SECTION 3: GUIDANCE ON ASSESSMENT OF THE HEALTH SYSTEM AND ITS CORE FUNCTIONS

MODULE 6: HEALTH FINANCING

6.1 Introduction

Most health systems in low- and middle-income countries are characterized by mixed public and private financing and delivery of care. For a health system to perform well and achieve universal health coverage (UHC)—that is, to provide needed, good-quality health services to all who need the services, without putting them at risk of impoverishment—countries need to generate an appropriate amount of revenue from all sources relative to what is possible in the country; pool risk effectively; use purchasing systems and provider payment mechanisms to ensure efficient use of funds and incentivize 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[1] show that more than half of total health spending is private out-of-pocket in at least 10 countries in Asia and 9 countries in Africa, including several of the world's most populous nations (Bangladesh, India, Nigeria, Pakistan). Governments should nurture pro-poor health care financing and service delivery programs to improve health and ensure financial protection among the most vulnerable.

This module looks at how the HSA approaches the core health system function of health financing.

- Subsection 6.2 defines health financing and its key components and describes how resources flow in a health system.
- Subsection 6.3 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.
- Subsections 6.4 and 6.5 present the indicators on which this part of the assessment is based.
- Subsection 6.6 provides guidance on how to synthesize findings and develop recommendations
- Subsection 6.7 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.

[1] http://www.who.int/gho/health_financing/out_pocket_expenditure_total/en/.

6.2 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). The 2010 World Health Report, "Health systems financing: the path to universal coverage," (WHO 2010) explicitly linked the role of health financing systems with moving towards UHC. It posited that health financing systems need to be specifically designed to "provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and] ensure that the use of these services does not expose the user to financial hardship." (p. 6)

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 core health system functions. The module draws from several seminal references:

- McIntyre, D. and J. Kutzin (2016), *Health financing country diagnostic: a foundation for national strategy development* (Geneva: World Health Organization), available at http://www.who.int/health_financing/tools/diagnostic/en/
- Gottret, P. and G. Schieber (2006), *Health Financing Revisited: A Practitioner's Guide* (Washington, DC: The World Bank)
- *Designing and Implementing Health Care Provider Payment Systems: How to manuals* (2009), edited by J. Langenbrunner, C. Cashin, and S. O'Dougherty (Washington, DC: The World Bank)
- World Health Organization (2010), *World Health Report 2010 Health systems financing: the path to universal coverage* (Geneva: World Health Organization)
- Cotlear, D., S. Nagpal, O. Smith, A. Tandon, and R. Cortez (2015), *Going Universal: How 24 Developing Countries are Implementing Universal Health Coverage Reforms from the Bottom Up* (Washington, DC: World Bank)
- Kutzin, J., W. Yip, and C. Cashin (2016), Alternative Financing Strategies for Universal Health Coverage, *World Scientific Handbook of Global Health Economics and Public Policy*.

WHO's Health Financing Country Diagnostic provides step-by-step guidance on how to undertake a situation analysis of a country's health financing system.

This guide to conducting a diagnostic considers a number of issues including the current level, mix and sources of funding for the health sector and institutional arrangements for health financing. It also assesses the performance of the system against the objectives and goals of universal health coverage (UHC).

The Diagnostic is written for Ministries of Health and other actors responsible for developing and implementing health financing policies, as well as those in an advisory role.

Health financing country diagnostic: a foundation for national strategy development (Geneva: WHO) http://www.who.int/health_financing/tools/diagnostic/en/.

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

- **Revenue collection**, also known as **resource mobilization,** 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 external development partner

contributions, are collected in some way from the general population or certain subgroups. Collection mechanisms include taxation of individuals, households and firms, social insurance contributions, private insurance premiums, and out-of-pocket payments. Collection agents could be government or independent public agencies (such as a social security agency), private insurance funds, or public and private health care providers.

- **Pooling** is the accumulation and management of funds from all sources in a way that insures individuals 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. Out-of-pocket payments do not involve the pooling of resources, are highly inequitable, and contribute to impoverishment.
- **Purchasing of health services** is the mechanism by which those who hold financial resources allocate and transfer 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. Common purchasers of health services are the MOH, a national or social health insurance agency, district health officials, insurance organizations, and individuals or households (when paying 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.

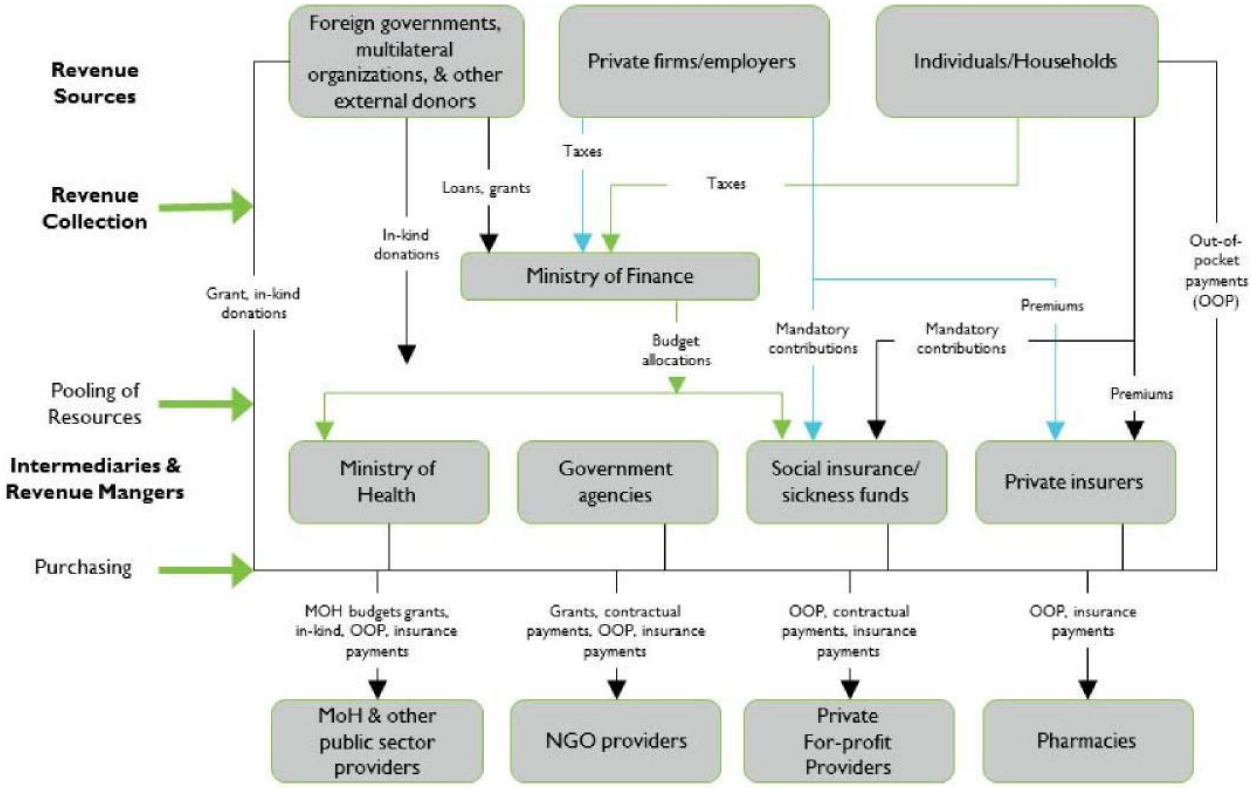
Three intermediate objectives of financing for UHC have been articulated by Kutzin (2013), and also serve as criteria for assessing health financing arrangements:

