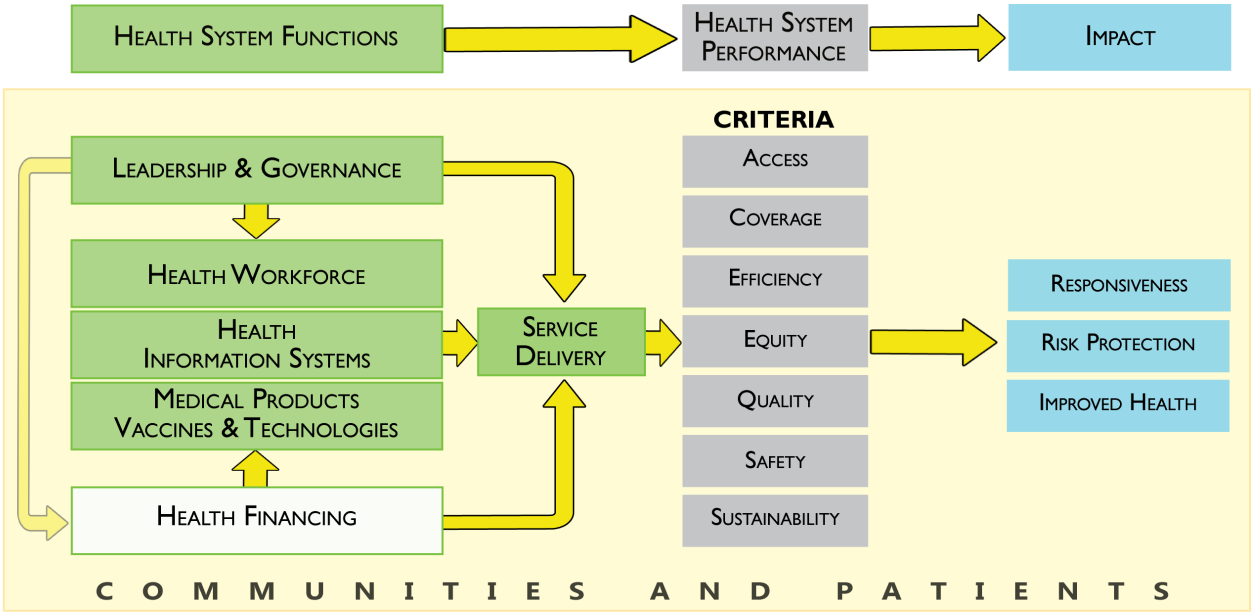
Module 3
Health Financing

This module describes the components of health financing and provides standard indicators to measure in order to understand the strengths and weaknesses of a country's level and structure of health financing.

FIGURE 3.3.1 IMPACT OF BUILDING BLOCK INTERACTIONS



Introduction

Most health systems in the developing world are characterized by mixed public and private financing and delivery of care. For a health system to perform well – that is, to provide needed, good-quality health services to all who need the services – public and private financing agents need to generate an appropriate amount of revenue from all sources relative to what is possible in the country; pool risk effectively; create appropriate incentives for quality service provision from all providers including public, private, and not-for-profit; and allocate resources to the most effective, efficient, and equitable interventions and services irrespective of the sector. These functions should be managed efficiently, minimizing administrative costs. Health expenditure data show that, although the public-private mix varies significantly by country, more than half of total health spending is private out-of-pocket in at least 19 countries in Asia and 15 countries in Africa, including many of the world's most populous nations (China, Bangladesh, India, Nigeria, Pakistan). Governments can also nurture pro-poor health care financing and service delivery programs that show promise to improve health and ensure financial safety of the most vulnerable.

This module looks at how the HSA approaches the health financing building block.

- Subsection 3.1 defines health financing and its key components and describes the process of resource flows – public and private – in a health system.
- Subsection 3.2 provides guidelines on preparing a profile of health financing for the country of interest, including instructions on how to customize the profile for country-specific aspects of the financing process.
- Subsection 3.3 presents the indicators on which this part of the assessment is based.
- Subsection 3.4 provides guidance on how to synthesize findings and presents suggestions for possible solutions to the most common problems in health system financing.
- Subsection 3.5 contains a checklist of topics that the team leader or other writers can use to make sure they have included all recommended content in the chapter.

TIP

Conducting the Assessment

- Select only indicators that apply to the specific country situation.
- Conduct a thorough desk review of all available secondary data sources before arriving in country.
- Stakeholder interviews should focus on filling information gaps and clarifying issues.
- Coordinate stakeholder interviews with team members so all six modules are covered and avoid interviewing the same stakeholder twice.
- Look at all health actors – public, for-profit and not-for-profit, involved in delivering health services.
- Tailor assessment questions to reflect the level of decentralization so the questions are relevant to the interviewee.
- Schedule team discussions in country to discuss cross-cutting issues and interactions.
- Finalize an outline for the assessment report early on so sections can be written in country.

3.1 What Is Health Financing?

In 2000, WHO defined health financing as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system"; the "purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO 2000). In 2007, it expanded on the definition: "A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient" (WHO 2007).

Based on these WHO definitions, this module discusses health financing – its functions, payment systems, the effect of health system decentralization on financing, indicators by which to assess it, and how to synthesize assessment findings with those of the other building blocks. The module draws from a Partnerships for Health Reform Primer for Policymakers on provider payment methods (Wouters 1999) and a discussion of funding health care by Mossialos and Dixon (2002).

Health financing has three key functions: revenue collection, pooling of resources, and purchasing of services.

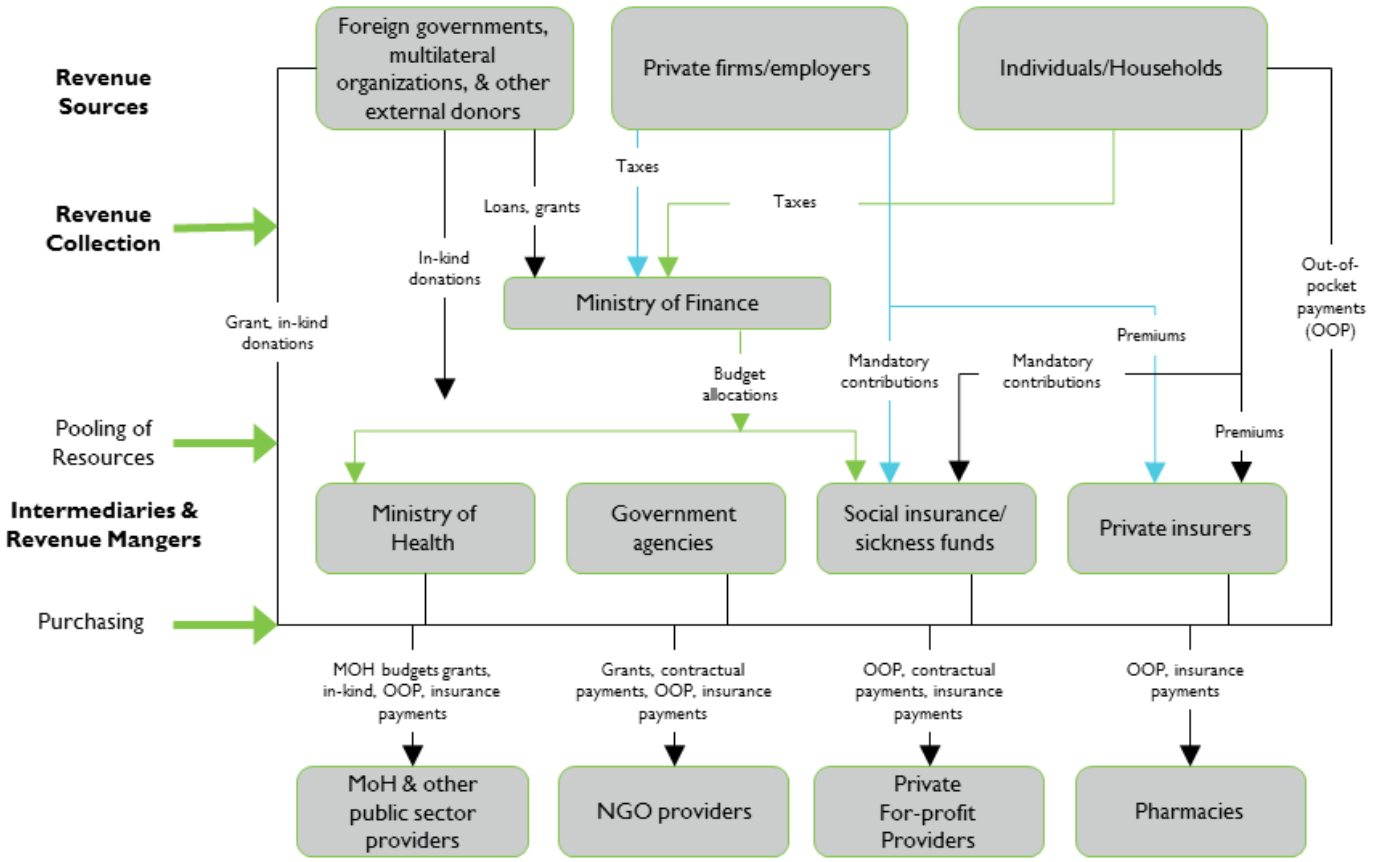
- **Revenue collection** is concerned with the sources of revenue for health care, the type of payment (or contribution mechanism), and the agents that collect these revenues. All funds for health care, excluding donor contributions, are collected in some way from the general population or certain subgroups. Collection mechanisms include taxation, social insurance contributions, private insurance premiums, and out-of-pocket payments. Collection agents (which in most cases also pool the funds and purchase health care services from providers) could be government or independent public agencies (such as a social security agency), private insurance funds, or public and private health care providers.

