

THE HEALTH FINANCING

PROGRESS MATRIX

COUNTRY ASSESSMENT GUIDE



HEALTH FINANCING GUIDANCE NO 9

THE HEALTH FINANCING PROGRESS MATRIX: COUNTRY ASSESSMENT GUIDE

Public Financial Management sub-module



This Guide should be read in conjunction with version 2.0 of the Health Financing Progress Matrix assessment, detailed in WHO Health Financing Guidance Paper #8; all documents released in December 2020 are available on the WHO website.

Feedback and suggestions in relation to any aspect of this document or the Health Financing Progress Matrix should be submitted using the dedicated <u>feedback form</u>.

The health financing progress matrix: country assessment guide

(Health financing guidance, no. 9)

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List of abbreviations

CBHI Community based health insurance

CIF Cost, insurance, and freight CHE Current Health Expenditure

DFID UK

Department for International Development of the United Kingdom of Great

Britain and Northern Island

DRG Diagnosis Related Groups

FMIS Financial Management Information System

FS Financing Schemes

GDP Gross Domestic Product

GGE General Government Expenditure

GGHE-D Domestic General Government Health Expenditure

GHED Global Health Expenditure Database

HF Health Financing

HFPM Health Financing Progress Matrix
HTA Health Technology Assessment
IHR International Health Regulations

ITP Illicit Trade Protocol (tobacco products)

IMF International Monetary Fund
JEE Joint External Evaluation
MCH Maternal and Child Health

MTEF Medium-Term Expenditure Framework

NCD Non-communicable diseases
 NHA National Health Accounts
 OOPs Out-of-pocket payments
 PBF Performance-Based Financing

PEFA Public Expenditure and Financial Accountability

PEMFAR Public Expenditure Management and Financial Accountability Reviews

PER Public Expenditure Reviews
PFM Public Financial Management

PHC Primary Health Care
PI Principal Investigator
P4P Pay for Performance
RBF Results-Based Financing

RMNCH Reproductive Maternal, Newborn and Child Health

SHI Social health insurance

SPAR State Parties Self-Assessment Annual Reporting

SSBs Sugar-sweetened beverages
UHC Universal Health Coverage

VAT Value added tax

VHI Voluntary health insurance WHO World Health Organization



Using this document

This Guide has been developed primarily to support Principal Investigators charged with conducting country assessments the Health Financing Progress Matrix (Version 2.0), in response to feedback during the proof-of-concept testing in twenty countries. Background and a full explanation of the Health Financing Progress Matrix is provided in the Guidance Paper (1).

This Guide accompanies and should be used together with the Data Collection Template. All documents were released in late 2020 and are available from WHO's <u>webpage</u> dedicated to the Health Financing Progress Matrix.



1. Background

1.1. About the Health Financing Progress Matrix assessment

The Health Financing Progress Matrix (HFPM) is the World Health Organization's standardized qualitative approach to assessing country health financing systems, in terms of both the development and implementation of health financing policy. Together with estimates of revenues and expenditures provided through the Global Health Expenditure Database, and measures of service coverage and financial protection, the HFPM assesses health financing arrangements in a country at a point in time against a set of benchmarks, expressed in the form of nineteen desirable attributes. While comprehensive in scope, assessments capture only the critical elements of the health financing system, drawing on readily available information and analyses. The HFPM hence complements existing work, pulling together diverse policy and technical documents into a single framework.

Background to the Health Financing Progress Matrix (HFPM) is provided in the Guidance Paper (1) which lays out the desirable attributes of health financing systems. These effectively summarize thinking on what matters in health financing, based on theory and evidence, in order to make progress towards UHC. Not only do HFPM assessments show where a country's health financing system currently stands relative to these benchmarks, it does so in a way which provides guidance on future directions. The HFPM also allows country progress to be systematically tracked over time, capturing the dynamic shifts in the policy development process, not only changes in outputs and outcomes.

1.2. Who are Health Financing Progress Matrix assessments for?

Country assessments are produced first and foremost for those engaged in developing, implementing, or overseeing health financing policy. While the first time an assessment is conducted i.e. a baseline assessment, takes an estimated 1-2 months, subsequent assessments can be completed more rapidly, focusing on marginal changes in the intervening period.

By focusing on the critical elements only, assessments are relatively short, and as a result can be conducted regularly to provide frequent feedback to policy makers as part of the annual cycle of policy development, implementation, review, adjustment and improvement. In summary, the goal of HFPM country assessments is to provide regular, timely and clear policy-relevant information, based on an objective assessment of a country's health financing system relative to a set of evidence-based benchmarks, with identified policy priorities.

By assembling a variety of policy documents, and analytical work, often conducted by different agencies, into a single coherent assessment, the HFPM can provide a common reference for the stakeholders engaged in health financing policy. Country assessments can also form the basis of dialogue domestically, for example between different agencies, and be used as the basis for reporting to governing bodies; similarly, assessments can be used for reporting to external funding agencies where relevant. Finally, the attributes, questions, and progress levels can be used for capacity building purposes, and as a focus for technical debate and discussion.

1.3. Recommended approach to implementing the HFPM

There may be several entry points for the implementation of a HFPM country assessment but in all cases this will be agreed between the WHO Country Office and the Ministry of Health. In most cases, a Principal Investigator should be hired to complete or lead the completion of the assessment, and should be recognized health financing expert with a deep knowledge of the country's health system, and widely respected. In some



cases, additional Investigators may be required. Conducting a country assessments involves reviewing and summarising secondary information sources with very limited, if any, primary analysis to be conducted. There may, in some cases, be insufficient information to assess certain questions, but this itself is important information, and provides an agenda for discussions on future priorities for analytical and technical work.

Principal Investigators will liaise closely with the Ministry of Health nominated focal-person and with relevant fora such as a Health Financing Technical Working Group. There is flexibility in the process followed by the Principal Investigator at the country level, but in all cases they will be supported by a backup team selected from WHO Regional Offices and the WHO health financing team in Geneva. This backup team will provide advice where useful, and feedback on draft responses, ensuring the quality of the assessment prior to formal review.

Once fully drafted, the assessment is subject to a two-stage review process to strengthen both the quality and objectivity of the assessment. The first review is conducted by two experts who not have been closely involved in the assessment, but ideally have some knowledge of the country and its health financing system. Each expert independently reviews the assessment, including any preliminary scoring provided, and then jointly agree a consensus score for each question. Review and further discussion is then held with the Principal Investigator to finalize scores and key messages.

The objective of the second-stage review is to verify the interpretation of a country's performance relative to the progress levels for each question, to ensure consistency across countries. This ensures credibility in the assessment process and the quality of information in the global database of HFPM country assessments onto which finalized assessments are uploaded.