- Equity in the distribution of health system resources (who benefits?);
- Efficiency in system organization, service delivery, and administrative arrangements (are outputs being maximized given the resources allocated?); and
- Transparency and accountability of the system to the population (is resource allocation responsive to the needs and preferences of the people?).

6.3 Developing a Profile of Health Financing Institutions and Flows

Figure 3.6.1 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 0 below. Customizing this flowchart will facilitate the process of synthesizing the findings from this module (Subsection 6.6).

Figure 3.6.1 Health Financing Flows



Revenue Collection

Sources of health financing include government, individuals/households, private firms, and external development partners. Evidence shows that a predominant reliance on public, compulsory, pre-paid funds is central to make progress toward UHC. Private financing arrangements do not equally lead to UHC, especially if they are voluntary. The MOF, Treasury, or social health insurance agency is typically the central collector of revenues for the government health care system. (See Section 3, Module 1, Country and Health System Overview regarding the macro-fiscal environment, which influences the scope for fiscal space expansion and the MOF's ability to raise revenue.) Government entities may receive funds from external development partners (in the form of grants or loans) and from private firms and individuals (in the form of fees and taxes). External development partner funds for health can be in the form of general budget support, earmarked for a specific sector (such as health), or provided in-kind (such as technical assistance or donations of supplies and pharmaceuticals). In addition to government revenue collection, a significant source of health financing in LMICs is households' out-of-pocket spending directly for health services. In this case, households have no financial protection and are at risk of impoverishment or not accessing needed care.

Pooling

Pooling of financial resources for health means that the healthy subsidize the sick and the wealthy subsidize the poor, promoting both equity and financial sustainability. Pooling may be conducted by various intermediaries that receive, manage, and disburse resources; in the System of Health Accounts 2011 terminology, these intermediaries are referred to as Financing Schemes and Financing Agents. Intermediary institutions could be the MOH, other central government agencies such as the Ministry of Defense (in charge of military health facilities), regional governments, social insurance and sickness funds, community-based insurance schemes, and private insurers.

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 Section 3, Module 1, Country and Health System Overview for a more detailed discussion of decentralization issues.) The MOH may receive external funds through a health sector-wide approach (SWAp) arrangement, whereby external funders pool aid resources and decide jointly with the MOH on their allocation. The MOH often receives a large share of external 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 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 may also receive government budget transfers, either as direct subsidies (for instance, when the scheme is not self-sustaining financially, which is often the case with nascent schemes) or as premium payments for subsidized groups (such as 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.

In general, risk pooling arrangements should be assessed collectively in terms of their impact on the whole population and health system, rather than at the individual scheme level. This is because an individual scheme may provide excellent coverage to its own beneficiaries, but further draw resources away from non-covered, disadvantaged populations. Almost all LMICs have a mix of public and private risk pooling schemes. This fragmentation compromises the potential benefits when, for example, SHI or private insurers cover the healthy and wealthy, and the government is left to cover the highest risk populations (poor, unemployed, elderly).

Purchasing

All financing intermediaries and health revenue managers as well as individuals and households are purchasers of health care services. The payment mechanisms used to purchase services from each type of provider vary across countries and 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), for a defined package of services.
- Case-based payment pays the provider for each patient treatment episode, according to a predetermined payment schedule. Payments are based on the estimated cost of all interventions typically prescribed for the treatment of the given episode. One version of case-based payment uses Diagnosis-Related Groups (DRGs).
- 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 systems reimburse providers for each individual health service provided to a beneficiary. Providers submit claims for each service to the payment agency.

TIP BOX

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 the interview questions to
- each level of decentralization so they 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.

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. Since the 1980s, many countries have pursued decentralization to improve efficiency and responsiveness by allocating funds directly to local governments or by shifting decision-making authority to the local level. At least two major variants are relevant for the health sector: general devolution of authority to local government entities for decision-making, finance and management (including for health); and deconcentration of MOH responsibilities to lower levels of government.

Under the former arrangement, the MOF allocates block grants to decentralized political units (such as provincial, district, or local government units) for multiple sectors (health, education, sanitation, roads), typically based on historical spending patterns and/or criteria such as share of total population. These block 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. The block grant may not include recurrent costs such as the salaries of public employees (like public health providers) who may continue to be paid directly as part of the national payroll system. In this case, local governments and health facility managers have varying degrees of control over public employees, who may or may not be unionized. The MOF may also allocate some funds to the central MOH to administer national health functions and

programs. Country examples include Angola, Benin, and Mozambique. In some countries, local governments can levy, collect, retain and/or allocate local tax revenues among health and other sectors.

Section 3, Module 1, Country and Health System Overview Module, Annex 3.1.A. (Decentralization) provides additional guidance on assessing financial decentralization.

6.4 Assessment Indicators

This section outlines core health financing indicators that can be used in the assessment. It shows the topics into which the indicators are grouped, defines the indicators, lists data sources to inform the indicators, and discusses how to deal with indicators that overlap with other modules. Finally, the section identifies key indicators to which the HSA technical team member can limit their work, if time precludes their measuring all indicators.

Topics

The indicators for this module are grouped into four topics (see Table 3.6.1), which cut across the three main functions of health financing that were illustrated in Figure 3.6.1 (revenue collection, pooling of resources, and purchasing).