- **Pooling of resources,** is the accumulation and management of funds from individuals or households (pool members) in a way that insures individual contributors against the risk of having to pay the full cost of care out-of-pocket in the event of illness. Tax-based health financing and health insurance both involve pooling. Note that fee-for-service user payments do not involve the pooling of resources. Some fees, however, may be set to "cross-subsidize" health care, by charging more than the cost of production for a service or a group so that less than the cost of production can be charged for another service or to another group.
- **Purchasing of health services** is the mechanism by which those who hold financial resources allocate them to those who produce health services. Purchasing of health services is done by public or private agencies that spend money either to provide services directly or to purchase services for their beneficiaries. In many cases, the purchaser is also the agent that pools the financial resources. Purchasers of health services are typically the MOH, social security agency, district health boards, insurance organizations, and individuals or households (who pay out of pocket at time of using care). Purchasing can be either passive or strategic; passive purchasing simply follows predetermined budgets or pays bills when they are presented, whereas strategic purchasing uses a deliberate approach to seeking better quality services and low prices.

3.2 DEVELOPING A PROFILE OF HEALTH FINANCING

Figure 3.3.2 shows a generic model of the flow of health care resources from sources of funds to health service providers. The assessment technical team member should redraw the flowchart to reflect country-specific characteristics of the health financing process. The payment mechanisms presented by the arrows that connect the various levels of health financing assessed are in Subsection 3.3 below, on indicators. Customizing this flowchart will facilitate the process of synthesizing the findings from this module (Subsection 3.4). Reports on HSAs that were done using this HSAA manual contain examples of how the flowchart may be structured.[1]

FIGURE 3.3.2 HEALTH FINANCING FLOW



Note: OOP=Out-of-Pocket

[1] See the Health Systems 20/20 project website, http://www.healthsystems2020.org/content/resource/detail/528/ or healthsystemassessment.org

Collection and Pooling

The MOF is typically the central revenue collector of funds for the public health care system. The MOF receives funds from foreign donors (in the form of grants or loans) and from private firms and individuals (in the form of taxes). Foreign donor funds for health can be in the form of general budget support or earmarked for a specific sector (such as health). The pooling of resources, the next step in health financing, is conducted by intermediaries and revenue managers, which could be the MOH and other central government agencies such as the Ministry of Education (in charge of medical education institutions) and the Ministry of Defense (in charge of military health facilities) or regional governments, social insurance and sickness funds, community-based insurance schemes, and private insurance entities.

The MOH receives government budget funds allocated for health from the MOF; the level of government decentralization dictates whether all or only part of the government health budget goes directly to MOH. (See below and the Country and Health System Overview Module 3.1 for a more detailed discussion of decentralization issues.) The MOH may receive donor funds through a health SWAp arrangement, whereby external donors pool aid resources and decide jointly with the MOH on their allocation. The MOH often receives a large share of donor contributions for health earmarked for specific disease programs and as in-kind contributions (e.g., vaccines, medicines, and technical experts).

Other ministries and government agencies can also receive central government funds for expenditures on health: for example, the Ministry of Education to fund university teaching hospitals and the Ministry of Defense for medical facilities that are under its umbrella. Social and private health insurers receive contributions in the form of insurance premiums from individuals or households and from private firms that purchase or subsidize insurance premiums for their employees. Social health insurance organizations also receive government funds, either as direct subsidies (usually when the scheme is not self-sustaining financially, which is often the case with nascent schemes) or as premium payments for individuals who are eligible for government-subsidized social health insurance contributions (usually children, the elderly, military recruits, civil servants, or the indigent or unemployed). NGOs working in the health sector receive direct contributions from private donors and multilateral organizations, often for disease-specific programs.

Payment Methods

All intermediaries and revenue managers as well as individuals and households are purchasers of health care services. The payment mechanisms used by health care revenue managers for each type of provider vary across countries (and provinces or districts within countries) but the most commonly used methods are the following:

- Line-item budgets are allocated for each functional budget category, such as salaries, medicines, equipment, and administration.
- Global budgets are allocated to health facilities; allocations typically depend on the type of facility, its historical budget, number of beds (for hospitals), per capita rates, or utilization rates for past years.
- Capitation allocates a predetermined amount of funds per year for each person enrolled with a given provider (usually a primary care provider, such as a family physician) or resident in a catchment area (in the case of hospitals, for example); usually there is a defined package for services covered by such schemes.
- Case-based payment is the estimated cost of all interventions typically prescribed for the treatment of a given condition. It pays the provider for each patient treatment episode, according to a predetermined payment schedule.
- Per diem payment is a predetermined payment that providers receive for each patient-day of hospital stay; the amount of the payment usually varies by hospital department.
- Fee for service is the out-of-pocket payment that patients make for each health care service at the point and time of use (also known as a user fee in the public sector), or payment by other entities (such as a health insurance organization) to providers for individual health services provided to beneficiaries.

TIP

Prioritizing Indicators

When constrained by limited time or resources prioritize as follows:

- First, assess Indicators 1-6, because data for them are readily available from the Health Systems Database (http://healthsystems 2020.healthsystems database.org).
- Second, assess Indicators 7, 10, 11, 13, 14, 15, and 19.
- Third, if possible, assess all remaining indicators to get a more comprehensive picture of health system financing in the country.

Country Story: St. Kitts and Nevis

HSA interviewees were passionate about finance issues. Favorite topics were: (1) government not having enough funds to do what people knew was needed; (2) frustration with lack of donor coordination and wasted donor resources; (3) equity issues – either people with ability to pay receiving exemptions from user fees, or poor people not being able to get the advanced care they needed.

Financing shortages – due to both the global economic crisis and the rise of chronic and noncommunicable diseases, which are very expensive to manage – are a concern for the MOH. The HSA team recommended that the government estimate future health sector costs and develop a national insurance system to ensure sustainable financing; stakeholders defined "develop sustainable financing mechanism for health" as a key priority recommendation at the dissemination meeting.

Health Financing in Decentralized Systems

The level of decentralization of the public health care sector and the government overall can influence how resources flow through the health system, as well as issues such as service provision (allocation of resources across programs, budget categories, etc.) and incentives that encourage providers to deliver high-quality services.

Under general government decentralization, a portion of government funds allocated to the public health care sector are distributed by the MOF to the MOH, for the general programs the MOH administers. The MOF also allocates block grants to decentralized political units (such as provincial, district, or local government administrations or district councils), typically based on criteria such as share of total population or burden of disease. These grants may or may not include earmarks for health. If they do not, health competes at the local government level with other sectors for budget resources. Alternatively, the MOF might pay certain recurrent costs such as the salaries of employees of public health facilities; here, funds flow directly from the MOF to MOH providers, and local governments do not have discretion over them. In many decentralized systems, local governments at different levels collect taxes and have authority to allocate local tax revenues among health and other sectors; they often fund a large share of the public health administrative unit.

In systems with only MOH decentralization, government funds for public health care flow to providers through a hierarchy of MOH administrative units, though the MOF still sometimes pays salaries directly. When government funds for health are allocated within the public health system without regard to local government decisions, the main resource negotiations are first between the central MOH and districts or regions and second between the central MOH and the MOF.

Both of these types of decentralization have strengths and weaknesses, and both can be managed well or poorly. Each country's health funding situation has to be examined on its own merits to identify how well it functions for adequate generation of revenues for health and for effective allocation of health resources to the service delivery level.

An assessment of the level of financial decentralization (as discussed in Annex 3.1.A) provides some context for the examination of health financing in the assessed country.

3.3 ASSESSMENT INDICATORS

This section focuses on health finance indicators – it shows the topical areas into which the indicators are grouped, lists data sources to inform the indicators, discusses how to deal with indicators that overlap with other building block modules, defines the indicators, and, in the "Interpretation" and "Issues to Explore" subsections, shows how to work with indicators. Finally, the section identifies key indicators to which the HSA technical team member can limit their work, if time precludes their measuring all indicators.