2. Stage 1 of the HFPM assessment

STAGE 1 OF THE HFPM ASSESSMENT IS A LANDSCAPING OF THE MAJOR HEALTH COVERAGE ARRANGEMENTS (SCHEMES AND PROGRAMMES) IN THE COUNTRY, OUTLINING THE OBJECTIVE AND KEY DESIGN FEATURES OF EACH; STAGE 1 PROVIDES A PICTURE OF THE EXTENT TO WHICH THERE IS STRUCTURAL FRAGMENTATION WITHIN THE HEALTH SYSTEM, PROVIDING USEFUL BACKGROUND FOR STAGE 2. INFORMATION FOR STAGE 1 SHOULD COME PRIMARILY FROM SECONDARY SOURCES WHICH SHOULD BE REFERENCED.

NOTE THAT STAGE 1 IS NOT NECESSARILY COMPLETED AS PART OF THIS PFM-FOCUSED ASSESSMENT; HOWEVER IT PROVIDES RELEVANT CONTEXT REGARDING THE HEALTH SYSTEM

2.1. Deciding which schemes and health programmes to include

Prior to completing Stage 1 a decision needs to be made with respect to which schemes or programmes to include; the Principal Investigator should discuss with the WHO health financing team. Note that schemes are not referred to here in the same way as in National Health Accounts (NHA). The objective in this assessment is to describe the key features of *important* or *relevant* financing arrangements (schemes or programmes) in the country's health system; important in the sense that a scheme should be included if it is relevant to discussions on future health financing reforms and policy directions. The aim is not to capture every single scheme or programme as in a NHA study, although these should be cross-referenced. In general, Stage 1 includes schemes or programmes which exhibit some of the following characteristics:

- represents a large amount of health expenditures, especially public expenditure; hence we include here the government health budget which may not typically be thought of as a programme or scheme.
- covers a significant part of the population e.g. a health insurance scheme
- is a distinct pool of funds managed separately
- is managed with separate governance arrangements from the main health system e.g. a vertical health programme
- represents a high-profile initiative taking new approaches e.g. for provider payment, even if not (yet) covering a large population group or representing a significant amount of expenditure

In terms of the private sector, private insurance should be included, ideally as one scheme or sector; while there is often great variation within this sector, this should be summarized for the purpose of Stage 1, focusing on the role played by private health insurance within the health system in relation to publicly funded benefits. Out-of-pocket payments (OOPs) should not be included as a separate scheme or category; the Sankey Diagram (see next section) shows the extent of OOPs in the health system, but these do not represent a scheme in terms of the criterion of a separate pool of funds managed for a specific purpose. Discussion should include:

- Principal Investigator
- WHO Country Office Responsible Officer
- Point of contact person in the Ministry of Health
- WHO Regional Office Advisor
- WHO Geneva designated staff



2.2. Describing each scheme or programme

STAGE 1 DESCRIBES THE WAY EACH SCHEME OR PROGRAMME IS DESIGNED IN TERMS OF A NUMBER OF CRITERIA INCLUDING THE MAIN HEALTH FINANCING FUNCTIONS. FURTHER DETAILS ARE PROVIDED IN THE TABLE BELOW, REPLICATED IN THE DATA COLLECTION TEMPLATE PROVIDED SEPARATELY.

	ASSESSMENT AREA	GUIDANCE NOTES	
А	FOCUS OF THE SCHEME	Once the scope of schemes has been agreed, describe each in terms of its focus; this may be all citizens in the case of general budget funding for health facilities, an insurance scheme for public sector employees, community-based insurance, free-care programmes, vertical disease programmes etc. In addition to adding a short description please code using the drop-down list.	
В	Please add here the best estimate of the number of people en receive services or other benefits under this scheme. This provide nominator for various equity related calculations.		
С	POPULATION COVERED	Please add data or estimates about the numbers covered relative to the target population. This figure provides numerator information and, in some cases, will be the same as the denominator e.g. where the basis for coverage (next question) is automatic. In other schemes such as those targeting informal sector/non-salaried workers, the figure of actual enrolees may be significantly lower.	
D	BASIS FOR ENTITLEMENT / COVERAGE What is the legal basis for coverage or entitlement? Is it a) mandate where entitlement to service benefits depends on a contribution made on behalf of individuals that is required by law (e.g. payroll-deduction a social health insurance scheme); b) automatic, i.e. where the base entitlement is "non-contributory" (e.g. citizenship, residence, in poverty status); or c) is participation and hence the basis for entitivoluntary, i.e. not required by government even if it may be required employer?		
E	BENEFIT ENTITLEMENTS	as being estered (positive inst). The an services estered with the example,	
F	CO-PAYMENTS (USER FEES)	Do users have to make a co-payment (user fee)? If so, please give further details of what services these are applied to, and whether to certain subgroups. Are there exemptions, based either on individual (e.g. income/poverty status, age, sex, disease) geographic (e.g. rural vs urban), or facility type (e.g. health centre vs hospital)? Finally, please describe how the co-payment is structured e.g. a single fixed amount, a series of fixed amounts, a percentage of the bill; if the latter, is there a ceiling on total payments over a period of time?	



	ASSESSMENT AREA	GUIDANCE NOTES		
G	OTHER CONDITIONS OF ACCESS	In addition to any co-payments which users may have to pay, there may be other conditions which must be met in order to access services. For example, patients may have to follow a referral system, or be limited to public health facilities or a preferred provider network. Other conditions may be that only generic medicines are provided, or there are limits on the treatment intervention provided; for example, in the early years of the Universal Coverage Scheme in Thailand, haemodialysis was only publicly funded as treatment for renal failure if peritoneal dialysis (the first line of treatment), was not effective.		
н	REVENUE SOURCES Where does funding for the scheme or programme come from? Funds in come from the health budget, for example as direct funding to health facilities, allocations to a targeted scheme e.g. under 5s, or transfers to health insurance scheme on behalf of the poor. Other examples are preportionally, indicate any funding from external sources.			
ı	POOLING Are revenues for the scheme held at the national level, or allocated t subnational government authorities? Does the scheme pool its revenue in single fund, or in multiple funds, for specific population groups of geographical areas?			
J	GOVERNANCE ARRANGEMENTS	Briefly describe the management and governance arrangements of the different schemes or programmes where possible. There is some similarity with pooling arrangements so please add here information about the line Ministry which the scheme falls under (e.g. Ministry of Health, Ministry of Social Welfare), as well as information about governing boards etc. Please add references for more detailed information.		
К	PROVIDER PAYMENT	I schame: there may be multiple approaches. Please code using the drop. I		
L	SERVICE DELIVERY AND CONTRACTING	Which type offacilities provide services under the scheme? Think in terms of inpatient, outpatient, primary, secondary or tertiary, and also whether publicly owned, private-for-profit, or private-non-profit? Is there an accreditation scheme, or a preferred provider network? Are contracts or service performance agreements used?		

