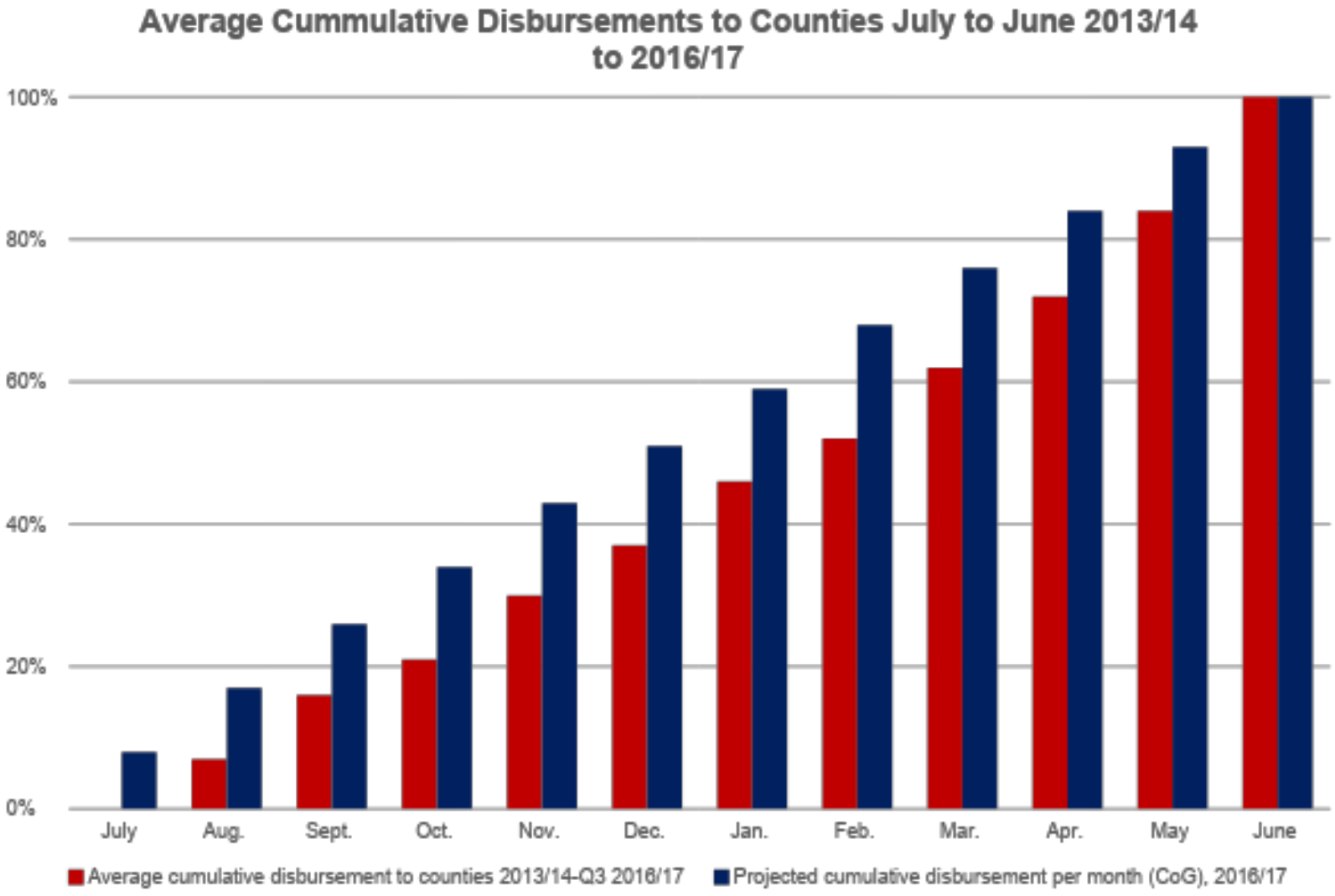
Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)

Improve stability (i.e. regular budget execution) in the flow of public (and external) funds

Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)

Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries

Improve regularity of financial flows



Taken together county governments are the largest purchaser of health services in Kenya by size of funds

Purchasing activities affected by irregularity of financial flows

Source: Data (left): Kinuthia 2017 Are the Taps Dry? Cash Flow in Kenya and the Implications for National and County Spending. IBP Kenya