Table 3.6.1 Topics and Indicators addressed in the Health Financing Module

A: Amount and Sources of Financing
Indicator 1: Total expenditure on health as % of GDP **Indicator 2**: Per capita total health expenditure at international dollar rate **Indicator 3**: General government expenditure on health as percentage of total government expenditure **Indicator 4**: General government expenditure on health as a percentage of total health expenditure **Indicator 5**: External resources for health as a percentage of total health spending **Indicator 6**: Out-of-pocket expenditure as a percentage of total expenditure on health
B: Pooling and Financial Protection
Indicator 7: Incidence of catastrophic and impoverishing expenditures **Indicator 8**: Proportion of population enrolled in insurance or entitled to coverage under a financial protection mechanism **Indicator 9**: Fragmentation and sustainability of financial protection mechanisms **Indicator 10**: Out-of-pocket spending: User fees and exemption policies **Indicator 11:** Out-of-pocket spending: Informal payments in the public sector
C: Purchasing (Budgeting, Resource Allocation, and Provider Payment)
Indicator 12: Prioritization and the process of government health budget formulation **Indicator 13**: Trends in government health resource allocations **Indicator 14**: Services covered by health benefit plans **Indicator 15**: Provider payment mechanisms **Indicator 16**: Contracting and performance-based payment mechanisms
D: Governance of the Health Financing System
Indicator 17: Health financing institutional capacity **Indicator 18**: Local-level spending authority and institutional capacity **Indicator 19**: Budget allocations for health in decentralized systems **Indicator 20**: Budget execution (trends in planned and realized public health expenditures)

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:

Standard indicators: Data are drawn mainly from existing and publicly available international databases.

- The Global Health Observatory (http://www.who.int/gho/database/en/) contains an extensive list of indicators, which can be selected by theme, country or region. It is the World Health Organization's main health statistics repository.
- 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) (http://dhsprogram.com/)
  - Service Availability and Readiness Assessments (SARA) (http://www.who.int/healthinfo/systems/sara_methods/en/)
  - Household consumption and expenditure surveys that include health expenditure modules, such as the Living Standards Measurement Survey (LSMS)
  - System of Health Accounts 2011 (formerly known as National Health Accounts). The Global Health Expenditure Database compiles health accounts reports in one consolidated website (http://apps.who.int/nha/database/DocumentationCentre/Index/en)
- For financial protection indicators, WHO offers an online calculation tool: http://www.who.int/health_financing/tools/financial-protection/en/

Secondary sources: Indicators should be gathered to the extent possible through desk review of reports and other documents.

- National health financing policy document or UHC strategy
- MOH budgets; central and local government budget data
- Public Expenditure Reviews (http://wbi.worldbank.org/boost/tools-resources/public-expenditure-review) and Public Expenditure Tracking Surveys (http://go.worldbank.org/84C1RUHTD0) if available
- Data, reports, and presentations (as available) on health financing topics, including fiscal space and resource mobilization, insurance coverage and other risk pooling systems, analyses of financial protection, public financial management reforms, and strategic purchasing initiatives.

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; Ministries of Social Welfare may be relevant in some countries if they oversee social insurance programs
- Local government officials, especially in decentralized systems
- Local health administrative units (such as District Health Offices)
- Staff involved in Health Accounts production if available
- Representatives of external development partner 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 (e.g., MOH or social security) or donor funds for service delivery.
- Social Security or National/Social Health Insurance program officials
- Representatives of private health insurance bodies and organizations
- Local academics that provide health economics and health financing analytic services

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 module has many indicators, it is not essential to measure all of them; some may not be relevant in the assessment country.

6.5 Detailed Indicator Descriptions

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

Topic A: Amount and Sources of Financing

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 sources. For all indicators in this group, the technical team member should do regional comparisons and look at trends over time in the country. 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 country has important differences from its regional neighbors in standards of living, per capita incomes, health system structure, or extent of donor contributions.

Table 3.6.2 Amount and Sources of Financial Resources

Indicator	Definition and Interpretation
1. Total expenditure on health (THE) as percentage of GDP	**Definition and Interpretation:** This indicates the level of health system expenditure within a country relative to that country's level of economic development. THE is the sum of all outlays for improving, restoring, or maintaining health 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).[a] 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 external 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 expensive technology and likelihood of inefficiencies. In 2014, a widely-cited Chatham House paper (Mcyintyre & Meheus 2014) analyzed the relationship between government spending on health and UHC and proposed a target of government spending on health of at least 5% of GDP. There are, however, no commonly accepted benchmarks or targets for an appropriate percentage of GDP that a country should spend on health.

Indicator	Definition and Interpretation
	Module link: Section 3, Module 1—Country and Health System Overview, Indicators 6 (GDP per capita) and 8 (total health expenditures per capita)
2. Per capita total health expenditure (THE) at international dollar rate	**Definition and Interpretation**: Per capita THE expressed in purchasing power parity (PPP) terms or international dollars. (An international dollar or PPP dollar is 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 appropriate amount of per capita THE. According to the Commission on Macroeconomics and Health (WHO 2001), providing a limited package of essential health interventions (including HIV/AIDS treatment) in low-income countries in sub-Saharan Africa would require USD 38 per capita by 2015 (expressed in 2002 dollars). The High Level Task Force put that figure at $54 (in 2005 dollars) for a more comprehensive set of services, The Chatham House analysis updated this estimate to $86 in 2012 dollars, and this is now widely cited as a minimum threshold for spending in low-income countries. Countries with relatively low per capita spending are likely to have poor access, low-quality health care, or both. **Module link**: Section 3, Module 1—Country and Health System Overview, Indicator 8 (THE per capita)
3. General government expenditure on health (GGHE) as percentage of total government expenditure	**Definition and Interpretation**: This measure indicates the priority a country gives to health in its public resource allocation. GGHE is defined as 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 extra-budgetary funds). It includes all expenditure made by these entities, regardless of the source, and so includes any external development partner funding passing through them; transfer payments to households to offset medical care costs and extra-budgetary funds to finance health services and goods; and current and capital expenditure (WHO 2008). 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). 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. Across the globe, the average share in 2012 was 11.5% (Kutzin et al. 2016). A relatively larger commitment of government spending to health suggests a high commitment to the sector and the potential to move towards UHC. For example, the Abuja Declaration of African Heads of State includes a target of allocating 15 percent of 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. To measure whether a government health budget is a sustainable source of funding for the health sector, the following questions may be useful: • Do government health expenditures keep pace with inflation and with population growth? If annual actual or planned expenditure is not increasing at the same rate as general prices

Indicator	Definition and Interpretation
	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). • 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 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.
4. General government expenditure on health (GGHE) as a percentage of total health expenditure (THE)	**Definition and Interpretation**: This indicator is a measure of the relative contribution of central and local government health spending to THE. If the percentage is relatively low (i.e., below 40 percent) it can reflect (1) low tax collection 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), (3) heavy dependence on out-of-pocket spending and/or (4) reliance on substantial external assistance. A low value for this indicator also means that the government has limited ability to act to address equity issues. Typically, the public share of total health expenditures increases as countries move into higher income categories (Gottret & Schieber 2006). 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.
5. External resources for health as a percentage of total health spending (THE)	Definition and Interpretation: 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. Strategies for helping the country increase its domestic resource mobilization (through for instance improved tax administration, increased budget allocations to the health sector, or established earmarked taxes or "sin taxes") may be needed. Compare this indicator to government health spending as a percentage of THE (Indicator 4) to assess the sustainability implications of the share of external funding. Very high dependence on external 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 household 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.