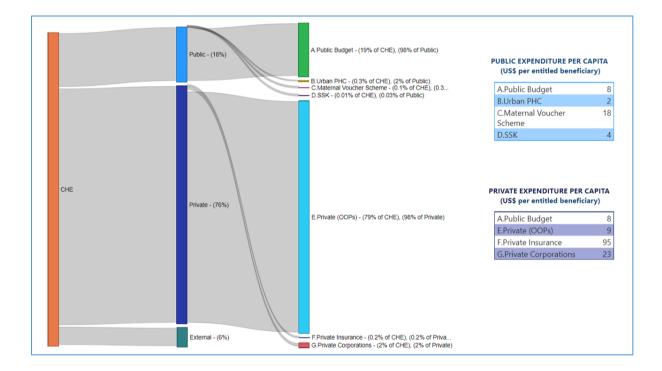
For several sections drop down coding lists have also been developed which should be used wherever possible.



2.3. Mapping health expenditures

THE HFPM PROVIDES A COMPLEMENTARY ASSESSMENT TO NATIONAL HEALTH ACCOUNTS. EXPENDITURE DATA FROM HEALTH ACCOUNTS STUDIES CAN BE MAPPED AGAINST THE SCHEMES AND PROGRAMMES DEFINED IN STAGE 1 TO COMPLEMENT QUALITATIVE INFORMATION AND PROVIDE AN INSIGHT INTO THEIR RELATIVE IMPORTANCE FINANCIALLY.

Once the schemes or programmes to be included in the Stage 1 assessment have been agreed, health expenditure data is mapped against each; a draft example using data from Bangladesh is shown below using a Sankey Diagram. Mapping health expenditure data against the schemes also allows estimates of per capita spending for each scheme or programme to be made, providing useful background information for the subsequent Stage 2 assessment. The best data source for this will be a recent country-specific NHA in which the names of the different "schemes" will be identified as "financing agents". Such diagrams can be developed with the support of the WHO health financing team.





3. Stage 2 of the HFPM assessment

3.1. Assessment areas and desirable attributes

THE HFPM ASSESSMENT IS ORGANIZED IN TERMS OF SEVEN ASSESSMENT AREAS OR DOMAINS BASED ON THE FOUR HEALTH FINANCING FUNCTIONS TOGETHER WITH THREE ADDITIONAL ASSESSMENT AREAS.

THIS SECTION OUTLINES THE ENTIRE ASSESSMENT OF WHICH THIS PFM-FOCUSED ASSESSMENT IS A PART

Seven assessment areas are identified in the current version of the HFPM which follow the health financing framework based on core functions, with a new module included for this Version 2.0 addressing issues related to public health functions, health programmes, and health security. These are:

1) Health Financing Policy, Process and Governance	3 attributes
2) Revenue Raising	4 attributes
3) Pooling Resources	2 attributes
4) Purchasing and Provider Payment	3 attributes
5) Benefits and Conditions of Access	5 attributes
6) Public Financial Management	2 attributes
7) Public Heath Functions and Programmes	(no unique attributes; draws on ot

Desirable attributes, previously referred to as guiding principles, have been developed for each assessment area; they describe a positive situation or state of affairs, in relation to each assessment area. These ideal, or desirable attributes are based on a theory of change, empirical evidence, and a results chain, and the assumption that movement towards these attributes is expected to improve health system performance, and progress towards UHC.

The number of unique attributes for each assessment area are listed above; however, many of these are cross-cutting, for example two of the attributes in the Revenue Raising assessment area are equally relevant to Public Financial Management (PFM). Similarly, while the assessment area Public Health Functions and Programmes has no unique attributes, it relies on five attributes drawn from other assessment areas. Given the cross-cutting nature of many elements of the assessment, multiple crosswalks are built into the accompanying database, allowing responses from country assessments to be viewed from a number of different perspectives (see details in the WHO Guidance Paper (1).

3.2. Assessment questions

THE HFPM ASSESSMENT (VERSION 2.0) COMPRISES THIRTY-THREE QUESTIONS, INCLUDES FOUR NEW QUESTIONS NOT INCLUDED IN VERSION 1; THESE ADDRESS HEALTH FINANCING AND HEALTH SECURITY, AND THE FINANCING OF HEALTH PROGRAMMES AND PUBLIC HEALTH FUNCTIONS, ALSO REFERRED TO AS COMMON GOODS FOR HEALTH.



Each assessment area comprises several questions each building on a desirable attribute, as detailed in the document WHO Health Financing Guidance #8, and listed at the beginning of each section of this document. Desirable attributes reflect a desirable or ideal situation with respect to one of the health financing functions, while each question digs deeper into specific elements of this attribute. As more countries use the HFPM to assess their health financing system, these questions will be reviewed, revised and improved. In this version, released in December 2020, there are thirty-three questions distributed as follows:

Health Financing Policy, Process and Governance
 Revenue Raising
 questions
 Pooling Resources
 Purchasing and Provider Payment
 Benefits and Conditions of Access
 Public Financial Management
 questions
 questions
 questions
 questions
 questions
 questions
 questions

NOTE THERE ARE 5 DEDICATED PFM QUESTIONS; ADDITIONAL QUESTIONS ARE MAPPED AS PFM RELEVANT

A full list of questions is provided below:

ASSESSMENT AREA	#	QUESTION TEXT		
1) Health	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?		
Financing Policy, Process and	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?		
Governance	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?		
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?		
	Q2.2	How predictable is public funding for health in your country over a number of years?		
2) Revenue Raising	Q2.3	How stable is the flow of public funds to health providers?		
-	Q2.4	To what extent are the different revenue sources raised in a progressive way?		
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?		
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?		
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?		
3) Pooling Revenues	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?		
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?		
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?		
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?		
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?		
4) Purchasing and Provider Payment	Q4.3	Do purchasing arrangements promote quality of care?		
,	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?		
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?		



ASSESSMENT AREA	#	QUESTION TEXT		
	Q4.6	To what extent do providers have financial autonomy and are held accountable?		
	Q5.1	Is there a set of explicitly defined benefits for the entire population?		
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?		
5) Benefits and Conditions of	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?		
Access	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?		
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?		
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?		
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?		
6) Public Financial Management	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?		
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?		
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?		
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?		
7) Public Health Functions and	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?		
Programmes	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?		
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?		

3.3. What matters and what does progress look like?

I EACH QUESTION CAPTURES ONE OR MORE DESIRABLE ATTRIBUTE. FOR EACH QUESTION, FOUR PROGRESS LEVELS ARE DEFINED, EACH DESCRIBING THE SITUATION AND STATE OF AFFAIRS AS THE SITUATION IMPROVES; THIS CONSTITUTES THE RUBRIC FOR COUNTRY ASSESSMENTS.