TOPICAL AREAS

The indicators for this module are grouped into four topical areas (see Table 3.3.1), which cut across the three main functions of health financing that were illustrated in Figure 3.3.2 (revenue collection, pooling of resources, and purchasing).

TABLE 3.3.1 INDICATOR MAP—HEALTH FINANCING

Topical Area	Health Financing Function	Indicator Numbers
A. Amount and sources of financial resources	Revenue collection	1–6
B. MOH budget and expenditures	Pooling and allocation of resources Purchasing	7–14
C. Health insurance	Pooling and allocation of resources Purchasing	15–19
D. Out-of-pocket payments (user fees and fee-for-service/product	Purchasing	20–22

DATA SOURCES

There are many sources to help the technical team member assess and analyze the health financing system. They are organized into three categories:

1. **Standard indicators:** Data are drawn mainly from existing and publicly available international databases.
    - Data on information products available in the Health Systems Database (http://healthsystems2020.healthsystemsdatabase.org/)
    - Other surveys that contain a wealth of information, and that can provide more nuanced analysis of access, equity, efficiency, and quality of health services in a specific country include:
        - Demographic Health Surveys (DHS)
        - AIDS Indicator Survey (AIS)
        - Household health expenditure survey
        - National Health Accounts (NHA)
        - Living Standards Measurement Survey (LSMS)

2. **Secondary sources:** Indicators should be gathered to the extent possible through desk review of reports and other documents.
   - National health financing policy document (if available)
   - MOH budgets; central and local government budget data
   - Public expenditure reviews (if available)
   - Public expenditure tracking surveys if available
   - Data, reports, and presentations on health insurance in the country (as available)
   - Special studies on user fees and unofficial payments
3. **Stakeholder interviews:** The document reviews should be complemented, and any information gaps completed, during discussions and interviews with key informants and local stakeholders. (See also, Summary of issues to explore in Stakeholders Interviews in Annex 3.3.A)
   - MOH, MOF, and Ministry of Local Government officials
   - Local government officials
   - Local health administrative units
   - Staff involved in NHA if available
   - Representatives of donor agencies, NGOs, and consumer advocacy organizations
   - Users of health services (through focus group discussions)
   - Medical and nursing professional associations
   - Health facility managers (both public and private); private clinicians and support personnel, and/or representatives of NGOs and other private providers receiving government or donor (e.g., MOH or social security) funds for service delivery.
   - Social security officials
   - Representatives of health insurance bodies and organizations

TIP

ENSURE EXCHANGE RATE CONSISTENCY

Use the exchange rates given by the World DataBank to convert indicator measures from local currency in USD (Word Bank 2010b). For cross-country comparisons, ensure that all amounts are in international USD (i.e., adjusted for purchasing power parity [PPP]).

For comparisons over time, ensure that figures are adjusted for inflation. Inflation rate data are available from the IMFs World Economic Outlook Database (IMF 2010).

Data sources for health financing indicators may not be readily available. The technical team member will be responsible for organizing and developing a process for the review of records, documents, and key informants' and stakeholders' interview responses to obtain information necessary to make judgments on the indicators listed.

While the health financing topic has many indicators, it is not essential to measure all of them, especially if they are not relevant in the assessment country. This manual has filters to guide the selection of critical indicators; the "screening questions" placed throughout this section are a guide to those indicators that may be skipped. If time limitations prevent examination of all relevant indicators, the box above, on priority indicators, provides guidance on how to prioritize the work. Further guidance on a short-list of key indicators can be found in the next subsection.

Answering a screening question "no" may indicate that the country is missing an important aspect of health financing. In such cases, the technical team member should consider investigating the reasons why and defining potential recommendations or interventions to address this problem. For example, if the country has no private health insurance market, a possible recommendation is that donors assist the country to develop private insurance.

Detailed Indicator Descriptions

This section provides an overview of each topical area and then a table that gives a definition and interpretation of each indicator.

Topical Area A: Amount and Sources of Financial Resources

Overview

This group of indicators measures how much is being spent on health care in the country and how much of this spending comes from public, private, and external donor sources. For all indicators in this group, the technical team member should do regional comparisons and look at trends over time in the country. The Health Systems Database has automated functions for producing such comparisons in table and chart formats. Regional comparisons are often used to suggest where a country fits in relation to neighboring countries or countries in the same region with similar economic and population profiles. Regional comparisons, however, are not necessarily good benchmarks when the HSA country has important differences from its regional neighbors in, for example, standards of living, per capita incomes, health system structure, and extent of donor contributions.

Amount and Sources of Financial Resources

Indicators	Definition and Interpretation
1. Total expenditure on health (THE) as % of GDP	Level of THE expressed as a percentage of GDP. THE is the sum of all outlays for health maintenance, restoration or enhancement paid for in cash or supplied in kind. It is the sum of General Government Expenditure on Health and Private Expenditure on Health (WHO 2008). The percentage of GDP spent on health is a measure of the share of a country's total income that is allocated to health by all public, private, and donor sources. A standard measure used for international comparisons, this indicator typically ranges between 2 and 15 percent of GDP spent on health. An extremely low percentage of GDP spent on health suggests that not enough resources are mobilized for health, that access to health care is insufficient, and/or that the quality of services is poor. An extremely high expenditure suggests a widespread use of high technology and likelihood of inefficiencies. There are, however, no commonly accepted benchmarks or targets for an appropriate percentage of GDP that a country should spend on health. Module link: Country and Health System Overview Chapter, Indicators 6 (GDP per capita) and 8 (total health expenditures per capita)

AMOUNT AND SOURCES OF FINANCIAL RESOURCES CONT...

Indicators	Definition and Interpretation
2. Per capita THE at international dollar rate	Per capita THE expressed in purchasing power parity (PPP) terms or international dollars. International dollar rate or PPP: A hypothetical currency unit that takes into account differences in relative purchasing power among countries (WHO 2008). This indicator reflects the average amount of resources spent on health per person, measured in international USD (i.e., adjusted for PPP across countries). It is another standard measure that can indicate whether spending on health is adequate to achieve appropriate access and quality. There is no universal benchmark for the minimum amount of per capita THE. According to the Commission on Macroeconomics and Health (WHO 2001), providing a package of essential health interventions (including HIV/AIDS treatment) in low-income countries in sub-Saharan Africa would require between USD 34 and USD 38 per capita per year over the period 2007–2015; the corresponding estimate for countries in the South and East Asia region is USD 29–USD 32 (WHO 2001; UNESCAP 2007). Countries with relatively low per capita spending (e.g., below USD 30 per capita) are likely to have poor access, low-quality health care, or both. Module link: Country and Health System Overview Chapter, Indicator 8 (THE per capita)
3. General government expenditure on health as percentage of total government expenditure	Level of general government health expenditure (GGHE) expressed as a percentage of total government expenditure. GGHE: The sum of health outlays paid for in cash or supplied in kind by government entities, such as the MOH, other ministries, parastatal organizations, or social security agencies (without double counting government transfers to social security and extrabudgetary funds). It includes all expenditure made by these entities, regardless of the source, and so includes any donor funding passing through them; transfer payments to households to offset medical care costs and extrabudgetary funds to finance health services and goods; and current and capital expenditure (WHO 2008). This indicator illustrates the commitment of government to the health sector relative to other commitments reflected in the total government budget. The allocation of the government budget to health is subject to political influences and judgments about the value of health spending relative to other demands for public sector spending. A relatively large commitment of government spending to health (e.g., above 20 percent) suggests a high commitment to the sector. For example, the Abuja Declaration of African Heads of State includes a target of allocating 15 percent for government budgets to the improvement of the health sector. Trends over time are a more reliable measure of the reliability of government spending on health, as a share of total government spending, than any single year. Note as well that if the country has a social security scheme, its funding for health is included as government funding, even though a large share of it comes from private sources (individual and employee mandatory contributions).
4. General government expenditure on health as a percentage of total health expenditure	Level of GGHE expressed as a percentage of THE (WHO 2008). This indicator is a measure of the relative contribution of central and local government, relative to THE. If the percentage is relatively low (i.e., below 40 percent) it can reflect (1) a low tax capability of the country's government, (2) a philosophy of a limited role for government in health (i.e., that public spending should not play a large role in financing or providing health services for the population), and/or (3) reliance on substantial donor assistance. A low value for this indicator also means that the government has limited ability to act to address equity issues. Trends over time are a more reliable measure of the reliability of government spending on health as a share of THE than any single year.

AMOUNT AND SOURCES OF FINANCIAL RESOURCES, CONT.