Indicator	Definition and Interpretation
6. Out-of-pocket expenditure as a percentage of total expenditure on health	**Definition and Interpretation**: Out-of-pocket payments are expenditures on health by households and individuals made as direct payments to health care providers, whether in the public or private sector. This indicator represents the direct expenditures that households make at the time of using health care and purchasing medicines, relative to THE. Out-of-pocket expenditures exclude payment of insurance premiums and should be net of reimbursements from health insurance, but include non-reimbursable insurance deductibles, co-payments, and any other fees. Out-of-pocket spending as a share of THE is correlated with rates of impoverishment due to health care spending, and as such is considered a good proxy indicator for financial protection in health. If out-of-pocket spending represents a large share of THE (e.g., above 30 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. Module link: Section 3, Module 1—Country and Health System Overview, Indicator 9 (out-of-pocket expenditures as percent of private expenditures); Section 3, Module 2, Health Service Delivery, Indicators 8 and 9 (Financial access); Section 2, Module 4, Medical Products, Vaccines and Technologies, Indicator XX (out-of-pocket spending on medicine as percent of total out-of-pocket spending on health).

a. Note that the commonly-used terminology of "Total Health Expenditure (THE)" is derived from the original System of Health Accounts (SHA) categories. The categories have been revised in the latest system of health accounts, SHA 2011, and the WHO's Global Health Expenditure Database is being revised to reflect the newer classification. The WHO notes that "this will change the terminology somewhat, but the basic logic of what is contained [here] … will remain." (McIntyre & Kutzin 2016)

Topic B: Pooling and Financial Protection

The indicators in this section investigate the extent of financial protection provided to individuals and families in the country, measured by the prevalence of catastrophic and impoverishing health expenditures, and the different available types of risk pooling systems used to provide that financial protection. These include health insurance schemes, although health insurance is only one mechanism for pooling risks. Financial protection mechanisms should be assessed in terms of their impact on the whole population and health system, rather than at the individual scheme level. In addition, enrollment in or affiliation to specific schemes—which might be documented by having an insurance card—is not necessarily synonymous with *effective coverage* (use of needed services with financial protection), and these concepts should be differentiated.

While myriad risk pooling arrangements exist globally, three broad categories are often described. Few systems will fit perfectly into any of these categories—most are a blend:

- **General-revenue-funded systems (National Health Service, National Health Insurance):** government-managed financial protection schemes typically financed through general taxation, usually with mandatory coverage for all citizens. They may be managed by the MOH or a separate national health financing body (such as the NHIS in Ghana). The government may directly provide health services (through MOH-owned facilities) or contract with private sector providers.

- **Social health insurance (SHI) schemes:** a government-organized program that provides a (usually) specified benefit package of health services to members, typically funded by mandatory payroll contributions from formal sector employers and employees (though it might also include voluntary membership from those who are not formally employed). Funds are typically managed by one or more independent or quasi-independent social insurance agencies. Subsidized contributions for priority population groups such as the poor, children, and pregnant women may be paid by the government.

- **Private voluntary health insurance**, which can be:

    - **Community-based health insurance (CBHI):** typically nonprofit health insurance that provides a limited package of health services to members who pay premiums to a community-based and community-managed health fund. CBHI schemes, also known as *mutuelles* in francophone Africa, are based on an ethic of mutual aid among members.

    - **Commercial (for-profit) health insurance:** voluntary insurance 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 actuarial risk rather than individuals' ability to pay.

      If CBHI or other private health insurance (or both) exist but cover very small populations or provide very limited coverage, this rapid assessment need not spend much time gathering data about them. Simply noting that small schemes exist is sufficient.

All countries face policy and implementation challenges with respect to risk pooling. To help analyze these, it may be helpful to develop a profile of the different financial protection programs that are available in the country, using Table 3.6.3 below. Much of this information should be available from secondary sources. Elicit comments from key informants about (I) any issues they have faced with respect to services and population covered, the funding, and provider payment mechanisms and subsidies used, and (2) any policy or implementation initiatives or reforms they are undertaking. Based on those discussions, identify for further exploration, analysis, or study key dimensions in which the design or implementation of these risk pooling systems could improved.

Table 3.6.3 Profile of Financial Protection Systems

Indicator	Program 1	Program 2	Program 3
Beneficiaries • Members: who is eligible? Who is enrolled? • Is enrollment mandatory or voluntary? • Percentage of total population enrolled / entitled to benefits • How are beneficiaries identified and targeted?			
Services covered • Types of services covered • Key exclusions or waiting periods • How are benefit packages selected and updated over time?			

Indicator	Program 1	Program 2	Program 3
Funding mechanisms • Sources of funding: general government revenue, earmarked taxes, sin taxes; mandatory contributions by formal sector workers (payroll taxes); beneficiary premiums; beneficiary cost sharing at the point of service? • Government subsidies for specific groups?			
Risk pooling and fragmentation • Is there one national risk pool, separate national risk pools for distinct beneficiary groups, or subnational level pools? • Are the poor cross-subsidized by higher income people?			
Payment mechanism for providers • Types of payment mechanisms used • Quality or accreditation requirements for provider payments			