Each assessment area comprises several questions and for each question background information is provided outlining why the question is important and why it matters in order to make progress towards UHC. Four progress levels are articulated for each question to illustrate what progress looks like. The core of the Progress Matrix is the belief that there are better and worse ways of designing and implementing health financing reforms, reflected in the desirable attributes. These in turn are based on accumulated global evidence as well as "common sense" thinking from the perspective of UHC assessed at the "whole system, whole population" level.

For each progress level, further information reflections and are provided to guide the Principal Investigator in their assessment. This focuses on characteristics that reflect increasing levels of "progress" in terms of the features of systems that are associated (and ideally have a causal effect) on health system performance goals and intermediate objectives, again from a system-wide perspective. The progress levels, labels and generic characteristics are presented below; note that some questions focus only on a) policy development, while others also address b) implementation.



PROGRESS LEVEL		GENERIC FEATURES OR CHARACTERISTICS		
1	EMERGING	 a) There is no clear or approved policy statement, and ongoing. Ongoing strategies do not reflect global evidence or use local evidence. b) Funding is not linked to policies, or to mechanisms which drive implementation. 		
2	PROGRESSING	 a) Policies under development but only partially reflect global evidence and local assessments of performance. Formal discussions conducted with stakeholders, b) Some aspects of policy are being implemented, or policy is being pilot tested. 		
3	ESTABLISHED	 a) Policy document formally approved; largely reflects global evidence and local assessments of performance problems. b) Widespread implementation with some assessment taking place, feeding into policy and implementation adjustments. 		
4	ADVANCED	 a) Approved policy document consistent with global evidence, local assessments of performance problems, disseminated to a wide range of stakeholders. b) Effective implementation taking place nationally with systematic monitoring and evaluation of performance to inform policy design improvements. 		

Within the context of the HFPM, these terms should be viewed as labels rather than having some intrinsic meaning. In addition, and while defined as four distinct categories for ease of exposition and communication, it is best to think of the progress assessment for any question as a continuous rather than a discrete variable. To support the Principal Investigator with the assessment, progress levels are in most cases described in terms of a number of criteria, with "for examples" also included.

3.4. Background quantitative indicators

IN SUPPORT OF THE COUNTRY ASSESSMENT PROCESS, RELEVANT PUBLICLY AVAILABLE
OUANTITATIVE INDICATORS HAVE BEEN COMPILED INTO A DASHBOARD. WHICH WILL EVOLVE

OVER TIME AS MORE INFORMATION AND INDICATORS ARE IDENTIFIED.

As part of the assessment process, relevant quantitative data needs to be obtained and organized to make a well-considered assessment, as well as to strengthen objectivity. Relevant indicators published on the Global Health Expenditure Database (GHED), and selected other databases, have been compiled into a dashboard specifically developed and tailored to support those conducting HFPM country assessments. The dashboard can be found via the <u>WHO website</u>.

Country-specific health accounts analysis should be used in addition to those indicators published on GHED. However, data which is only available in-country will be equally, if not more important for the assessment. In many cases this information will provide greater detail than that available from published databases.



3.5. Issues to consider during assessments

FOR MANY QUESTIONS THE PRINCIPAL INVESTIGATOR WILL NEED TO REACH OUT TO LOCAL SOURCES FOR ADDITIONAL INFORMATION AND FOR VALIDATION PURPOSES. NOTE, HOWEVER, THAT HFPM ASSESSMENTS PRIMARILY INVOLVE PULLING TOGETHER EXISTING INFORMATION RATHER THAN CONDUCTING NEW ANALYSIS.

While some collection of data will be necessary, Principal Investigators (PI) are not expected to conduct any significant new analysis; indeed, an important part of the assessment is to identify areas where little information exists, and which are a potential priority for future work. Certain issues are likely to arise during the assessment, which should be discussed with the back-up team, some of which are discussed below:

- The aim of the assessment is to assess how well-aligned health financing arrangements in a country are with progress towards UHC. The key thing is to look at how the entire health system is performing, not simply one or two individual schemes. After considering how individual schemes are organized and perform, look at how coherently these fit together to make up the health system in its entirety. The PI should also consider any potential positive or negative spill-over effects from individual schemes or programmes for the wide health system and for the population not covered by the scheme (see for example Q3.5 (vhispill)).
- WHO uses the concept of health financing functions, for example revenue raising, pooling, purchasing, to allow a common assessment of health financing systems across countries organized in different ways, often labelled as "tax-financed" or "social health insurance". The language in the assessment follows the functional language, not the language of "labels" so the Principal Investigate needs to translate from what is seen in the country health system into the different functions and assessment areas.
- Much of the assessment focuses on "fragmentation" which is often the cause of performance problems in health systems. Fragmentation can arise from multiple coverage schemes in the same country e.g. an insurance scheme for civil servants, another for salaried workers in the private sector, and CBHI for informal sector workers. Stage 1 of the assessment maps out these schemes. In many countries such schemes do not exist, particularly where a traditional budget funded approach dominates; even in these systems, however, fragmentation can arise when separate health programmes e.g. for TB, or HIV, establish their own systems of benefits, provider payment etc. While it is highly unlikely, if there is no fragmentation in the health system in question, this should be indicated in your responses and it may not be necessary to answer some of the questions.
- A key aspect of the assessment is to capture the dynamic of policy development and implementation, not simply to provide a static picture of the current situation. In practice, this means looking at what discussions and, for example, analytical work is taking place, and how policy is evolving, and in which directions, even if under development or in draft form. This allows assessments and feedback to be provided on a more regular basis.



Public financial management

AS A CROSS-CUTTING ISSUE IN HEALTH FINANCING, PUBLIC FINANCIAL MANAGEMENT HAS CONSIDERABLE OVERLAP WITH OTHER ASSESSMENT AREAS; HENCE QUESTIONS FROM OTHER AREAS ARE ALSO MAPPED TO THE DESIRABLE ATTRIBUTES BELOW. SIMILARLY, SEVERAL QUESTIONS IN THIS SECTION DRAW ON ATTRIBUTES FROM OTHER SECTIONS.

ASSESSMENT		QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
		Q6.1	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	IONS	Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	PRIMARY QUETIONS	Q6.3	bdgtprcss	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	PRIM/	Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
		Q6.5	expinfmon	Is health expenditure reporting comprehensive, timely, and publicly available?
	QUESTIONS MAPPED FROM OTHER ASSESSMENT AREAS	Q2.2	predict	How predictable is public funding for health in your country over a number of years?
PUBLIC FINANCIAL		Q2.3	stable	How stable is the flow of public funds to health providers?
MANAGEMENT		Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
		Q3.4	revpool	Are multiple revenue sources and funding streams organised in a complementary manner, in support of a common set of benefits?
		Q4.1	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	MAPPE	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
	ESTIONS	Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	ηΌ	Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?