Indicators	Definition and Interpretation
5. External resources for health as a percentage of total health spending	External resources for health expressed as a percentage of THE (WHO 2008). The share of a country's THE financed by external sources measures the contribution of international agencies and foreign governments to THE. A very high external contribution (e.g., above 10 percent) is a concern for financial and possibly institutional sustainability if the external contributions are withdrawn. Compare this indicator to government health spending as a percentage of THE (Indicator 4 above) to assess the sustainability implications of the share of donor spending. Very high external source health spending suggests that the government would have to increase its health spending by a large proportion to replace external source contributions, should they be withdrawn, to avoid placing the burden on private spending. Because external contributions are in foreign currencies and the country's government spending is in local currency, this percentage can be affected by fluctuations in exchange rates. Also, because external contributions can fluctuate with political situations, they can be subject to frequent changes in amount, target of spending assistance, or both. Therefore, trends over time are a more reliable measure of the reliability of external sources on health (and of the country's dependence on external sources), than any single year. Consider also exploring the distribution of total external sources among key external sources. A high share of external contributions coming from one or a few sources may indicate high potential risk for sustainability of external funding. Assess whether the share of total external funding that is allocated for specific diseases corresponds to their share of the disease burden in the country.
6. Out-of-pocket expenditure as a percentage of total expenditure on health.	The expenditure on health by households and individuals as direct payments to health care providers irrespective of sector. It should be netted from reimbursements from health insurance. This indicator represents the expenditures that households make out of pocket at the time of using health care services and purchasing medicines, relative to THE. Out-of-pocket expenditures exclude payment of insurance premiums, but include nonreimbursable insurance deductibles, co-payments, and fees for service. If out-of-pocket spending represents a large share of THE (e.g., above 60 percent), pooling of private resources is limited and/or government spending on health is low. It means that households usually need to produce funds at the time of seeking care, which can be a barrier to accessing care and can threaten the financial status of the household (e.g., push some into poverty). In lower-income countries, out-of-pocket spending often represents a high share of THE. Look at special studies or data that might be available on the incidence of catastrophic out-of-pocket health expenditures by households, including variations across income groups (see Alva, Kleinau, Pomeroy, et. al 2009 for review of available resources on this topic). Module link: Country and Health System Overview Chapter, Indicator 10 (out-of-pocket expenditures as percent of private expenditures); Health Service Delivery Module, Indicator 9 (Financial access)

Topical Area B: Ministry of Health Budget and Expenditures

Overview

The indicators in this group are related to MOH budget trends, the process of health budget preparation at various levels of health system administration, and the distribution of central and local government funds across different types of spending categories, services, and regions. This section looks at the types of purchasing mechanisms used by the MOH, such as performance contracts that may be made between MOH and public or private providers and vouchers for health services.

In most countries, multiple government ministries have health-related responsibilities (e.g., Ministry of Education for medical education, Ministry of Defense for military health) and therefore funding for health services or activities are included in their budgets. For purposes of the rapid assessment, the following indicators concentrates only on the MOH budget because that is available to the whole population and is usually the major source of recurrent health spending. See the box, "Definition of Reccurent and Investment Budget" on this page for definitions.

TIP

Definition of Recurrent and Investment Budget

The recurrent budget includes costs incurred on a regular basis. Examples of recurrent costs in health are personnel salaries, medicines, utilities, in-service training, transportation, and maintenance.

The investment budget includes costs for purchase of assets that are used over many years. Examples of investment costs in the health sector are construction of new health care facilities, major renovations, or the purchase of medical equipment. The investment budget for health is quite often developed and executed by ministries of planning, especially when it is done in coordination with donor investment or capital cost grants.

MINISTRY OF HEALTH BUDGET AND EXPENDITURES

Indicators	Definition and Interpretation
7. Trends in MOH planned and realized expenditures	Planned (or authorized) expenditures represent the approved budget amount for a given time period; realized expenditures are the actual expenditures that have occurred at the end of the budget period. The four questions are commonly used to measure whether an MOH budget is a sustainable source of funding for the health sector. Use the template provided in Table 3.3.2 to summarize the data collected for these indicators for the past several years (depending on data availability). a. Do MOH expenditures keep pace with inflation[a] and with population growth? If annual actual or planned expenditure is not increasing at the same rate as the annual general price level plus the rate of population growth, then there is a real decrease (decline in purchasing power) of resources allocated by the MOH. The MOH funding cannot provide the same level of services to people that it provided to them in the previous year(s). b. Does the country have any mandated level of public spending on health as a percentage of total public spending? If not, is the MOH share of the total government recurrent budget increasing or decreasing? If the MOH share of the total government budget is decreasing, this trend indicates a decrease over the years in commitment of the government to fund health. c. What percentage of the total public health budget is for capital investments? Capital investment is investment made in assets such as physical infrastructure and medical equipment. Capital expenditures can be as high as 40–50 percent of the total public health care budget in low-income countries where the infrastructure is being created or restored after years of conflict. Knowing how much capital spending is occurring relative to recurrent spending is important to ensure that capital spending is not wasted or is not siphoning off funds needed for other inputs; for example, once a health facility is built, are there funds to stock it with health workers and medicines? d. What is the trend in difference between the authorized budget and actual expenditures? If actual expenditure is less than what is planned or authorized, then the budget is unreliable and unpredictable as a source of funds for health. In such cases, salaries tend to be paid late and medicine allotments tend to be less than needed. Actual expenditures are rarely higher than planned expenditures (if they are, budget controls and financial management are most likely the problem). In countries with SWAp funding from donors, the funds are often channeled through the MOH budget. In this is happening in the HSA country, the technical team member should examine changes in SWAp funding amounts when assessing MOH budget increases or decreases.

[a] Inflation (measured by the consumer price index) and rate of population growth are indicators in the Country and Health System Overview chapter.

TABLE 3.3.2 TEMPLATE; MOH BUDGET TRENDS: AUTHORIZED OR PLANNED AND ACTUAL EXPENDITURES

Budget	(Year)				
	Authorized or Planned Expenditure		Actual Expenditure		
	Amount	Percentage Change over Prior Year	Amount	Percentage Change over Prior Year	Percentage Difference from Authorized (+ or –)
Total MOH recurrent budget					
Total government recurrent budget					
Total MOH investment budget					

Ministry of Health Budget and Expenditures cont...

Indicators	Definition and Interpretation
8. Process of MOH budget formulation	This indicator examines the method used by national and subnational health management to estimate projected expenditures for the following fiscal year. a. Are MOH budgets developed based on last year's budget or historical budget totals, or are they based on estimates of resources required to meet the population's health needs? When budgets are historically based, they usually allocate funds based on the number of hospital beds or health workers without regard to the hospital occupancy rate; they simply repeat the amount of funding budgeted for the previous year, with perhaps an adjustment for inflation or changes in overall government spending. "Needs-based" MOH budgets, conversely, are built each year from estimates of the population's health service delivery needs as well as needs for public health prevention; disease control; information, education, and communication; and other programs according to epidemiological and health profiles in the various areas of the country. Over time, historical budgeting does not reflect changing health care funding requirements. This leads to inefficiency in the health system, with more funding than needed allocated to some functions and less than needed to other functions. Needs-based budgets are more likely to reflect actual use and funding requirements for population and inflation changes and, subsequently, are more likely to lead to allocation of funds to where they are needed. Such budgeting can point to underused facilities that can be closed or consolidated. b. Is budget planning done centrally or is the budgeting process bottom-up, beginning at the district or local level (i.e., accumulation of district or local budget planning requests)? Historical or needs-based budgets can be developed centrally, with little input from local levels and facilities, or they can be developed from the bottom up, with budget requests coming from districts to regions, provinces, or states, and then to the central MOH and finally to the MOF. Bottom-up budgets, if written, approved, and executed well, are more likely than top-down budgets to reflect actual health funding needs. They are more likely to allocate funds effectively and to be sustainable. Although the bottom-up budget preparation approach may exist as policy, examining the practice to see if local input actually influences central MOH decision making is important. c. Does the MOH have the technical and organizational capacity to provide direction and oversight of health financing activities? This indicator speaks to the capacity of the MOH to provide overall guidance and direction to health financing. Typically, there is an MOH unit, often within the policy or planning department, with an explicit mandate for health financing (e.g., Health Economics Unit). Assess if such unit exists, if it has a clear mandate/role within the MOH, and if it is staffed by an adequate number of technically qualified staff; if it has access to necessary information and institutional resources (such as IT infrastructure); and if it has appropriate influence within its department and the MOH in general. d. Does the MOH have access to local technical resources in health financing? Is the MOH using these resources effectively for budget formulation and setting health financing policies? This indicator speaks to the availability of local technical resources in health financing, including capacity within the country to carry out and use health financing research. Investigate to find answers to the following questions: Are there local institutions that train health financing specialists or health economists (e.g., a specialized higher education program in a major local university)? Are there local organizations that produce health financing research such as NHA, Public Expenditure Reviews, and other health economics studies? These organizations might include institutes, think tanks, private consulting organizations, or specialized unit(s) within the MOH. To what extent does the MOH effectively use the data and research produced by such organizations? For example, does the MOH use NHA data in formulating health financing policies or budget allocations? Does it use evidence from cost-effectiveness or cost-benefit studies in prioritizing resources? Assessing the gaps in availability of local technical capacity to produce and effectively use health financing research and information can help the assessment team identify important areas for capacity-building assistance. Note that the information needed for this indicator is likely to be found in the Leadership and Governance module.