Table 3.6.4 Pooling and Financial Protection

Indicator	Definition and Interpretation
7. Incidence of Catastrophic and Impoverishing Expenditures	**Definition:** The incidence of "catastrophic" health expenditures and the incidence of impoverishment due to health expenditures are the two core measures suggested by the World Health Organization and World Bank to measure financial protection (WHO and World Bank 2014). They capture slightly different underlying constructs, the first reflecting the principle that "no family or household should contribute any more than a reasonable proportion of their income to finance a system of social protection in health and/or specific health services" and the second that households should be protected from "falling into or remaining in poverty, as a result of excessive contributions to the financing" of their health care (ILO 2002). High rates of catastrophic or impoverishing expenditures imply that a country lacks adequate financial protection systems for its populace. **Catastrophic health spending** is typically measured as the proportion of households that spend more than a specified fraction of their available resources to pay for health care (WHO and World Bank 2014). The "resources available" denominator can be defined as total household income or consumption, or as household spending net of spending on food (non-food consumption). Nonfood consumption is advocated by the WHO because it is felt that health spending should not compete with households' ability to obtain food and other necessities (WHO 2000). Common thresholds for health spending that is considered catastrophic are 10% of total household income and 25% or 40% of total non-food consumption. The **impoverishment** indicator captures the extent to which health spending causes extreme hardship by pushing families below the poverty line, or deeper into poverty if they are already poor (WHO and World Bank 2014). It is measured as the number of non-poor households whose health spending causes them to cross a poverty line, combined with already-poor families who incur any out-of-pocket health spending, as a proportion of all households. Poverty may be defined using a country's existing national poverty line or by constructing a food poverty line (income needed to purchase 2,100 calories per day) (Wagstaff & van Doorslaer 2003).

Indicator	Definition and Interpretation
	Household expenditure surveys are required to calculate both of these indicators. Many countries now produce these measures routinely, while others may only produce them via special studies. If possible, it is helpful to disaggregate the incidence of catastrophic expenditures by income group.
8. Proportion of population enrolled in insurance or entitled to coverage under a financial protection mechanism	**Definition and Interpretation:** The percentage of the population enrolled in a health insurance scheme or entitled to benefits under a financial protection system, and their demographic characteristics. Membership in risk pooling schemes, including insurance, can provide financial protection against high costs of health care at the time of use, compared with paying out-of-pocket whenever the need for health care arises. Being enrolled in the scheme or otherwise entitled to benefits thus improves financial access and reduces the financial barriers to use of the health care services that the mechanism covers. This indicator is intended to capture a variety of possible mechanisms, such as voluntary coverage through private health insurance, mandatory coverage in social health insurance, or entitlement to government-subsidized coverage because of membership in a particular group (such as pregnant women or children under five). As noted in the summary Table 3.6.3 above, other useful dimensions for assessing financial protection mechanisms include: • Who is entitled to benefits? Only those people who pay premiums or contributions? All or some of their family members? Public employees? Formal sector (non-public) employees? Urban vs rural inhabitants? Who is excluded? • How are beneficiaries identified and targeted? Is enrollment mandatory or voluntary? • Among those entitled to benefits, what proportion has accessed those benefits? • How has coverage changed in recent years—is it expanding? • Does the government or another entity (e.g., charities, NGOs) subsidize membership for any groups, such as the indigent, the informal sector, the elderly or the young children?
9. Fragmentation and sustainability of financial protection mechanisms	**Definition and Interpretation:** This indicator aims to describe the characteristics of pooling arrangements in the country, and specifically the extent to which there is fragmentation of health funds (numerous small pools with limited membership). The aim of pooling is to redistribute prepaid funds in an equitable manner; fragmentation means that "there are barriers to redistribution of available prepaid funds" for health and thus "lower potential for cross-subsidies to flow across the health system" (McPake and Kutzin 2016). Where there is greater fragmentation, problems like adverse selection tend to be more acute and high-risk groups are more likely to be excluded from coverage. The WHO's Health Financing Country Diagnostic (2016) provides several good suggestions for describing and assessing problems with fragmentation (see Box 3, page 15). It suggests reviewing three important characteristics of health funds pooling to assess the country's capacity to redistribute funding on behalf of the sick and the poor: • **Size** and **diversity**—the larger the number of health fund contributors within a given pool, and the greater the mix of health risks and socioeconomic characteristics, the greater the capacity to cross-subsidize from rich to poor and from healthy to sick • **Compulsory vs voluntary participation**—in voluntary schemes, sicker people tend to join, while healthier people do not. This can destabilize fund pools, requiring increased premiums—or exclusions of certain members or certain health services—to maintain financial sustainability. When membership is compulsory or automatic, it is much easier to ensure consistent coverage for all population groups.

Indicator	Definition and Interpretation
	Other factors that can affect the financial sustainability of insurance include financial mismanagement and weak control of provider payments.
10. Out-of-pocket spending—User fees and exemption policies	**Definition and Interpretation:** User fees are out-of-pocket charges at health facilities that patients must pay at the point of service to receive care. They are often levied by government or faith-based health facilities to supplement insufficient budget transfers, and may cover local operating costs, including the purchase of drugs, supplies, and salary supplements. They may constitute a substantial proportion of health facility revenues in some contexts, and may be especially important for covering recurrent costs. However, user fees can be a significant barrier to access, especially for the poor. Recall that household out-of-pocket spending on all forms of direct fees is high in LMICs. In this case there is no financial protection and households are at risk of impoverishment or not accessing needed care. User fee exemption and waiver policies aim to reduce the financial burden on patients and increase access to health care services by reducing or eliminating fees for certain services (i.e., delivery care) or certain groups (i.e., pregnant women or under-five children). Waivers and exemptions must be administered well and accurately, however, and this is often difficult to do. 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.). Depending on context, consider assessing the following questions: • How prevalent are user fees, and for what types of services are they levied? (outpatient visits, medicines, supplies, laboratory tests, inpatient care?) What is the average percentage that user fee revenue constitutes of facility operating costs? • Are all or a portion of user fee revenues retained at the facility where they are collected? If so, are there guidelines for use of fee revenues? Allowing a facility to retain and use the user fee revenues it collects may be an incentive for the facility to use fee revenue for improvements in quality. 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? Community participation in the use of fee revenues can increase the probability that they will be used to improve quality. • Are there policies (fee exemptions or waivers) that remove the payment of user fees for some patients or services, in particular': ○ 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 an essential services package, other chronic care? • What 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). • Does the country have a mechanism to compensate facilities for the revenue lost through exemptions and waivers? If not, there is an incentive for the facilities to give fewer exemptions. • To what extent are user fee policies that exist followed in practice? Explore the reasons for gaps between user fee policies and practices.