Question 6.1 (pfmdiag):

Is there an up-to-date assessment of key public financial management bottlenecks in health?

BACKGROUND TO THE QUESTION

This question is concerned with whether a health-sector specific assessment of PFM bottlenecks has been conducted. A broad assessment of the PFM system looks at weaknesses in budget formulation, budget execution and budget reporting i.e. the key steps of the budget cycle. Country assessments are generally conducted with the support of the Public Expenditure and Financial Accountability (PEFA) Secretariat and use a pre-established framework that includes a scoring system per PFM subcategory.

Public Expenditure Reviews (PER) conducted with the support of the World Bank, and the related Public Expenditure Management and Financial Accountability Reviews (PEMFAR) are also helpful resources. Consulting these resources, if available, will be helpful to begin understanding the key PFM bottlenecks which impact on overall public spending in the country. However, to effectively address bottlenecks in the health sector, a detailed health-specific diagnostic analysis is required, rather than only a general PFM assessment. It is crucial to capture the sector-specific issues that may impact public spending in health. While some issues may be common with other sectors, health is particularly sensitive to the way the budget is formulated and spent, and to the level of flexibility provided when programming and utilizing public resources. In recent years, guidelines have been developed by several partners to support health sector specific assessment. See for example the WHO process guide (3) which assessed alignment issues between PFM and health financing policies; the World Bank toolkit (4) on PFM and health service delivery, and the UNICEF guide (5) on PFM in health with a focus on children. Study outputs are generally accessible locally and will be a helpful resource for this question.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

This question looks for the existence of country PFM diagnostics across the public sector overall, and for the health sector specifically. What also matters is the quality and depth of the analysis undertaken. Health-specific assessments should provide detailed information on key PFM bottlenecks that affect health spending at both central and subnational levels.

LEVEL 1: EMERGING

No generic PFM assessment exists or only an outdated assessment.

A generic PFM assessment may have some relevance for health sector PFM issues, but usually this is very limited. For "recently", think in terms of the past 3-4 years.

LEVEL 2: PROGRESSING

Only a generic PFM assessment has been conducted which is up-to-date.

The generic assessment will inform on key bottlenecks for the overall PFM system. It is a good start but generally not specific enough to allow the design of health sector-specific policy actions.



LEVEL 3: ESTABLISHED

A rapid health-specific assessment was conducted in the last 2 years which examined some bottlenecks in health spending.

The assessment looked specifically at the health sector, but only at certain aspects i.e. not comprehensively from budget formulation to execution and reporting.

LEVEL 4: ADVANCED

Extensive, up-to-date health-specific diagnosis/assessment conducted; key bottlenecks identified.

Assessment covers all aspects, from budget formulation to execution and reporting, and identifies specific issues which undermine the quality of health spending.

I QUANTITATIVE INDICATORS

PEFA country assessments are available <u>here</u> and provide a rapid overview of the quality of PFM systems. For each PFM subcategory, countries are provided a score; for an example go to:

https://www.pefa.org/assessments/summary/486.



Question 6.2 (pfmallocprty):

Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

BACKGROUND TO THE QUESTION

This question looks at the extent to which the design and implementation of health budgets enables public funds to be "matched" to stated priorities and aligns with related reforms in the purchasing of services. Budget structure refers to the organization of a government budget and is based on standard classifications (6); the main budget classifications used across sectors are: input (sometimes called "economic"), administrative, functional and programmatic. Input-based budgets introduce rigidities for health spending as they are often presented as detailed line-items and do not allow re-allocations across budget lines. Where that is the case, there is a misalignment with provider payment mechanisms aimed at driving providers towards more efficient organization and use of their resources. This question therefore has important implications for strategic purchasing, and in particular links to question 4.1 on linking payment to needs, and question 4.6 on provider autonomy.

Countries introduce alternative budget classifications with the view to provide more flexibility in the programming and use of budgets, but also to strengthen the link with expected outputs, referred to as programme budgets. There are three key advantages for health spending: 1) they support better alignment with health sector policies and strategies; 2) they can provide more flexibility in fund management, notably at the service provider level, enabling providers to respond to the incentives designed into provider payment reforms; and 3) they cultivate stronger financial and non-financial transparency and accountability with a focus on results.

However, in the absence of sector-specific guidance and, in general, limited preparation of key stakeholders, governments may take a range of different steps and approaches as they transition to programme budgets. As a result, most countries frequently get stuck at the pilot stage due to severe bottlenecks in reform design. In other cases it has led to hybrid models and incomplete transformation. For this question, it is important to assess the reform status and capture its implications for how Ministry of Health budget allocations are formulated (i.e. whether by line items, programmes or functions) and to what extent the programme envelopes match with the policy priorities and needs of the health sector. A mapping of programmes and national health priorities will help to get a better understanding of their alignment (7, 8, 9, 10, 11). In addition, consider how budgets are spent; often, even after a change in budget formulation, public funds continue to be spent, authorized, controlled and or reported by detailed line-items. This substantially limits the ability of fund-holders (e.g. managers of central-level health programmes, district health programmes, and health facilities) to manage spending to improve performance in response to provider payment incentives, and to be held accountable.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

What matters for this question is flexibility in budget structure, and flexibility in budget execution. Also of importance is the level of alignment between pooling (programme) structure, purchasing mechanisms, provider autonomy, and PFM processes and mechanisms. Ideally, public funds flow to priority populations, interventions and services, and payment to providers is based on service outputs and performance. Ideally, disbursements are aligned with health priorities, flow of funds is predictable, and there is flexibility in purchasing and provider payment which ensures efficiency and value for money. Where a Programme Budget exists, Programme Managers should also be given the authority to use funds flexibly within a given envelope for that pool of funds. Where the system is decentralized, lower levels of government should also have the appropriate authority over spending decisions. At the provider or facility level, managers should have the authority to retain and use funds.



Refer to the <u>WHO repository of health budgets</u> which consolidates open source information on finance laws and related documents applicable to the health sector for more than 100 countries.

LEVEL 1: EMERGING

Health policy priorities are poorly defined, and not reflected in the budget; rigid input-based line-item budget dominates.

- Budgets are structured by administrative and input lines without mechanisms for adjustment/re-allocation (i.e. virement policy is strict), and with tight line-item ex-ante expenditure control.
- No flexibility in resource use and rigid ex-ante central controls (no financial managerial autonomy for public providers); spending responsibility remains in Treasury.

LEVEL 2: PROGRESSING

Input-based line-item budget and ex-ante financial control still dominates; some piloting of programme-based budgets provides more flexibility in resource use, and performance information is increasingly used.