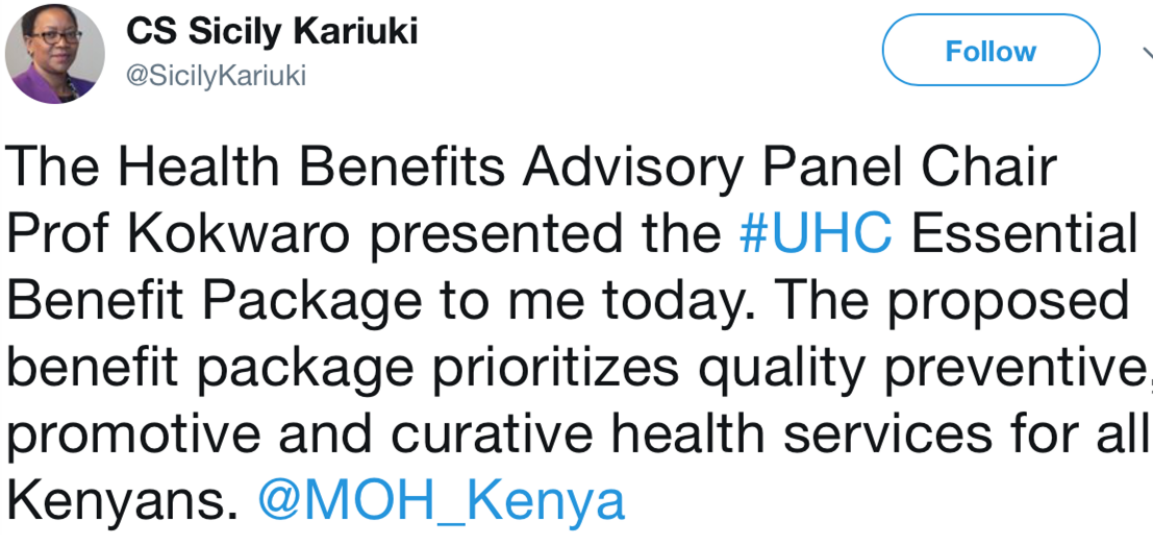
Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)

Improve stability (i.e. regular budget execution) in the flow of public (and external) funds

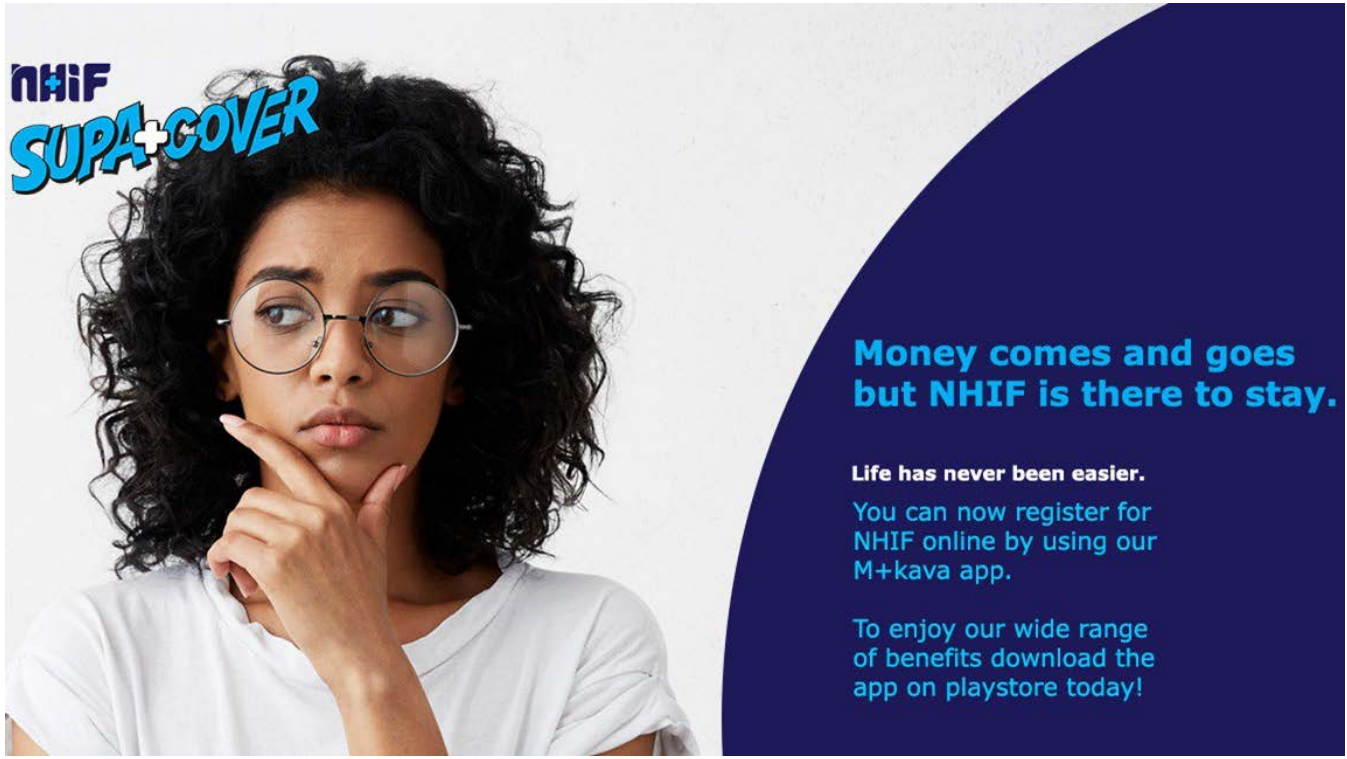
Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)

Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries

Clarify the population's legal entitlements



Improve the population's awareness



Health Financing Progress Matrices:
What are they and why are they being developed?

World Health Organization

A number of ongoing issues and questions

- Is the way that health financing policy is being developed and implemented consistent with the goals of UHC? How do we know? How can we make any assessment systematic?
- Quantitative outcome measures (SDG) tell us whether or not progress has been made (at least two years ago), but are not enlightening in terms of how policy and or implementation needs to change……
- …..nor do they capture ongoing dialogue & developments, be they positive, or negative.
- The need to make the case for health system strengthening efforts better, and give greater visibility to their value.

What we want to develop

- Something which…..
  - is **useful** for those engaged in health financing policy development and its implementation, in order to:
    - look back critically at recent developments
    - review current plans
    - inform future action
  - provides a **structured & systematic approach** to do this, rooted in the guiding principles & guideposts
  - is **sensitive** to and captures the dynamic nature of policy development and implementation - over time - within a country - less so across countries
  - provides **rapid feedback** to policy makers, and facilitates policy adjustments and refinements; identifies priority action points, next steps; sequencing & prioritisation

and which is also….

- **credible** and rooted in principles / values, and evidence.

- May 2018 review meeting. **Strong opinions that the matrices are more than something to monitor progress**; can support diagnostic and evaluation work, inform policy development.

- evolving into a synthesis of everything we (think we) know about health financing and the values inherent in the UHC agenda.

- deliberately sacrifice detail in depth to be comprehensive in breadth, capturing key health financing features which matter.

a series of matrices….

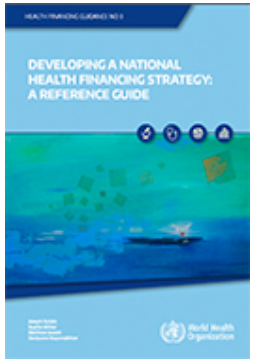
- Based around the health financing functions plus:
  - Policy development process
  - Public financial management
  - Governance arrangements for health financing

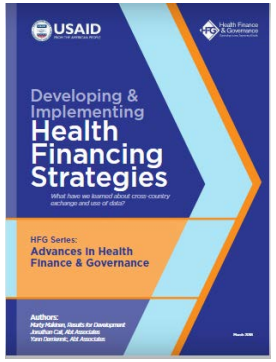
- Evolution over previous applications; also inspired by clarity of ‘maturity model” idea.

- Can use / build on existing assessments rather than duplicate.

- Evolving into a synthesis of everything we (think we) know about health financing and the values inherent in the UHC agenda.

Health financing strategy development





Process guide: PFM / HF alignment (WHO& R4D)

Foundations & structure of the Health Financing Progress Matrices

Professor Soonman Kwon, Seoul National University, Korea

World Health Organization

I. Rationale

1. Qualitative

Qualitative assessment of the overall financing system
(from the perspective of the governance of health financing system)

A few existing quantitative models
- Obvious and straightforward
- Time lag before reliable data become available
- Often fails to provide contextual stories and directions for policy change

This qualitative approach can be supplemented by quantitative indicators (with agreed-on set of indicators, but we should be aware of the time lag)

2. Process and progress

Examines the policy process and progress to achieve the UHC intermediate objectives and final coverage goals