MINISTRY OF HEALTH BUDGET AND EXPENDITURES CONT...

Indicators	Definition and Interpretation
9. MOH budget allocation structure	Budgets may be structured by line items, programs, or another or mixture of methods. What structure does the MOH use to allocate its budget? Line items? Programs? Other? Line-item budgets allocate funding by object class (e.g., salaries, electricity, fuel, medicines, and rent). Program budgets allocate funding by program or service delivery area (e.g., Expanded Program on Immunization (EPI), TB, HIV/AIDS prevention and treatment, maternal health care or broadly defined primary health care (PHC), prevention, or curative and inpatient hospital care).

Screening question:

Do local government authorities have responsibilities for health in systems in which general government is decentralized? Does the central government allocate to local government administrative authorities funds that are specifically earmarked for health? If the answer to both questions is "no," then proceed to Indicator 11.

MINISTRY OF HEALTH BUDGET AND EXPENDITURES CONT...

Indicators	Definition and Interpretation
10. Central and local government budget allocations for health in decentralized systems	Often given as a percentage of total central or local budget spending on health. The budget allocation for health includes all funds earmarked for health-related spending at the various levels of government. a. How does the central government allocate funds for health to lower-level administrative units such as states, regions, provinces, and districts? Different methods of allocating funds from the central to local levels offer the local levels different incentives for the way they use those funds for health. Block grants are the most common form of allocation to local levels in systems where government administrative authority is decentralized. If instead grants are earmarked for health and if those earmarks are adjusted for the locality's health needs (e.g., for population or socioeconomic indicators), the funds are more likely to be spent on health, reflect equity considerations, and maintain (or improve) the local population's access to health services. b. Do local government units have local taxing authority? If so, do they appropriate funds for health? Do they have any other method of local public funding for the health sector? Local government taxing authority that can raise and allocate additional funds for health increases the possibility of sustainable and adequate health funding. In general, experience suggests that in the early years of decentralization, funding for health and especially for priority PHC services may decline or become unreliable, thus affecting access and sustainability. If wealthier local governments provide additional health funding from their own budgets, inequality across districts or regions can increase. Describe the combination of sources of funding for health at the local level (central government grant, local government tax-financed budget, MOH contribution toward salaries and other expenses, etc.). Review recent funding trends in central government allocation to local administrations to see if this mechanism promotes reliable funding for health and equity of distribution of central government health funding across the country.

MINISTRY OF HEALTH BUDGET AND EXPENDITURES CONT...

Indicators	Definition and Interpretation
11. Percentage of government health budget spent on outpatient/inpatient care	Amount of government funding spent on outpatient care divided by total government spending on health; amount of government funding spent on inpatient care divided by total government spending on health This is a general indicator of the sustainability of outpatient care funding through the MOH budget. The MOH budget allocated to inpatient care often crowds out funding for outpatient care (and thus PHC services), especially in a tight MOH budget. Although public spending for inpatient care is generally higher than for outpatient care, no standard benchmarks exist to define an appropriate, sustainable, or efficient ratio between these two main categories of services. Trends are likely to be more important for interpreting the implications of the ratio than the funding in any one year. If the share the MOH budget allocates to outpatient services declines steadily, or periodically, it means that outpatient care is being cut in favor of inpatient spending. Such cuts can, indicate that outpatient care is declining as a government priority or that the disease profile of the population is changing in a way that requires more inpatient care. Donor funding is frequently targeted to PHC and related outpatient care services. Examine whether this is the case and whether the MOH budget provides less funding for PHC and other outpatient care because it is relying on donors to cover those costs. Note that although a common indicator for spending by level of health services compares spending on PHC and hospital care, comparing spending on *outpatient* and *inpatient* services is preferable because it accounts for PHC services that are provided at outpatient departments of hospitals (and avoids overestimating expenditures on inpatient hospital care). In addition, the definition of *outpatient care* is more straightforward than the definition of *PHC*, which varies widely across countries. Finally, a standardized NHA measures outpatient and inpatient care expenditures. If obtaining data on the breakdown between inpatient and outpatient government spending is difficult, consider instead the percentage of the budget allocated to hospital and non-hospital facilities as a proxy for this indicator. *Module link:* Health Service Delivery Module, Indicator 11 (primary care or outpatient visits per person per year)
12. Recurrent government health budget allocation	Percentage of the government health budget spent on: • Salaries of health workers • Medicines and supplies • Facility and equipment maintenance costs • Other recurrent costs (e.g., administrative costs at central and district levels, in-service training) The amount and shares of funding for salaries and medicines are the most relevant categories to assess for purposes of a rapid assessment. Generally, as much as 70–80 percent of an MOH budget is allocated to salaries and benefits, most of it for health worker salaries and benefits. When the budget is not sufficient to cover the costs of medicines, people have to pay for medicines separately at the public health facility or at a local private pharmacy, and health workers lack the supplies needed to treat patients. This shortfall affects the quality of care, as well as equity. However, even when a high proportion of the MOH budget is allocated to salaries, it may not be sufficient to adequately pay health workers. The HSA team should examine whether salaries are paid on time and regularly, and compare the distribution of spending to that of other countries with a similar per capita income level, if possible. This group of indicators is most easily measured from a line-item MOH budget or an NHA that included this breakdown. If neither is available, the calculations must be done manually in consultation with MOH budget officials. See also the Medical Products, Vaccines, and Technologies Module 3.6. *Module link:* Medical Products, Vaccines, and Technologies Module, Indicators 3 (government expenditures on pharmaceuticals) and 32 (proportion of annual expenditure on medicines financed by government budget, donors, charities, and private patients).

MINISTRY OF HEALTH BUDGET AND EXPENDITURES CONT...

Indicators	Definition and Interpretation
13. Local-level spending authority and institutional capacity	The degree of autonomy that administrative units below the central level have in allocating their health budgets, as well as their ability to do so. a. Do administrative units below the central level (e.g., provincial, district, local government areas) have autonomy in allocating their health budget? Local government autonomy to allocate health budgets can help ensure that budget allocation is responsive to local health needs and priorities. b. Do MOH health facilities have autonomy in making recurrent cost expenditures such as procurement of supplies, gasoline, and medicines, and hiring of supplemental personnel? Having authority to make decisions about allocating spending to the service delivery costs at the facility level is important to ensure that funds are prioritized and spent for needed items. This authority can be granted in line-item budgets if the facility manager can reallocate among the designated expenditure categories (e.g., from supplies to transportation for outreach). It can also be made available in global budgets, which is generally the most effective method. With a global budget, facility managers have the discretion to allocate the total funds across uses according to their service delivery needs. c. Does a system exist at the central, district, or facility level for tracking and auditing budget expenditures? Systems to track and audit expenditures against budget authorizations are essential to good financial management and accountability, and can be key to efficient management and allocation of resources. d. Do local governments have the capacity to implement health financing policies? Institutional capacity of local governments to implement national health financing policies, develop budgets that align with district/local health plans, use spending authority effectively, track and report health expenditures, and implement user fee policies according to guidelines is important to ensure adequate health financing functions at the local level. This indicator is particularly relevant in a decentralized system where local governments have increased responsibilities and authority for health care. Assess whether local government staff responsible for the health sector are trained in basic functions of health financing, and whether they have access to relevant IT infrastructure. Note that the information needed for this indicator is likely to be found in the Leadership and Governance chapter (see Module 3.2). Exploring the different administrative and service delivery levels of the system separately on this issue is important because different facility levels (e.g., health post, clinic, secondary, or tertiary hospital) may have different rules for autonomy and expenditure tracking. In decentralized systems, different jurisdictions (zones, districts) may have different policies regarding budget flexibility and cost control measures for ensuring proper use of budgeted expenditures, as well as different levels of capacity in health financing. *Module link:* Medical Products, Vaccines, and Technologies Module, Indicator 15 (procurement processes). Country and Health System Overview Module, Annex 3.1.A. (Decentralization)

MINISTRY OF HEALTH BUDGET AND EXPENDITURES CONT...