- Central Ministry of Health has some degree of flexibility to use and reallocate across budget lines (i.e. virement policy has been updated and or line-items are aggregated into broader lines); institutional arrangements being made in Ministry of Health to take on greater responsibility for spending.
- There is some piloting of programme-based budgets to reflect sector priorities and provide more flexibility in resource use, performance information is starting to be used in budget deliberations. However, funds remain disbursed by input-based line-item and rigid ex-ante financial control still dominate.
- Reforms in provider payment methods may have been introduced, but the rigidities in budget design and implementation at both purchaser and provider levels limits or even contradicts their intended impact.

LEVEL 3: ESTABLISHED

Use of performance information and implementation of programme-based budgets are becoming widespread, better directing budgets to sector priorities using mechanisms that are consistent with provider payment incentives, thereby providing greater flexibility in resource use.

- Changes in budget formulation are accompanied by flexible rules for expenditure management (e.g. flexible release and re-allocation of funds, with ex-post reporting).
- Spending authority is fully transferred to the Ministry of Health, and managers of central funds can use resource envelopes (e.g. budgetary programme) in a flexible and responsive manner; however, constraints may remain at lower levels of government.
- Public sector health facilities/providers have some limited authority to manage budget resources, including to move funds across certain line items (usually not salaries) without higher level approval.

LEVEL 4: ADVANCED

Health sector priorities, medium term expenditure framework and annual budgets are fully aligned and structured around well-designed budgetary programmes, and stable, predictable funds are directed to health sector priorities and service providers.

- Budgets are structured and executed to ensure that budget spending is flexible. Programme managers and providers have the flexibility to reallocate resources.
- Fund-holders can re-allocate funds across budget lines, including frontline providers, to better respond to health needs.
- The introduction of programme-based budgets in health has been harmonized with payment reforms, allowing a full output/population-based financing system to operate. Funds are released by programme envelope, providers are incentivized for the achievement of pre-defined outputs, and reporting is set against these targets.



Question 6.3 (bdgtprcss):

Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?

BACKGROUND TO THE QUESTION

Engaging in budget preparation, understanding guiding principles of budgeting as well as the political dynamics that enable the budget elaboration and approval process, is essential for Ministry of Health. In many countries, the consequences of not doing so means that health policy-making, planning, costing and budgeting take place independently of each other, leading to a misalignment between health priorities and allocation and use of resources. This question aims to capture the level of Ministry of Health engagement in budgeting processes, and specifically to assess their inputs for the development of an integrated multi-year expenditure framework that would incorporate sector spending.

Look at the engagement process of Ministry of Health throughout the budgeting phase (is Ministry of Health informed of the budget calendar? When? Is there sufficient time for defining budget proposals? Are budget ceilings communicated in advance? Is the space for negotiation clearly identified/formalized (e.g. budget conferences)? Once the budget is approved, mid-year re-allocations are frequent. In some countries, the adjustment process is not transparent. Budget re-allocations are made without consultations with sectors like health. PI should check whether the revised budget law has been discussed with Ministry of Health and whether the final output has been communicated to relevant stakeholders in the sector. This has a crucial impact on budget execution and policy implementation.

Since the late 1990s, budgeting reforms worldwide have been concerned in a significant way with engineering a shift from planning and approving budgets for one year at a time to a multi-year perspective to improve predictability and sustainability in public funding. Given that the disconnect between planning and budgeting was recognized as a common feature of the health sector, health MTEF has increasingly come to be regarded as a central element of public expenditure management reforms. However, their introduction is heterogenous across countries. In addition, the quality of the overall MTEF, as well as sector-specific allocations, are often subject to various issues (e.g. poor quality of revenue forecasts, historical allocations). To date, health MTEF (and MTEF more broadly) have seen, however, a mixed impact on increasing funding predictability for health. To assess the impact of MTEF on sectoral allocations and their effectiveness in driving predictability, PI can conduct a retrospective comparison between MTEF and Ministry of Health annual allocations for the considered period.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

What matters here is the proactive engagement of the Ministry of Health in budget planning. This involves several steps: i) being aware of the budget calendar, requirements and templates; ii) engaging in sufficient technical preparation i.e. priority-setting, costing; iii) ensuring a consultation process with sector stakeholders; iv) developing a robust annual and multi-year budget proposal, v) promoting the budget request in negotiation processes.



LEVEL 1: EMERGING

Current budget process often bypasses the Ministry of Health, with no or very limited dialogue between Ministry of Health and Ministry of Finance.

There is very limited engagement of the Ministry of Health in the budget planning processes which is driven by Ministry of Finance, resulting in a disconnect between budget allocation the priorities and needs defined by the health sector. There may be no multi-year budget plan for the health sector.

LEVEL 2: PROGRESSING

Budget process is consultative and transparent but to a limited extent, and input from health sector is minimal; Ministry of Health not consulted over mid-year re-allocations.

There is greater engagement with and involvement of the Ministry of Health in the budget development process, but the approved finance still does not reflect the priorities and needs defined by the health sector. To the extent that there is a multi-year plan (e.g. MTEF), there is no linkage between that and the annual budget process.

LEVEL 3: ESTABLISHED

Budget process is becoming institutionalized through formal budget meetings, and a systematic, broad consultation process including health sector and civil society stakeholders.

The Ministry of Health develops robust budget proposals which is aligned with the priorities defined in health policy documents and costed; proposed annual and multi-year budgets are extensively discussed with sector stakeholders as well as with the Cabinet.

LEVEL 4: ADVANCED

Budget process is consultative and transparent, based on dialogue between Ministries of Health and Finance, within a clear multi-year budgeting framework; all appropriate administrative levels are consulted and engaged.

The budget dialogue process discussion focuses on budget definition, implementation mid-term review etc. and alignment of budget with sector priorities. Where relevant, lower administrative levels are consulted and engaged in budget definition process. Ministry of Health engagement is also directly aligned with the MTEF framework, and annual Ministry of Health budget allocations are aligned with MTEF forecasts.



Question 6.4 (bdgtcntrl):

Are there measures to address problems arising from both under- and over-budget spending in health?

BACKGROUND TO THE QUESTION

Budget under-execution has long been recognized as a chronic problem in the health sector in many low- and middle-income countries. Health financing reforms require effective budget execution to ensure that money flows to providers for the delivery of priority services. Poor budget execution refers to a deviation from the approved budget, i.e. the budget is not implemented according to authorizations granted by the law, either finance- or policy-related. Weak underlying processes are often the cause of underspending (the most common), overspending (when spending exceeds budget allocations) or misspending. Underspending and overspending may occur at the same time (e.g. between different budget lines or between different programs).

Assessing the quality of budget execution, and the extent to which expenditure deviates from approved plans, relies on effective reporting systems. Even where data exist, budget execution rates will differ whether the estimation is based on audited expenditure, payments or commitments. At the very least, a comparison pf audited expenditure and gazetted budget allocations for the Ministry of Health should be made; data for both are typically available in the public domain.