Indicator	Definition and Interpretation
	Module link: Section 3, Module 2, Health Service Delivery, Indicator 6 (financial access to health services); Module 4, Medical Products, Vaccines, and Technologies Module, Indicator XX (out of pocket expenditure for health on medicines) **Module link**: Section 3, Module 7, Leadership and Governance, Indicators 8, 15, 16, and 22 (financial accountability of public authorities)
11. Out-of-pocket spending—Informal payments in the public sector	**Definition and Interpretation**: Informal payments, also known as under-the-table payments, are public sector fees that are not officially sanctioned. 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. Like formal user fees, there is no financial protection and households are at risk of impoverishment or not accessing needed care. • Are informal fees common in the government health sector? If so, what is the typical form of informal fee payments? • 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.

Topic C: Purchasing (Budgeting, Resource Allocation, and Provider Payment)

This section looks at the resource allocation and purchasing processes used by the government, insurance agencies and other health care purchasers. Purchasing includes the formal budget preparation process, other types of resource allocation decision-making (such as health technology assessments and benefit package design), efficient funds transfers, and effective price negotiation for inputs (such as health worker salaries or bulk pharmaceutical procurement) as well as the design and implementation of various provider payment mechanisms, including the use of performance-based incentives.

As noted in the introduction to this chapter, countries are likely to achieve better health outcomes and greater value for money when they promote *strategic purchasing*:

> "…proactively identifying which models of care and interventions to invest in (taking into account cost-effectiveness, burden of disease, and population preferences); determining how they should be purchased (including contractual mechanisms, pricing, and payment systems); for whom they should be purchased …; and selecting which health-care providers to purchase services from—ideally those who can provide the highest quality of care most efficiently, whether public or private sector. Not only can this active purchasing approach ensure that scarce resources are allocated appropriately, but also—if designed well—the mechanisms for paying providers can incentivise improvements in performance and quality of care." (Koblinsky et al. 2016)

Throughout this section, the assessment should aim to capture the extent to which purchasing is occurring in a strategic, proactive manner.

Country performance against these indicators is highly influenced by public financial management (PFM) systems generally.[2] The extent of health system decentralization may also influence how health purchasing arrangements are structured. For instance, the process of health budget preparation may take place at various levels of health system administration, each influencing the distribution of funds across different types of spending categories, services, and regions. Note that while other sectors may have health-related responsibilities and budgets, (e.g., Ministry of Education for medical education, Ministry of Defense for military health), for purposes of the rapid assessment, the following indicators concentrate on health sector institutions.

Table 3.6.5 Purchasing (Budgeting, Resource Allocation, and Provider Payment)

Indicator	Definition and Interpretation
12. Prioritization and the process of government health budget formulation	**Definition and Interpretation**: This indicator examines the process used by national and subnational health financing institutions to allocate resources and develop budgets for the following fiscal year. Resources for health are constrained in every context, acutely so in low-income contexts. Decisions prioritizing which services and populations will receive funding have life and death consequences. Resource allocation decision-making should thus be systematic, evidence-based, equity-focused, and transparent, ideally making clear the tradeoffs among different possible investments in health (Glassman and Chalkidou 2012). • Are health sector budgets developed based on the prior year's budget or historical budget totals, or are they based on estimates of resources required to meet defined population health needs? When budgets are historically based, funds are often allocated based on the number of hospital beds or number of health workers on the payroll, without regard to where there is greatest need; budgets simply repeat the amount of funding allocated for the previous year, with perhaps an adjustment for inflation or changes in overall government spending. "Needs-based" budgets, in contrast, 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, 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. • 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)? 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 respond to local needs. Although the bottom-up budget preparation approach may exist as policy, examine actual practice to see if local input influences central MOH decision making.

[2] The PEFA (Public Expenditure and Financial Accountability) program provides summary indicators on public financial management performance for most countries. See https://pefa.org/assessments/listing for more information.

Indicator	Definition and Interpretation
	• Is there an explicit health priority-setting institution or process in place, such as health technology assessments? A systematic process of priority-setting for health can be structured in various ways (Glassman and Chalkidou 2012). Some countries (such as Thailand, the United Kingdom, and Colombia) have established formal institutions with a technology assessment or priority-setting mandate. They may analyze the cost-effectiveness of various health interventions, drugs, and diagnostics; assess budget impacts of funding such interventions and technologies; analyze their equity and financial protection implications; assess popular preferences and incorporate feedback from advocacy groups; and make recommendations for allocating public funding. In other contexts, these functions may be conducted informally or by several institutions. Assess whether there is local capacity for explicit and transparent health priority setting; the types of input considered by those responsible for priority setting; and the extent to which these processes effectively influence budget allocations. • What classification system does the MOH (or other health financing institution) use to structure its budget? Budgets may be structured by line items, programs, outputs, or mixture of methods. 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). Line-item budgets may be administratively convenient, but they have a very weak relationship to promoting achievement of desired health system objectives (WHO/OECD, in press). When budgets must be executed according to line items, health facilities have little flexibility to reallocate as population needs evolve, and they usually cannot carry over funds from year to year. When budgets are organized around outputs, such as programs or services for specific populations, it is more likely that funds will flow to what the government has promised to buy. The WHO, OECD, and Results for Development Institute recently published a helpful guide for assessing alignment between health financing objectives and public financial management systems [WHO/OECD, in press].
13. Trends in government health resource allocations	**Definition and Interpretation**: This indicator looks at the results of the resource allocation, budgeting and prioritization processes described in the above indicators, and tracks observed trends in how the government has allocated public funds. Recall that the public health budget may be a mix of MOH, local government, and risk pooling budgets. • **What percentage of the total government health budget is spent on outpatient vs. inpatient care?** This indicator aims to capture the relative prioritization of government spending on outpatient services, and particularly whether spending on inpatient care is crowding out funding for primary health care. Although inpatient care is more resource-intensive than 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 than the funding in any one year. If the share the MOH budget allocates to

Indicator	Definition and Interpretation
	outpatient services declines steadily, or periodically, outpatient care may be diminishing as a government priority or the disease profile of the population may be changing in a way that requires more inpatient care. Examine whether and how trends in donor funding may be influencing MOH budget allocations for PHC and other outpatient care—is displacement of local resources occurring? (Note that although another common indicator 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. Standard Health Accounts estimations measure outpatient and inpatient care expenditures. If obtaining this data is difficult, consider instead the percentage of the budget allocated to hospital and non-hospital facilities as a proxy.) • **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. See box, "Definition of Recurrent and Investment Budget" for definitions. 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. Probe to investigate whether the MOH and MOF plan adequately to increase the recurrent budget for staff and supplies once new physical capacity is added (e.g. a health facility is built).
	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.
	• **What percentage of the total public health budget is for recurrent spending, and how is it allocated?** Using recent budget or Health Accounts estimates, or in consultation with government health officials, calculate the percentage of the government health budget spent on: o Salaries of health workers o Medicines and supplies o Facility and equipment maintenance costs o 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. Compare the distribution of spending to that of other countries with a similar per capita income level, if possible. Often, as much as 70-80 percent of a MOH budget is allocated to health worker salaries