Indicators	Definition and Interpretation
14. Contracting mechanisms between the MOH and public and private service providers	Performance contracting (sometimes called pay for performance) is increasingly used by the public sector (MOH) for purchasing health services from both public and private sector providers. Contracts relate health worker pay or facility allocations to performance (measured by, for example, indicators of quality of care, number of patients served, and efficiency of resource use). Different provider payment methods give the providers different incentives for the quality and quantity of services they provide and the number of patients they serve. These incentives affect quality, access, and efficiency. Often the payment method is as important as the amount of payment. a. Within the public sector (MOH, social health insurance providers, or both), are any contracting mechanisms or performance incentives used? Salaries alone have proven to provide the least incentive for outstanding health worker performance. Nevertheless, salaries are the most common method that MOHs use to incentivize public sector health workers. Public sector performance contracts may also relate facility recurrent cost budget allocations to facility performance (e.g., percentage of children the facility fully immunizes, percentage of relevant patients receiving family planning counseling, percentage of cases with correct diagnosis). The performance criteria promote provision of services to attain MOH coverage targets. b. Are any contracting or grant mechanisms or performance incentives in place in the funding arrangements between the MOH and private health care providers? Performance contracting is becoming more common in the arrangements between the public sector and private providers. Traditionally, public payments to NGOs and other nonprofit providers have been in the form of a grant, without conditions for payment of the public funds. Careful choice of performance criteria can improve the provider incentives for quality, access for priority services or populations, and efficient use of resources. Distinguish between inpatient hospital care and PHC and between private nonprofit (NGOs, FBOs) and commercial providers, if relevant. Assess with key informants whether alternative or revised payment methods or health worker incentives may be needed. c. Are there any programs that provide vouchers to specific population groups for using health services free of charge (e.g., vouchers for maternal care provided to pregnant women)? Vouchers for health services are a health financing mechanism to subsidize the price of health products and services for a target population. Voucher recipients can use the vouchers to pay - partially or fully - for eligible health services received from providers contracted by the voucher program. Voucher programs aim to improve access, equity, and quality of health care. Describe the target group(s) that are beneficiaries of such program(s), the types of services covered, and the types of providers participating in the program(s). Investigate any issues with targeting of voucher recipients – for example, to what extent are the intended beneficiaries receiving and using the vouchers, and is there "leakage" of vouchers to non-eligible recipients? *Module links:* Country and Health System Overview chapter, (structure of government and private sector in health care); Service Delivery chapter, Indicator 3 (private sector service delivery)

Topical Area C: Health Insurance

Overview

The indicators in this section investigate the different types of insurance schemes (if any) operating in the country of interest. Three major types of health insurance may be available:

- National health insurance (NHI): a government-managed insurance financed through general taxation, usually with mandatory coverage for all citizens. Often, the government directly provides health services but a growing number of African NHI schemes allow for consumer choice and include private sector providers as well.
- Social health insurance (SHI): a government-organized program that provides a (usually) specified benefit package of health services to members. It is frequently funded by mandatory payroll deductions for formal sector employees, but it might also include voluntary membership from those who are not formally employed. In some programs, government subsidizes premiums for population groups such as the poor, children, and pregnant women.
- Private health insurance, which can be:
  - Community-based health insurance (CBHI): a nonprofit private health insurance that provides a (usually) specified benefit package of health services to members who pay premiums to a community-based and community-managed health fund. CBHI is based on an ethic of mutual aid among members.
  - Private for-profit health insurance: a voluntary program that covers a specified benefit package of health services and is offered by private for-profit insurance companies. It is funded by premiums (and often co-payments and deductibles) that members pay to the insurance company, with premium levels usually charged based on the purchaser's risk rather than ability to pay.

Basic Benefit Package

A basic benefit package (BBP) is usually a defined group of essential and cost-effective services provided by government health facilities. BBPs of PHC services usually include the typical and routine services provided at lower-level health facilities, such as maternal health services, preventive services for children (e.g., immunizations), services related to integrated management of childhood illness, and essential medicines. A BBP may cover selected hospital services when lower-level facilities have made a referral. Typically, BBP services are free of charge for users. Depending on the financing scheme some private (commercial and not-for-profit) providers are paid to deliver BBP services to target population groups.

If CBHI or other private health insurance (or both) exists but covers very small populations or provides very limited coverage, this rapid assessment need not spend much time gathering data about them. Simply noting that small schemes exist is sufficient. Nevertheless, one should not discount these small schemes when considering strategies to improve risk pooling.

Use the guidelines for information and data collection provided in Indicators 15 through 18 to fill in Table 3.3.3. These data develop a profile of the three major types (NHI, SHI, and/or private) of health insurance that might be available in the country. All countries face policy and implementation issues with respect to insurance. Elicit comments from key informants about (1) any issues they have faced with respect to services and population covered, the funding, and provider payment mechanisms and subsides used, and (2) any policy or implementation initiatives or reforms they are undertaking. Based on those discussions, identify for further exploration, analysis, or study issues that would improve the design or implementation of any of the three insurance types. For example, CBHI schemes are typically very small, but they are of increasing interest to governments and international donors.

Table 3.3.3 Characteristics of Insurance Schemes: National Health Insurance, Social Health Insurance, and Private Health Insurance

Indicator	NHI	SHI	Private Health Insurance
15. Population coverage • Members: who is covered? • Percentage of total population covered			
16. Services covered • Types of services covered • Key exclusions • Waiting periods			
17. Funding mechanisms • Sources of funding • Government subsidies			
18. Payment mechanism for providers • Types of payment mechanisms used • Quality or accreditation requirements for provider payments			

Screening Question:
Do NHI, SHI, CBHI, or other private voluntary health insurance exist in the country? If yes, continue with Indicators 15 through 19; otherwise proceed to the next topical area.

HEALTH INSURANCE

Indicators	Definition and Interpretation
15.Population coverage of health insurance	The number and percentage of population and its demographic and locational characteristics. a. Who belongs to the scheme? Public employees? Formal sector (non-public) employees? Informal sector: urban and rural workers? Membership in risk pooling adds financial protection against high costs of health care at the time of use and over time, compared with paying user fees to a provider whenever the need for health care arises. It thus improves financial access and reduces the financial barriers to use of the health care services that the insurance covers. Generally, social and private health insurance schemes cover primarily urban populations working in the formal sector for wages. CBHI is often developed by rural and urban informal sector populations who join together to help cover the costs of user fees in the public sector, the private sector, or both. b. What percentage of the population is covered? The percentage of the population covered by insurance indicates the proportion of the population with risk pooling that shares the costs of health care across the healthy and the sick. If any of the types of voluntary insurance have existed for several years, exploring their evolution over time is useful to see if population coverage has expanded. c. Who is entitled to benefits under the scheme? Only those people who pay premiums? People who pay premiums and all or some of their family members?
16. Services covered by health insurance	General description of the types of services covered by the various insurance schemes. a. Which services are covered by the insurance (e.g., a basic package of ambulatory PHC, hospital inpatient services)? The greater the range of health care services covered by insurance, the more financial protection that members have against high costs of health care. b. Are any priority health services (e.g., child immunizations, family planning, childbirth, counseling and testing, antiretroviral therapy for HIV-positive patients) excluded from the benefit package? Also important is finding out if the government offers priority services (e.g., immunization, family planning) free of charge at the time of use (e.g., as part of a BBP). In that case, one would not expect to find those services included in an insurance package. c. What co-payments are required? Is coverage provided for medicines and, if so, at what prices or co-payments? If an insurance plan requires members to pay a significant co-payment at the time of using a service, it will weaken the financial protection of the plan for members. If co-payments for covered services are very high, exploring how those requirements might have affected use of covered services is important.
17. Funding mechanisms and sustainability of health insurance	The means through which insurance schemes are financed can have a direct impact on their sustainability. Is the insurance adequately funded, or does it consistently have losses? Although many factors affect the financial sustainability of insurance, a key factor is whether a scheme is underfunded (e.g., because of adverse selection of members, failure of members to pay premium installments, financial mismanagement). Does the government or another entity (e.g., charities, NGOs) subsidize membership for any groups? (For example, does it pay premiums for the indigent or elderly or contribute a general subsidy, such as from general tax revenue?) The poorest population groups are generally unable to afford either private commercial or CBHI premiums and are typically not covered by SHI because they are in the informal sector. If the government or charitable organization subsidizes or pays the premiums to cover the poorest, however, it extends the financial protection of insurance to them, thus increasing equity of financial access.

HEALTH INSURANCE CONT...

Indicators	Definition and Interpretation
18. Provider payment mechanisms under health insurance	See subsection 3.2 for definitions of the most common mechanisms that purchasers of health services use to pay providers. What are the mechanisms used by insurance schemes to pay health service providers? Different payment mechanisms provide different incentives to providers. For example, fee for service promotes responsiveness and quality but may lead to cost escalation and inefficiency. Capitation and case-based payment promote efficiency and sustainability but may jeopardize quality. Quality assurance is promoted if only the providers who are accredited or licensed can be paid for services covered by the insurance plan.
19. Institutional capacity of health insurance organizations	This indicator speaks to a country's capacity to manage health insurance schemes and therefore expand coverage. Do health insurance bodies (e.g., NHI or SHI agency, CBHI committees) at various levels have adequate technical and organizational capacity provide policy direction and oversight of health insurance entities, and implement and manage health insurance functions? The technical team member should focus only on NHI or SHI organizations, and CBHI if a vibrant CBHI movement exists, or there is interest among donors and the MOH to develop CBHI at the national scale. Health insurance schemes ultimately must be managed by organizations with technical and institutional capacity to set benefit packages and premiums, manage the claims process, and manage financial resources effectively. Explore whether health insurance managers at various levels have timely access to necessary data and information, and the ability to use this information effectively for health insurance policy, planning, and oversight. Interview health insurance managers at various levels to assess their technical qualifications and to determine whether they have the institutional support to be effective. Donors supporting health insurance in the country can also provide insights on the gaps in organizational and institutional capacity that might need to be addressed in order to build an effective health insurance system or unit.