Agreement on final outcomes/goals of health financing for UHC (e.g., financial protection measures) does not necessarily inform policy makers of LMICs how to move toward achieving the UHC goal

This model aims to provide more detailed guidelines (although they can be adjusted to local contexts) or policy options how to reorganize health financing systems to make progress to UHC

3. Parsimonious

Good model needs to be parsimonious

The matrices do not aim to cover all possible aspects of health financing

- Initially targets about 50 questions in total to grasp the essential/key aspects

4. Implementation

Some existing models are highly technical and too long, and only experts and hired consultant can complete the assessment

For this approach, government officers (MoH, MoF, finance/insurance agency, etc), development partners (WHO, WB, etc), and other stakeholders in each country ideally get together and complete the assessment on a consensus basis

Opportunity for government officers to review their system and contemplate the future policies

5. Local contexts

This approach aims to provide a general framework that can be applied to different types of health financing system

Each country can choose

- To further separate the questions: e.g., pay for primary care and pay for hospital care
- Not to answer some questions if they are not relevant to its system

This approach does not aim to produce a league table of countries in health financing progress/performance:

Inter-temporal comparability is important while cross-country comparability is not

6. Questions and scales

Two options

- Lengthy questions with simple scales such as “very underdeveloped”, “underdeveloped”, “developed”, “highly developed”
- Short questions with lengthy scales containing more explanations: e.g., Scales can incorporate the quality dimension of policy (in addition to its existence)

This approach tries to frame both the questions and scales with some details (Optimal degree of details?)

- Questions themselves need to be understood clearly (as health financing may seem too technical to government officers)

7. Structure and logical framework

Health financing system (main functions of health financing)

- Policy development process for health financing
- Raising revenue
- Pooling revenue
- Purchasing and provider payment system
- Benefits and entitlements
- PFM (Public Financial Management
- Governance

Each question is based on Guiding Principles in national health financing strategy (Kutzin, Witter, Jowett, and Bayarsaikhan, 2017)

II. Guiding Principles for Health Financing Reforms in support of UHC

1) Revenue raising (RR)	
Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)	(RR1)
Increase predictability in the level of public (and external) funding over a period of years	(RR2)
Improve stability (i.e. regular budget execution) in the flow of public (and external) funds	(RR3)

2) Pooling revenues (PR)	
Enhance the redistributive capacity of available prepaid funds	(PR1)
Enable explicit complementarity of different funding sources	(PR2)
Reduce fragmentation, duplication and overlap	(PR3)
Simplify financial flows	(PR4)

3) Purchasing services (PS)	
Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance, or a combination	(PS1)
Move away from the extremes of either rigid, input-based line item budgets or completely unmanaged fee-for-service reimbursement	(PS2)
Manage expenditure growth, for example by avoiding open-ended commitments in provider payment arrangements	(PS3)
Move towards a unified data platform on patient activity, even if there are multiple health financing / health coverage schemes	(PS4)

4) Benefit design and rationing (BR)	
Clarify the population's legal entitlements and obligations (who is entitled to what services, and what they meant to pay at the point of use)	(BR1)
Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries	(BR2)
Align promised benefits/entitlements with provider payment mechanisms	(BR3)

III. Health Financing Progress Matrices

MATRIX 1: Policy Development Process

World Health Organization

1	**Assessment of current performance and identification of the determinants of performance:** **Has an in-depth diagnosis or assessment of your health financing system been conducted recently which examines the impact on health system performance along with the causes of performance problems?** **➔ If necessary, you can separate this question into four in terms of 1) revenue raising; 2) pooling; 3) purchasing; and 4) benefits**
2	**Formulation of appropriate strategies:** **Is there an up-to-date policy statement related to health financing, which has been converted into relevant legal documents/government orders?**
3	**Monitoring and evaluation:** **Does a system exist to routinely monitor health financing, and are data used to track progress (e.g. on expenditure patterns and financial protection) and to strengthen public accountability?**
4	**Are evaluation studies undertaken on a systematic basis to assess the implementation of specific health financing reforms and their consequences for policy objectives, and are findings used to inform the design & revision of health financing policies?**