Indicator	Definition and Interpretation
	and benefits. This large near-fixed expenditure can crowd out budget allocations to medicines and supplies, resulting in patients having to pay out-of-pocket for medicines at local pharmacies and health workers lacking the supplies needed to treat patients. This shortfall affects the quality of care, as well as equity. However, even a large budget allocation to salaries may not be sufficient to adequately pay health workers. The HSA team should examine whether salaries are paid on time and regularly. Module link: Section 3, Module 2—Service Delivery, Indicator XX (primary care or outpatient visits per person per year); Module 4—Medical Products, Vaccines, and Technologies, Indicators XX (total expenditure on pharmaceuticals), XX (government expenditures on pharmaceuticals), and XX (proportion of annual expenditure on medicines financed by government budget, external development partners, charities, and private patients).
14. Services covered by health benefit plans	**Definition and Interpretation:** General description of the types of services covered by social insurance and other financial protection schemes. • Which services are covered by the scheme (e.g., a basic package of ambulatory PHC, hospital inpatient services)? How is the benefit plan defined, and how is it updated or revised over time? The greater the range of health care services covered by insurance, the more financial protection members have against high costs of health care. See Nakhimovsky et al. (2015) for a review of global lessons on using evidence to define and update health benefit plans. • 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 as part of an essential services package. In that case, one would not expect to find those services included in an insurance package.
15. Provider payment mechanisms	**Definition and Interpretation:** Provider payment mechanisms are the ways that health purchasing institutions pay health care providers to deliver services. They create economic incentives that influence behaviors about which services to provide, how much to provide, how to deliver the services and what combination of inputs to use (Cashin, ed. 2015). See subsection 0 for definitions of the most common mechanisms that purchasers of health services use to pay providers. The Joint Learning Network for Universal Health Coverage produced a practical guide for countries to use in assessing their health provide payment systems (Cashin, ed. 2015). It provides detailed suggestions for specific questions to use for a deep-dive provider payment assessment. Another seminal resource is The World Bank and USAID's *Designing and Implementing Health Care Provider Payment Systems: How-To Manuals* (http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/ProviderPaymentHowTo.pdf). Selected questions are highlighted below. • **What are the mechanisms used by purchasing institutions (such as health insurance agencies or the MOH) to pay health service providers, and what incentives do these entail for quality, efficiency, and responsiveness?** Different payment mechanisms provide different incentives to providers. For example, fee for service promotes

Indicator	Definition and Interpretation
	responsiveness and quality but may lead to cost escalation and inefficiency. Capitation and case-based payment promote efficiency and sustainability but may jeopardize quality. • How are payment rates established and updated? Are there adjustments for case-mix (variations in the health status of covered populations, making some more expensive than others), providers in the public vs private sector, geographical variations, price inflation? • What quality monitoring and assurance systems are used in conjunction with the payment mechanism? For instance, are only accredited facilities or licensed providers eligible for payment? Is there an independent quality monitoring entity?
16. Contracting and performance-based incentive mechanisms	**Definition and Interpretation**: Performance-based incentives (sometimes called pay for performance, performance-based financing, or results-based financing) are increasingly used by health purchasers to promote high-quality service provision among both public and private sector providers. A payment agency (most commonly the government) establishes contractual arrangements with health districts, health facilities, or staff working in facilities, and agrees to provide financial incentives contingent upon the achievement of specific, quantifiable goals. These may be improved quality of care, increased number of patients served or population coverage, or improved health status measures in targeted groups). 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 coverage targets. • Within the public sector (MOH, social health insurance providers, or other public providers), are any contracting mechanisms or performance incentives used? Are any contracting or grant mechanisms or performance incentives in place 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 among public, private nonprofit (NGOs, FBOs) and commercial providers, if relevant. Assess with key informants how effective the contracting arrangements are, and whether alternative or revised payment methods or health worker incentives may be needed. • What performance monitoring systems are in place to verify the achievement of **performance** targets? • 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.

Indicator	Definition and Interpretation
	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**: Section 3, Module 1—Country and Health System Overview, (structure of government and private sector in health care)

Topic D: Governance of the Health Financing System

This section looks at the institutions responsible for managing the health financing system, and their capacity and effectiveness at implementing the different health financing functions (resource mobilization, pooling, and purchasing). It also looks at health financing stewardship in decentralized systems, including local autonomy in financing-related decisions.

Table 3.6.6 Governance of the Health Financing System

Indicator	Definition and Interpretation
17. Health Financing Institutional Capacity	**Definition and interpretation**: This indicator speaks to the capacity of the MOH (or other relevant health financing institutions) to provide overall guidance and direction to the health financing system. • Does the MOH have the technical and organizational capacity to provide direction and oversight of health financing activities? Typically, there is a MOH unit, often within the policy or planning department, with an explicit mandate for health financing policy, analysis, and research (e.g., Health Economics Unit). Assess whether this unit 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. • 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? 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 Health Accounts, 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 Health Accounts 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.

	• Do institutions responsible for funds pooling and purchasing have adequate technical and organizational capacity to implement these functions? Pooling and purchasing functions must be implemented by organizations with advanced technical and institutional capacity—to collect revenues, identify and reach beneficiaries, prioritize services covered, manage provider payments, control costs, promote efficiency, and manage financial resources effectively. Explore whether managers at these institutions have necessary technical qualifications, timely access to necessary data and information, and the ability to use this information effectively for policy, planning, and oversight. Determine whether they have the institutional support to be effective. External development partners supporting pooling and purchasing institutions in the country can also provide insights on the gaps in organizational and institutional capacity that might need to be addressed in order to promote effective health financing system stewardship. **Module link**: Health Governance
18. Local-level spending authority and institutional capacity	**Definition and Interpretation:** This indicator reviews the degree of autonomy that administrative units below the central level (including government health facilities) have in allocating their health budgets, as well as their ability to do so. • Do administrative units below the central level (e.g., provincial, district, local governments) 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. • Do government health facilities have autonomy in making recurrent expenditures such as procurement of supplies, gasoline, and medicines, and hiring of supplemental personnel? Having authority to make decisions about allocating resources at the facility level is also important to ensure that funds allocation is responsive to local needs. This authority can best be granted through global budgets, under which facility managers have the discretion to allocate total funds across uses according to their service delivery needs. • Do local governments have the capacity to implement health financing policies? Strong institutional capacity of local governments is needed to implement national health financing policies, develop budgets that align with district/local health plans, use spending authority effectively, and track and report health expenditures. This indicator is particularly relevant in a decentralized system where local governments have substantial responsibilities and authority for health care. Assess whether local government staff responsible for the health sector have a basic understanding 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). • Does a system exist at the central, district, or facility level for tracking and auditing 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.