Topical Area D: Out-of-Pocket Payments (user fees and fee-for-service/product)

Overview

The indicators in this section help investigate out-of-pocket payments that consumers make for health services.

The term most commonly used for this payment in the public sector is user fee. User fees are usually a fixed charge that pays for services, supplies, and medications provided by public health care facilities. The primary purpose of user fees is to help facilities with cost recovery, and thus to improve quality and sustainability of service provision. Another purpose is to prevent unnecessary use of services, because cost-sharing discourages overutilization of health care or use of services at a higher level than necessary. However, user fees add a financial barrier to the use of services, especially for the poorest, thus producing inequalities.

The private sector term for user fee is fee for service. Its primary purpose is to enable the private health care provider to cover costs as well as earn a profit. Many private providers – particularly small, individually owned businesses – barely eke out an existence serving lower-income groups while other private providers/practices earn a handsome living serving wealthier income groups.

The challenge for policymakers is to create a risk-pooling mechanism that captures all the out-of-pocket expenditures that can be used to reimburse public or private health care providers in order to mitigate against catastrophic health expenses and help ensure equitable access to health care.

OUT-OF-POCKET USER FEES

Indicators	Definition and Interpretation
20. Policies for user fee payments in the public sector	This indicator examines whether formal user fees are in place, at which levels of care, for what types of services, and whether there are exemptions for certain groups (elderly, poor, invalid, veterans, etc.). a. Do patients have to pay for outpatient care: visits, medicines, supplies (e.g., bandages), and laboratory and other diagnostic tests? b. Do patients have to pay for hospital inpatient care: for their stay (e.g., per day or per admission); for doctors' or nursing services; for medicines, supplies, and laboratory and other diagnostic tests? c. Are there policies (fee exemptions or waivers) that remove the payment of user fees for some patients using PHC services, in particular[1]: • Socio-demographic groups, such as children under age five, students, elderly, military personnel, health care workers, or the poor? • Health care services, such as immunizations, services included in a BBP (see definition box page 29), TB-DOTS (Direct Observation Treatment, Short Course), other chronic care? Fee waivers and exemptions can promote equity of financial access for the poor and use of services by priority population groups or people with conditions requiring follow-up or continual care. Waivers and exemptions must be administered well and accurately, however, and they must not erode the purpose of user fees in the first place (helping to pay for the quality and availability of health services in the public sector, especially when MOH budgets are constrained). For example, many countries establish official user fees and then provide exemptions and waivers that cover 80–90 percent of PHC visits. Find out if fees are set nationally or locally. If locally, they are more likely to be in line with the local population's ability to pay. Investigate formal criteria for identifying patients who are eligible for fee exemptions or waivers, especially for waivers for the poor (such criteria are often controversial and difficult to establish). Find out if the country has a mechanism to compensate facilities for the revenue lost through exemptions. If not, there is an incentive for the facilities to give fewer exemptions. d. To what extent are user fee policies that exist followed in practice? Explore the reasons for gaps between user fee policies and practices. *Module link:* Health Service Delivery Module, Indicator 10 (user fee exemption and waivers); Medical Products, Vaccines, and Technologies Module, Indicator 33 (cost recovery methods)

[1] Although fee exemption and waiver policies may exist for inpatient hospital care, this issue is primarily raised with respect to PHC services, especially priority services. For purposes of the rapid assessment, concentrate on PHC for question 19c.

Indicators	Definition and Interpretation
21. Allocation of user fee revenues	This indicator examines the portion of user fees that are retained at the facility where they were collected as well as how user fee revenues are spent. a. Are all or a portion of user fee revenues retained at the facility where they are collected? Allowing a facility to retain and use the user fee revenues it collects is an incentive for the facility to collect the fee, and fee revenue can lead directly to improvements in quality and access to care. b. If so, are there guidelines for use of fee revenues? Describe the suggested or required uses of fee revenue retained at facilities (e.g., to buy additional medicines, to subsidize the poorest or give them fee waivers, to make infrastructure renovations, to provide staff bonuses). Is there community participation or oversight for the use of fee revenues? User fees are typically established for purposes of increasing resources for non-salary operating costs, especially when MOH budget allocations to facilities for those purposes are low. Community participation in the use of fee revenues can increase the probability that they will be used to improve quality. c. What is the average percentage that user fee revenue constitutes of non-salary operating costs for hospitals and for PHC facilities? If, on average, retained user fees constitute a substantial percentage of non-salary operating costs of facilities, then fees are likely to contribute significantly to the quality of services, as long as the MOH (or local government in a decentralized system) is not offsetting its budget allocation to the facility by the amount of user fees. *Module link:* Module 3.2 Leadership and Governance, Indicators 8, 15, 16, and 22 (financial accountability of public authorities); Module 3.6 Medical Products, Vaccines, and Technologies Chapter, Indicator 33 (cost recovery methods)
22. Informal user fees in the public sector	Informal user fees in the public sector are fees that are not officially sanctioned. a. Are informal user fees common in the public health sector? If so, what is the typical form of informal fee payments? Informal user fees often are called "under-the-table payments." They can exist in the form of cash, in-kind payments, or gratuities, and are often charged for access to scarce items such as medicines, laboratory tests, and use of medical equipment. b. To what extent are informal user fees a financial barrier to use of services? The amount of informal user fees that will be charged is difficult for patients to anticipate and can act as a barrier to care, just as formal fees do. Allocation of the revenue from informal user fees is subject to the discretion of the provider and, as opposed to revenue from official user fees, may not be used to increase the quality or access to public health services.

KEY INDICATORS

Table 3.3.4 identifies six key health financing indicators. These indicators are particularly useful to: (1) monitor and track health financing progress over time; and (2) guide a technical team member with severe time constraints to focus on the most important measures of health finance. Depending on the scope, time, and resources available for the particular assessment, modify this table and create a list of key indicators.

TABLE 3.3.4 KEY INDICATORS TABLE

No.	Indicator
1.	THE as a percentage of GDP
2.	Per capita total health expenditure at international dollar rate
4.	General government expenditure on health as a percentage of total health expenditure
5.	External resources for health as a percentage of total health expenditure
6.	Out-of-pocket expenditure as a percentage of total health expenditure
15.	Population coverage of health insurance

3.4 SUMMARIZING FINDINGS AND DEVELOPING RECOMMENDATIONS

Section 2 Module 4, describes the process that the HSA team will use to synthesize and integrate findings and prioritize recommendations across modules. To prepare for this team effort, each team member must analyze the data collected for his or her module(s) to distill findings and propose potential interventions. Each module assessor should be able to present findings and conclusions for his or her module(s), first to other members of the team and eventually in the assessment report (see Annex 2.1.C for a suggested outline for the report). This process is iteractive; findings and conclusions from other modules will contribute to sharpening and prioritizing overall findings and recommendations. Below are some generic methods for summarizing findings and developing potential interventions for this module.

ANALYZING DATA AND SUMMARIZING FINDINGS

The health financing chapter of the assessment report includes specific suggestions for analysis within the discussion of each indicator. These indicators are best understood when examined as a group by their functions or their topical area.

Using a table that is organized by the topic areas of the chapter may be the easiest way to summarize and group findings; see Table 3.3.5 for a template and Table 3.3.6 for an illustrative example. Rows can be added to the table to reflect the specific country context. In anticipation of working with other team members to put findings in the SWOT framework, each finding should be labeled as an S, W, O, or T (See Section 2 Module 4, for explanation of the SWOT framework). The "Comments" column can be used to highlight links to other modules and possible impact on health system performance in terms of equity, access, quality, efficiency, and sustainability.

TABLE 3.3.5 TEMPLATE: SUMMARY OF FINDINGS—HEALTH FINANCING MODULE

Indicator or Topical Area	Findings (Designate as S=strength, W=weakness, O=opportunity, T=threat.)	Source(s) (List specific documents, interviews, and other materials.)	Comments[a]

[a] List impact with respect to the five health systems performance criteria (equity, efficiency, access, quality, and sustainability) and list any links to other chapters.

As discussed in Section 1, Module 1, and Annex 2.4.A, the five WHO health system performance criteria – equity, efficiency, access, quality, and sustainability – can also be used to examine the strengths and weaknesses of the health system (WHO 2000). Table 3.3.6 is an example of how the Ukraine HSA summarized the performance criteria in a modified SWOT table (Tarantino et. al 2011).