MATRIX 2: REVENUE RAISING

1	**What is your country's approach to developing revenue raising policies and strategies, within an overall process of policy development and implementation planning for health financing?**
2	**To what extent does health financing in your country rely on public/compulsory funding sources (e.g. taxation/public revenues, including mandatory contributions for national/social health insurance)?**
3	**To what extent is public funding for health in your country predictable over a period of years?**
4	**To what extent is the flow of public funds stable, as a result of regular execution i.e. timely release of funds in line with approved health budgets?**
5	**To what extent are the different revenue sources raised in a progressive way (i.e. based on capacity to pay), and hence promote equity in the way the health system is funded?**

MATRIX 3: POOLING REVENUES (1)

1	Describe the existing health coverage schemes (or pools) with the key characteristics of each, for example the target population, actual population covered, and revenue sources.
2	What is your country's approach to arrangements for pooling revenues, within the overall process of policy development and implementation planning for health financing?
3	To what extent are there limits to the re-distributional capacity of prepaid funds in your country, which arise from health financing institutional arrangements?
4	To what extent are there measures, related to benefit design, provider payment, or non-financial underlying systems, that address problems arising from fragmented pools?

MATRIX 3: POOLING REVENUES (2)

5	**To what extent are different revenue sources and funding streams organized in a complementary manner, for the purpose of financing a benefit package for the entire population?**
6	**To what extent are voluntary health insurance (VHI) arrangements a source of inequity, creating potentially harmful spillover effects for the wider health system?**
7	**To what extent are fund flows incoherent and duplicative, limiting the potential to use the government budget and donor funds effectively?**

MATRIX 4: PURCHASING & PROVIDER PAYMENT(1)

1	To what extent do fund allocations to lower-level purchasers e.g. local governments, and/or payment rates to providers, reflect population health needs?
2	To what extent are provider payments harmonized across schemes/revenue sources, and across public and private sectors, to ensure coherent incentives for providers? – Payment method and level
3	To what extent do provider payment methods and purchasing in general, promote quality of care, and care coordination across specialties and different levels of care?
4	To what extent do purchasing contracts specify quality of care requirements, including the availability and appropriateness of care, and then monitor/enforce these on a regular basis?
5	To what extent do provider payment methods promote efficiency in resource allocation e.g. reduce over- or under-provision of services, and manage expenditure growth? – Primary care, hospital care

MATRIX 4: PURCHASING & PROVIDER PAYMENT(2)

6	**To what extent are standard claim forms, based on standard patient encounter forms, used regardless of the patient's scheme affiliation, and used to review and assess the claims?**
7	**To what extent do provider payments cover only a portion of total costs, or cover total costs including salary, recurrent expenditures etc?**
8	**To what extent are providers given financial autonomy, and held accountable, to an extent which is realistic and in line with their capacities?**
9	**To what extent is provider accreditation or selective contracting established, functioning, and used for purchasing?**
10	**To what extent is purchasing and payment for pharmaceuticals implemented to promote efficient medicines use (e.g. generics rather than originator) and also to improve financial protection for patients?**

MATRIX 5: BENEFITS AND ENTITLEMENTS(1)

1	**Please describe key features of the essential service coverage of your system**
2	**To what extent are benefit decisions and revisions made in a transparent way, based on a clearly-defined process, and agreed criteria e.g. cost-effectiveness, financial protection, budget impact?**
3	**To what extent do benefits entitlements explicitly reflect population health needs?**
4	**To what extent do benefits prioritize priority population groups e.g. for improved use of high priority services and financial protection?**

MATRIX 5: BENEFITS AND ENTITLEMENTS(2)

5	**To what extent are population entitlements and obligations explicitly defined and understood by people?**
6	**To what extent are benefits aligned with provider payment, to ensure that they are delivered and that there is financial protection for patients? (e.g., balance billing)?**
7	**To what extent are benefits, including cost-sharing for patients, aligned with revenues, to ensure adequate funding for approved benefit entitlements?**

MATRIX 6: PUBLIC FINANCIAL MANAGEMENT(1)

1	Has an in-depth diagnosis/assessment of health-sector specific PFM bottlenecks been conducted within the last e.g. 3 years?
2	To what extent are information/evidence on health sector performance used to inform future budget allocation decisions?
3	To what extent is budget process consultative and transparent, e.g. engagement of MoH and lower levels of governments, scope of budget process, etc?
4	To what extent are the health budget allocations aligned with health sector priorities and MTEF (level, structure, nature)?