	Explore the various administrative and service delivery levels of the system separately on this issue, especially in decentralized settings. Different facility levels (e.g., health post, clinic, secondary, or tertiary hospital) and different jurisdictions may have different policies regarding budget flexibility, autonomous financial decision-making, expenditure tracking and cost control measures, as well as different levels of capacity in health financing. **Module link**: Section 3, Module 1—Country and Health System Overview, Annex 3.1.A. (Decentralization); Module 4—Medical Products, Vaccines, and Technologies, Indicator XX (public sector procurement processes)
19. Budget transfers for health in decentralized system	**Definition and Interpretation**: This indicator describes how resources for health are allocated and transferred from central government to lower-level administrative units such as states, regions, provinces, and districts. • 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. Analyze the incentives inherent in how funds are allocated to local governments. Does the country use block grants (providing broad latitude for the local authority to allocate funds to any sector) or are budget transfers earmarked for health? If there is earmarking, is there any adjustment for the locality's health needs (e.g., for population or socioeconomic indicators)? What specific limitations are put on the use of funds? • 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 governments with taxing authority may be able to raise and allocate additional funds for health. However, experience suggests that in the early years after 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.
20. Budget execution (trends in planned and realized public health expenditures)	**Definition and Interpretation**: 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. If actual expenditure is significantly less than what is planned or authorized, this indicates weak public financial management capacity—a core aspect of health system stewardship—and it implies that the public sector budget is an unreliable source of funds for health. • What is the trend in differences between the authorized budget and actual expenditures? What accounts for the differences, and what are the practical implications for health care providers? Poor budget execution may reflect restrictive rules regarding release of funds and procurement, or restrictions on reallocating funds across budget line items. It may reflect delays in funds transfers to health providers, or inability to carry over any surpluses from year to year. In such cases, hiring new staff is delayed, salaries tend to be paid late, and procurement of medicines and supplies tends 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).

Key Indicators

Table 3.6.7 identifies several key health financing indicators. These indicators are particularly useful to: (I) 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 3.6.7 Key Indicators Health Financing

No.	Indicator
1, 2, 4, 5, 6	Core Health Expenditure Indicators:
	Total Health Expenditure as a percentage of GDP (Indicator 1)
	Per capita total health expenditure at international dollar rate (Indicator 2)
	General government expenditure on health as a percentage of total health expenditure (Indicator 4)
	External resources for health as a percentage of total health expenditure (Indicator 5)
	Out-of-pocket expenditure as a percentage of total health expenditure (Indicator 6)
8	Proportion of the population enrolled in insurance or entitled to coverage under a financial protection mechanism
15	Provider payment mechanisms

6.6 Summarizing Findings and Developing Recommendations

Section 2 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 interactive; 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 topics.

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 3.6.8 for a template and Table 3.6.9 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 3.6.8 Template: Summary of Findings—Health Financing Module

Indicator or Topic	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 modules.

As discussed in Section 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 3.6.10 is an example of how the Ukraine HSA summarized the performance criteria in a modified SWOT table (Tarantino et. al 2011).

Table 3.6.9 Example: 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 external 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	• Current health financing is unsustainable 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 result in a large portion of government funds being spent on wages, utility costs, and other inputs • Facility managers are not able 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 authorities have limited autonomy regarding allocation of funding 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 each 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 3.6.10 summarizes the health financing indicators that address each of the performance criteria.

Table 3.6.10 Health Financing Indicators Mapped to 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 7. Incidence of catastrophic and impoverishing expenditures 8. Proportion of population enrolled in insured or entitled to coverage under a financial protection mechanism 9. Fragmentation and sustainability of financial protection mechanisms 10. Out-of-pocket spending—User fees and exemption policies 11. Out-of-pocket spending—Informal fees in the public sector 19. Budget transfers for health in decentralized systems
Efficiency	8. Prioritization and the process of MOH budget formulation 9. Fragmentation and sustainability of financial protection mechanisms 12. Prioritization and the process of government health budget formulation 13. Trends in government health resource allocations 15. Provider payment mechanisms 16. Contracting and performance-based incentive mechanisms 18. Local-level spending authority and institutional capacity 19. Budget transfers for health in decentralized systems 20. Budget execution
Access	1. Total expenditure on health as % of GDP 2. Per capita total expenditure on health at international dollar rate 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 7. Incidence of catastrophic and impoverishing expenditures 8. Proportion of population enrolled in insured or entitled to coverage under a financial protection mechanism 9. Fragmentation and sustainability of financial protection mechanisms 10. Out-of-pocket spending—User fees and exemption policies 11. Out-of-pocket spending—Informal fees in the public sector

Performance Criteria	Suggested Indicators for Health Financing
	14. Services covered by health benefit plans
Quality	1. Total expenditure on health as % of GDP 2. Per capita total expenditure on health at international dollar rate 12. Prioritization and the process of government health budget formulation 13. Trends in government health resource allocations 14. Services covered by health benefit plans 15. Provider payment mechanisms 16. Contracting and performance-based incentive mechanisms
Sustainability	3. General government expenditure on health as a percentage of total government expenditure 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 8. Proportion of population enrolled in insured or entitled to coverage under a financial protection mechanism 9. Fragmentation and sustainability of financial protection mechanisms 13. Trends in government health resource allocations 14. Services covered by health benefit plans 15. Provider payment mechanisms 17. Health financing institutional capacity 18. Local-level spending authority and institutional capacity

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, suggests an approach that the HSA team can use for synthesizing findings across other health system function topics and for crafting recommendations.

6.7 Assessment Report Checklist: Health Financing

- Profile of Country Health Financing
  - Overview of health financing
  - Create health financing flowchart (should include):
    - Revenue collection
    - Pooling
    - Provider payment methods
- Health Financing Assessment Indicators
  - Amount and sources of financing
  - Risk Pooling and Financial Protection
  - Purchasing (Budgeting, Resource Allocation, and Provider Payment)
  - Governance of the Health Financing System

- Summary of Findings and Recommendations
  - Presentation of findings
  - Recommendations

6.8 Bibliography

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