Country assessments by the Public Expenditure and Financial Accountability (PEFA) framework characterizes poor budget execution as a deviation of audited expenditure equal or greater than 15% from the original budget, not from the revised budget. This equates to a PEFA indicator score C, where aggregate expenditure outturn is between 85% and 115% of the approved aggregate budgeted expenditure.

The source of budget financing can also add complexities when assessing budget execution. Some external funders channel support through the recipient government's budget process during the preparation phase but may subsequently execute activities outside the budget. This gives the perception of poor budget execution as different systems are used to monitor and report on spending. In many countries health budget underspending is a significant problem. Think about the underlying reasons for this such as over-estimated revenues, a disconnect between planning and budgeting, the lack of a formal budget preparation process, delays in operationalizing PFM reforms, or unrealistic plans with poor data. Other reasons may include late or misaligned disbursements, limited Ministry of Health capacity to plan expenditures, procurement delays, or rapidly rising prices of key goods and services.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

What matters is the level of spending relative to the annual budget allocation i.e. the budget execution rate for the Ministry of Health. What is also important is the timeliness of spending. Across sectors, there may pressure to spend, especially towards the end of a fiscal year, to reach satisfactory levels of execution and budget compliance; with the risk of spending being misaligned with sector priorities. Satisfactory annual execution rates can also hide major issues in expenditure management, such as the timeliness of disbursements within a fiscal year (i.e. late quarterly disbursements). Countries with a health budget composed of a high share of personnel expenditure may also experience better execution performance despite having weak expenditure management practices for other expenses. Where data exist, these aspects should be documented.



LEVEL 1: EMERGING

Health budget implementation frequently fails to comply with basic budget discipline due to poor planning, insufficient or unpredictable revenue streams, and few if any measures are taken to address the issue.

Public spending on health is disconnected from or misaligned with health sector needs and priorities, reflecting poor budget credibility. Cash budgeting may also be in place putting the health sector at risk of funds shortage, and high levels of unpredictability.

LEVEL 2: PROGRESSING

Health budget implementation complies with basic budget discipline, but there are still major shortfalls and significant under-spending in health.

For example, underspending represents more than 20% of the original budget. There may also be long, unplanned delays in the distribution of health budgets to the sector.

LEVEL 3: ESTABLISHED

Limited under or over-spending on a yearly basis, but delays remain in fund releases for health service providers specifically.

Good levels of overall budget execution for Ministry of Health, for example with a deviation of below 10%, but more detailed analysis may reveal specific weaknesses, such as end-of year spending misaligned with health sector priorities, poor execution for certain categories of spending, or delays in the release of funds to providers.

LEVEL 4: ADVANCED

Health budgets are fully executed and comply fully with budget discipline; significant underspending rarely happens.

Budgets are based on accurate forecasts and plans, with risk analysis. There is a planned, transparent and reliable cash management system, allowing the timely release, and stable flow of funds to frontline service providers.

II QUANTITATIVE INDICATORS

If available, Ministry of Health budget execution rates would be useful when assessing this question, ideally for a five-year period.



Question 6.5 (expinfmon):

Is health expenditure reporting comprehensive, timely, and publicly available?

II BACKGROUND TO THE QUESTION

This question is concerned with transparency and accountability in the reporting of health expenditures, and an assessment of how robust the financial information system is, for example whether health expenditures reported regularly, whether financial information is transparent and publicly available, and whether information in relation to performance is also communicated. Many low- and middle-income countries have introduced Financial Management Systems, often referred to as FMIS, to monitor and track health expenditure.

Having information on both the financial and non-financial performance of the sector is essential from the perspective of holding spending agents to account. Often these two aspects of performance are monitored separately and not connected. The presence of a performance monitoring framework that encompasses both aspects, in order to allow an assessment of what the sector has achieved, and with what level of resources, is a feature of mature accountability systems. The public availability of this information is fundamental to a system which is both transparent and has strong accountability mechanisms.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

What matters for this question is the existence and quality of the financial information system and its application to health expenditures. Look, for example, whether the FMIS captures provider level expenditures, and if so in what level of detail. Also, assess the extent to which the information is both reliable and publicly available.

LEVEL 1: EMERGING

No computerized systems for performance or expenditure monitoring; numerous parallel reporting systems with no centralized reconciliation.

At this level, there is no reporting to the public in terms of how funds have been used, or what has been achieved, either by the Ministry of Health or the national health purchasing agency.

LEVEL 2: PROGRESSING

Computerized system being developed and strengthened, but with limited or poor-quality routine data; financial reporting in health remains fragmented.

The use of funds and performance of health budget are reported to the public, but not fully, and are not communicated in a way that the public can easily understand. Across the health system, financial reporting is still fragmented across schemes and health programmes.

LEVEL 3: ESTABLISHED

A functioning financial information system is in place but not aligned with health sector accountability requirements.

An FMIS has been scaled up including for the health sector providing a good overview of public spending for the sector, particular regarding expenditures, with details on inputs; information is made publicly available.



Level 4: Progressing

Financial management information system allows monitoring by multiple categories; information is publicly available and used to inform new budget decisions.

Tailored and integrated FMIS-type information systems allow for the consolidation of cross-category monitoring, for example by programme, by inputs, costs and by health facility.), up to lower levels of government. Information is publicly available. Information is used to inform the development of future budgets. Reporting on the use of funds and the performance achieved as a result of health spending are reported to the public on a regular basis and in a form that can be easily understood.

I QUANTITATIVE INDICATORS

Country assessments using the Public Expenditure and Financial Accountability (PEFA) framework review the quality of the financial information system are a helpful resource for this question. In addition, consultations with key health stakeholders may be helpful to provide a more sector-specific perspective on the issue.



Question 2.2 (predict):

How predictable is public funding for health in your country over a number of years?

II BACKGROUND TO THE QUESTION

This question is concerned with the predictability of public funding for the health sector, critical for the effective planning and delivery of health services to avoid disruptions in services. A Medium Expenditure Framework (MTEF) helps to make revenues more predictable, as would moving any external funding on-budget i.e. flowing through domestic public systems, rather than through parallel budgeting and reporting channels. Consider both domestic public funds, as well as external funds flowing through domestic public systems when answering this question.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

This question looks for the existence of a multi-year budgetary process in the country based on the MTEF (or similar tool) as being the accepted mechanism to plan and forecast future funding. The question also looks at whether the MTEF is being implemented effectively, and to what extent annual budget allocations for Ministry of Health align with MTEF forecasts.

LEVEL 1: EMERGING

There is little or no forward budgeting, and there are large or significant year-to-year fluctuations in public funding for health (and where relevant, external funding).