CURRENTLY BEING FINALISED

MATRIX 6: PUBLIC FINANCIAL MANAGEMENT(2)

5	**To what extent is the health budget structured and executed to enable flexibility in spending? -> If necessary, you can separate this question into two in terms of 1) flexibility in structure and 2) flexibility in execution**
6	**To what extent is health budget fully executed and in compliance with basic budget discipline, e.g., in terms of exceptional procedure and the level of under-spending?**
7	**Alignment of PFM and purchasing:** **To what extent are budget structure and PFM rules on budget formulation and expenditure control aligned with strategic purchasing?**

CURRENTLY BEING FINALISED

MATRIX 7: GOVERNANCE (1)

1	To what extent are roles and responsibilities (related to health financing goals and performance in revenue raising, pooling, purchasing, benefits, etc.) clearly defined and divided across governing institutions in health financing?
2	To what extent does governing institutions in health financing have adequate capacity, including human resources (technical and managerial capacity) and ICT?
3	To what extent are accountability mechanisms for purchaser/financing agencies, including autonomy and governing board of purchaser, rewards/sanctions, etc. in place to ensure that health financing policy supports progress towards sector goals, and funds are used effectively for priority populations, programs, and services?

MATRIX 7: GOVERNANCE (2)

4	**To what extent is the use of funds or performance of national health care purchasing agency or health budget reported to the public (e.g., annual report)?**
5	**To what extent are MoF, MoH, and national health insurance agency engaged and communicated in health financing policy process?**
6	**To what extent is policy making process for health financing transparent and participative?**

World Health Organization

HEALTH FINANCING PROGRESS MATRICES

Version V1.2.1

World Health Organization

MENU

Instructions

Start using the matrices

Check completeness

Your assessment summary

Health system objectives

Print your assessment

Acknowledgement

Thanks are due to those who contributed to the development of the matrices as part of the review meeting held in Geneva in May 2018. Financial support from the Republic of South Korea and the UK (DfID MCHSS) was used to support this work and is also gratefully acknowledged.

http://www.who.int/health_financing/events/symposium-2018/en/

Mapping questions to health system objectives

Most of the issues addressed in the matrix questions have an influence on health system performance; for example, greater reliance on public revenues is expected to improve financial protection. WHO has mapped each question to the objectives and goals of health systems, and is continually reviewing these. On this page you can see a summary of your results in relation to these goals, so for example where your assessment reflects a well-developed situation, or considerable progress, the effect on health system performance is expected to be stronger, and this is reflected below in terms of a darker shade of blue.

underdeveloped — *developed*

		Questions	Efficiency	Equity in resource distribution	Transparency and accountability	Equity in finance	Financial protection	Quality	Utilization relative to need
sing	Q2.1	What is your country's approach to developing revenue raising policies and strategies, within an overall process of policy development and implementation planning for health financing?							
	Q2.2	To what extent does health financing in your country rely on public/compulsory funding sources (e.g. taxation/public revenues, including mandatory contributions for national/social health insurance)?							

https://youtu.be/dPfvgiL_0KY

Reflections from preliminary country application: Tanzania, Peru, Myanmar

World Health Organization

Health financing progress matrices: the experience of Tanzania (1)

- A useful tool to assess process towards Fair and Sustainable health financing
  - Provides the country with a tool to assess itself using options already identified in the tool.
  - It can allow for international comparability
  - The findings can be share in various policy forums such as annual reviews and therefore prompt for policy changes.
  - Provides the level of efforts that has been undertaken by the government in instituting health financing reforms.
- It needs participation and involvement of many parties working in health sector financing; those structures exists in Tanzania; Health financing Technical Working Group; and SWAp dialogue structure.

Health financing progress matrices: the experience of Tanzania (2)

- **Preliminary findings;**
  - Policy development processes are at different stages of development; regular PER and NHA are taking place, legislation for National Health insurance exists. Limited evaluation of health financing reforms implementation
  - Revenue raising the government commitment is on tax and compulsory health financing although at the moment household expenditure also plays a major role
  - Pooling revenue; at the moment many pools the government is moving towards a Single pool.
  - Purchasing and provider payment a mixed up of arrangement for government and public health facilities it is combined for private health facilities is separate.
  - Benefits and entitlement are determined normatively by professionals
  - Public Financial Management on going efforts to improve them with automation of systems
  - Governance the exists structures which are being strengthened.