Table 3.3.6 Summary of SWOT Findings for Equity, Access, Efficiency, Quality, and Sustainability From the Health Financing Module, Ukraine (2011)

Strengths and opportunities	General health services, HIV/AIDS, and TB	• A relatively high percentage of GDP (7 percent) is spent on health care • Ukraine's health sector is minimally dependent on donor funding • The government is pursuing health financing reforms that could improve efficiency and quality of care • Political and economic imperatives exist to pursue health reform, including an IMF conditional loan • Donor funding of HIV/AIDS, TB is significant in the near term
Weaknesses and threats	General health services	• The health system is unsustainable in its current form and the state cannot afford to deliver the guaranteed health benefit package • There is a lack of adequate government spending on health care • Expenditure on health is reliant on private sources, predominantly out-of-pocket payments • Current economic conditions have impacted government revenues, threatening decreases in spending for health • There is a notable absence of risk-pooling schemes • Health facility budgetary norms and allocations do not take into account volume and quality of services rendered or health service needs of the population • Budgetary norms and provider payment approaches foster a large portion of government funds be spent on wages, utility costs, and other inputs • Facility managers are not able to manage their finances to reinvest savings and reallocate funds for greater efficiency, responsiveness to health needs • A disproportionate share of expenditures are for inpatient care, with only 15% expended for outpatient care • Local government administrations have limited autonomy regarding allocation strategies for health services • The system of inter-budget transfers to equalize regions and to provide subsidies for social protection programs is not linked to the health needs of a region's population • There is a lack of comprehensive and reliable information on health financing, particularly to assess the contributions of various financing sources (public, private, households, donors) and ascertain the expenditure amounts on various health activities (inpatient care, outpatient care, HIV/AIDS, TB).
	HIV/AIDS and TB	• Strict separation of health budgets for selected health issues (TB, HIV/AIDS, etc.) leads to parallel medical providers, and limits optimization/rationalization • The five-year National AIDS Program budget allocations for prevention activities among MARPs [most at-risk populations] and the general populations are inadequate. • The national HIV/AIDS and TB programs rely considerably on donor support (around 50 and 15 percent, respectively); however, these programs remain significantly underfinanced

Table 3.3.7 summarizes the health financing indicators that address each of the performance criteria.

TABLE 3.3.7 LIST OF HEALTH FINANCING INDICATORS ADDRESSING THE KEY HEALTH SYSTEM PERFORMANCE CRITERIA

Performance Criteria	Suggested Indicators for Health Financing
Equity	4. General government expenditure on health as a percentage of total health expenditure 6. Out-of-pocket expenditure as a percentage of total expenditure on health 8. Process of MOH budget formulation 10. Central and local government budget allocations for health in decentralized systems 12. Recurrent government health budget allocation 15. Population coverage of health insurance 17. Funding mechanisms and sustainability of health insurance 20. Policies for user fee payments in the public sector 22. Informal user fees in the public sector
Efficiency	8. Process of MOH budget formulation 9. MOH budget allocation structure 13. Local-level spending authority and institutional capacity 14. Contracting mechanisms between MOH and public or private service providers 22. Informal user fees in the public sector
Access	1. Total expenditure on health as % of GDP 2. Per capita total expenditure on health at international dollar rate 6. Out-of-pocket expenditure as a percentage of total expenditure on health 7. Trends in MOH planned and realized expenditures 8. Process of MOH budget formulation 10. Central and local government budget allocations for health in decentralized systems 14. Contracting mechanisms between MOH and public or private service providers 15. Population coverage of health insurance 16. Services covered by health insurance 20. Policies for user fee payments in the public sector 22. Informal user fees in the public sector
Quality	1. Total expenditure on health as % of GDP 2. Per capita total expenditure on health at international dollar rate 7. Trends in MOH planned and realized expenditures 12. Recurrent government health budget allocation 14. Contracting mechanisms between MOH and public or private service providers 18. Provider payment mechanisms under health insurance 20. Policies for user fee payments in the public sector 21. Allocation of user fee revenues
Sustainability	4. General government expenditure on health as a percentage of total health expenditure 5. External resources for health as a percentage of total health expenditure 7. Trends in MOH planned and realized expenditures 8. Process of MOH budget formulation 9. MOH budget allocation structure 10. Central and local government budget allocations for health in decentralized systems 17. Funding mechanisms and sustainability of health insurance 18. Provider payment mechanisms under health insurance

Developing Recommendations

After summarizing findings, it is time to synthesize findings across chapters and develop recommendations for health systems interventions. In developing recommendations, team members should consider best practices used in other countries in the region to address problems similar to those identified in this assessment. It is useful to group recommendations into short-term and long-term solutions, or interventions that are relatively easy versus more challenging to implement in the context of this country.

Section 2, Module 4, suggests an approach that the HSA team can use for synthesizing findings across building block topics and for crafting recommendations. This subsection focuses on common health financing interventions to consider in developing recommendations; Table 3.3.8 lists the interventions.

Table 3.3.8 Illustrative Recommendations for Health Financing Issues

Health System Gap	Possible Intervention
Amount and Sources of Financial Resources	
Country is heavily dependent on donor spending	• Develop policy initiatives or reforms for raising funding for health from domestic public and private sources. In post-conflict or rebuilding state situations, these measures would typically be developed as longer-term goals, phased in over a longer period than in other more stable states or economies. For example, initiatives may need to be undertaken to increase the MOH budget or to introduce user fees (with waivers for the poorest) in the public health facilities. SHI and CBHI initiatives may also be appropriate. For countries with a vibrant private sector and/or reaching middle-income status, consider policies and mechanisms to harness out-of-pocket spending and leverage domestic private sector resources.
Out-of-pocket spending is a large share of health spending in the country and appears to be due to inadequate government funding (i.e., not deliberate ideological policy)	• Alternative methods for cost-sharing along with initiatives to increase the MOH or SHI budgets or both (e.g., more evidence-based budget formulation process, stronger budget advocacy skills).
Policy initiatives are underway to address major health care financing issues	• If appropriate, propose technical assistance to assist in the design, implementation, or evaluation of current policy efforts.
MOH Budget and Expenditures	
MOH spending for inpatient and outpatient services appears to be inequitable or out of balance	• Establish policies and regulations to re-direct public resources and staffing to PHC services • Alternative financing methods might be appropriate, such as forms of insurance for select populations or selected inpatient services or higher user fees with appropriate waivers and exemptions for higher levels of service
A substantially higher portion of the MOH budget is spent in urban areas (relative to the share of urban population in the country)	• Establish policy initiatives or reforms to redistribute MOH funds

TABLE 3.3.8 ILLUSTRATIVE RECOMMENDATIONS FOR HEALTH FINANCING ISSUES, CONT.

Health System Gap	Possible Intervention
Insufficient government funds to cover growing cost of medicines and increasing number of stock-outs	• Establish an essential drug list and adopt use of generic pharmaceutical policies and improved prescribing practices as strategies to contain costs. • Explore ways to better coordinate with private retail pharmacies to supply medicines on essential drug list at reduced prices to target population groups during stock-outs.
Government is slow to pay FBOs delivering services through service-level agreements FBOs claim payments do not cover true cost to deliver contracted services	• Strengthen MOH contracting capacity to assess value of contracts for services, including costing studies comparing public to private services. • Work with MOF to streamline payment system and timing.
Health Insurance	
No or negligible public, private, or community-based insurance exists	• Examine feasible strategies to establish and/or expand existing risk-pooling mechanisms. • If SHI exists but does not reach informal sector workers, explore alternative mechanisms to target informal sector workers if their access to health care appears to be substantially lower than formal sector workers. • If a BBP exists that provides selected services free of charge at the time of use, consider risk-pooling mechanisms for high-cost, high-risk services outside of the package.
Out of Pocket Payments	
Formal user fees appear to have a negative impact on utilization of PHC or other priority health care services in the public sector	• Strengthen the waiver and exemption systems. • Examine the process for setting the level of fees at PHC and hospital facilities. • Evaluate the perceived quality of health care services. • Explore the willingness and ability to pay for different types and levels of health care services.
Excessive/prohibitive informal user-fees which limit access to care	• Explore feasibility of introducing user fees for select services and users. • Consider methods for increasing health worker wages, either through salary increases or performance-based payments.

3.5 Assessment Report Checklist: Health Financing

❑ **Profile of Country Health Financing**

A. Overview of health financing

B. Create health financing flowchart (should include):

a. Collection and pooling

b. Payment methods

c. Health Financing and decentralization

❑ **Health Financing Assessment Indicators**

A. Amount and sources of financial resources

B. MOH budget and expenditures

C. Health insurance

D. Out-of-pocket payments (user fees and fee-for-service/product)

❑ **Summary of Findings and Recommendations**

A. Presentation of findings

B. Recommendations

Notes