WHO symposium on health financing for UHC

Health financing progress matrices: Insights of an application in Peru

Midori de Habich

Liverpool, October 2018

Health financing progress matrices

World Health Organization

We have learned that we can use the HFPM:

- To stimulate and facilitate reflection. Not as a “how to” guide.
- To understand where the country is and why.
- To prioritize the main challenges and related matrices/items. Not necessarily to develop the totality of the tool.
- To help set an improvement trajectory: a direction.
- To enable decisions and concrete actions.

The rationale and actors of the exercise

- **Why:** need to continue moving towards UHC in a fragmented health system.

- **Who**: top leadership of public health insurance funds:
  - SIS: Public Health Insurer, tax based (17 Million / 54% of insured Pop.)
  - EsSalud: Social Security Institute, contribution based (10 Million / 31%)
  - SALUDPOL: National Police Fund, contribution based (0.4 Million / 1%)
  - National Superintendence of Health: oversight of insurers and providers.

- **What:** jointly identify health financing challenges from a system view point that relate to their day-to-day problems and agree on collective actions.

Approach and process

World Health Organization

How:

- Setting the scene: *where in the journey towards UHC are we?*
- Presenting and discussing the Guiding Principles (GP): *do we agree with them?*
- Linking the GP to specific challenges and problems faced by the institutions: *how do they relate to the real problems we face?*
- Prioritizing the GP that are related to the common challenges: *which GP do we move towards?*
- Identifying and applying the matrices that are closely related to the prioritized GP*: how are we doing?*
- Taking action.

Results so far

World Health Organization

Prioritization:

- **Governance**
  - Roles and responsibilities are clearly defined and divided across governing institutions in health financing *[to reduce fragmentation].*
- **Purchasing and provider payment**
  - Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance, or a combination of both.
  - Move towards a unified data platform on patient activity, even if there are multiple health financing/health coverage schemes.

Taking action:

- Agreement to move to a common data platform for standard patient encounter claims, to be used regardless of the patient's scheme affiliation.
- Working group has been setup with SUSALUD ongoing support.

World Health Organization

To be continued…

Thanks

mdehabich@iages.com.pe

Using the Health Financing Situation Assessment Tool: Insights from Myanmar

Dr. Thant Sin Htoo
Chair, Health Financing Group
HSS-TSG, MHSCC
Ministry of Health and Sports
09 October, 2018

Outline

- Usefulness of the tool in clarifying ideas and concerns
- Current and potential for use of the tool in Myanmar
- Insights in using the tool
- Comments and suggestions for improvement

Usefulness of the tool in clarifying ideas and concerns in health financing

- Reflects the perception of where a country is in developing its health financing system
- Helps country take into account what has been done, is currently doing and needs to do
- Allows country to do periodic self-assessment to check on progress

Current and potential use in Myanmar context

- Serving as guides in developing Myanmar Health Financing Strategy – Checklist
  - Helps flag elements of the financing strategy that will need more attention, or even inclusion
- May help plotting progress in improving performance of health financing policy development
- Determine where more effort or resources are needed to strengthen financing policy-making

Insights in using the tool

- Self-assessment subject to bias and may not be reflective of reality when information is sensitive (e.g. mismatch between actual performance vs official government report)
- User needs technical level English skills to understand questions and provide answers, especially narratives. Who is going to be the intended user of the tool?
- Information needed to fill up tool may not be available with a single person. Should the tool should be answered collectively?
- Focus on specific details may lose sight of big picture, i.e. how does the whole financing system work vs individual elements
- Many inputs highly subjective and depends on user perception. Is there intention to use the tool to compare countries?

Comments and suggestions for improvement

- Simplify tool by reducing need for narratives
  - Need for detailed descriptions can be obtained through another approach
  - Need to decide if this is a quick vs comprehensive assessment tool
- Improve graphics to display results or outputs (e.g. spider diagram)
- Accomplishment of the tool and interpretation of results/outputs will need coaching support
- Need to further test how results can be used within and across countries (?)

Thank you

tshtoo@nimu-mm.org

WHO Symposium on Health Financing for UHC: Managing politics and assessing progress

World Health Organization

9th October 2018 @ the 5th Global Symposium on Health Systems Research

Some next steps

World Health Organization

- Review & further develop the guiding principles and guideposts
- Build stronger evidence base in terms of link between actions and objectives / outcomes
- Expand illustrations of the different “progress levels”
- Finalise PFM module & prepare complementary quantitative indicators
- Review experience of initial country application
- Without being prescriptive, provide greater guidance on the use and application of the matrices at the country level, to minimise subjectivity bias.