No systematic forward budgetary planning exists in terms of a multi-year budgetary process through the development of an MTEF; as a result, the resource envelope for health is unclear and unpredictable. There is no multi-year revenue scenario for government or expenditure framework for the sector, and no longer-term plans for external funding, etc.

LEVEL 2: PROGRESSING

Although revenue and expenditure scenarios exist, predictability of the level of public funding for the health sector remains poor.

There are frequent in-year budget adjustments, external aid flows are off-budget. An MTEF exists but is of poor quality, with over-estimation of revenues and poor predictability in future available funds. There is no link between the MTEF and the annual budget process, public revenue scenarios are inaccurate, and central government is unable to influence the planning and budgeting processes of devolved levels of government.

LEVEL 3: ESTABLISHED

The level of public funding for the health sector is relatively predictable due to well-functioning budgetary processes.

For example, there is reliable revenue forecasting, a clear budget formulation process, as well as links between medium-term plans and annual budget processes, regular engagement with subnational governments on planning and budgeting, but some problems remain especially in relation to failures to consider aid fungibility etc.



LEVEL 4: ADVANCED

The level of public funding for health is highly predictable.

Under this scenario there is, for example, accurate revenue forecasting and information on sector-specific budget ceilings. A good quality MTEF exists, with dialogue between health and finance jointly defining a health-specific used for rolling 3-year budgets. A health-specific MTEF has been introduced and is a good predictor of annual budget allocations to Ministry of Health. The MTEF has clear links to annual budget formulation processes, close engagement between central and subnational governments in planning and budgeting, external aid flows which are "on budget", and the potential for offsetting declines in domestic funding incorporated into negotiations and planning.

I QUANTITATIVE INDICATORS

Taken from the Public Expenditure and Financial Accountability (PEFA) database, indicator PI-21: Predictability of in-year resource allocation assesses the extent to which the central Ministry of Finance has the capacity to forecast commitment and cash requirements and provide reliable information on the availability of funds to budgetary units for service delivery. Countries for which data are available are given a score from A (high) to D (low). Note that this indicator refers to public expenditure overall and is not specific to public spending on health.

Other contextual information can be gained from trend or time-series information on indicators such as GGHE% GGE, and GGHE pc available on the supporting indicators dashboard.



Question 2.3 (stable):

How stable is the flow of public funds to health providers?

BACKGROUND TO THE QUESTION

This question looks beyond budgets approvals and is concerned with how well those budgets are executed. Low budget execution is a significant problem in many countries and is often used as a counterargument to efforts to increase budget allocations to health. Think about the underlying reasons for this, such as over-estimated revenues, a disconnect between planning and budgeting, the lack of a formal budget preparation process, delays in operationalizing PFM reforms, or unrealistic plans with poor data. Other reasons may include late or misaligned disbursement or release of funds, limited Ministry of Health capacity to plan expenditures, and procurement delays; all of this affects how stable the flow of funds is to health providers. Unstable fund flow can lead to delays in salary payments, and stock-outs of essential supplies, and in turn the effectiveness of other interventions, such as strategic purchasing, can be undermined.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Progress on this issue is captured in measures which can mitigate low budget execution and disruptions in the flow of funds to health providers. Criteria include:

- quality of expenditure forecasting
- counter-cyclical measures to smooth expenditures
- timely release of funds
- transparent cash-management systems
- subnational units have flexibility to reallocate expenditures
- short turn around for claims processing and payments (for insurance funds)

LEVEL 1: EMERGING

Health budgets at central and subnational levels, and SHI agencies where relevant, are rarely executed as planned.

Health budget frequently fails to comply with basic budget discipline. Reasons may include poor revenue forecasts leading to insufficient or unpredictable revenue streams, late and or irregular release of funds, changes in mid-year prioritization, rigid line item controls, and widely differing capacities of subnational units. Cash budgeting in place putting sector at risks of funds shortage. As a result under-execution of budgets is a significant problem.

LEVEL 2: PROGRESSING

Health budgets are sometimes executed as planned.

Health budget implementation complies with basic budget discipline, but with some shortfalls, underspending, and or exceptional procedures. Similar problems to Level 1 but not as severe; social health insurance (SHI) fund revenues (where relevant) flow irregularly with long delays between submitted claims and payments, unclear policies in place regarding reserves, timeliness of contribution and budget transfers, etc.



LEVEL 3: ESTABLISHED

Health budgets (including SHI fund) are usually executed as planned.

Similar but less severe problems in comparison with level 2, but neither government nor SHI has strong counter-cyclical mechanisms in place to smooth expenditures when revenues fall unexpectedly. There is limited underspending or over-spending on a yearly basis, but delays remain in fund releases e.g. quarterly.

LEVEL 4: ADVANCED

Flow of public funds to the health sector is highly stable.

Thanks to good revenue forecasting, budget formulation process, timely execution of approved budgets as planned, and reserves or other counter-cyclical allocation mechanisms in place to smooth financial flows during lower-than-expected revenue inflows. Transparent and reliable cash management system allows the timely release of funds to frontline service providers. Significant underexecution rarely happens.

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QUANTITATIVE INDICATORS

Taken from the Public Expenditure and Financial Accountability (PEFA) database, indicator PI-1: Aggregate expenditure out-turn measures the extent to which aggregate budget expenditure outturn reflects the amount originally approved, as defined in government budget documentation and fiscal reports. This indicator assesses the credibility of the budget by calculating the extent to which actual aggregate expenditure deviates from the original budget for the last three years of available data (including expenditures financed externally by loans or grants reported in the budget, along with contingency vote and interest on debt). If expenditure consistently varies from the original budget, this points to issues with the quality of budget planning and or challenges in budget execution.

Countries for which data are available are provided a score from A (high) to D (low). Note that this indicator refers to public expenditure overall and is not specific to public spending on health. Details PEFA assessments can be found here:

https://www.pefa.org/assessments?c_ids[]=95

Other useful contextual information can be gained from trend or time-series information on indicators such as GGHE-D per capita, and GGHED%GGE.



Question 3.3 (fragsolve):

What measures are in place to address problems arising from multiple fragmented pools?

BACKGROUND TO THE QUESTION

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

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

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

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

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



LEVEL 1: EMERGING

There are no compensating measures to address inequity and inefficiency arising from fragmentation.

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

LEVEL 2: PROGRESSING

Some measures in place to address inequity and inefficiency arising from fragmentation.

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

LEVEL 3: ESTABLISHED

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

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

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

LEVEL 4: ADVANCED

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

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



Question 3.4 (revpool):

Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?

BACKGROUND TO THE QUESTION

Different revenue sources and fund flows within a health systemmay or may not complement each other. Public funding streams include health budgets, compulsory health insurance contributions, and external/donor funds; these various revenue sources should ideally complement each other; private revenues include voluntary health insurance contributions whether for profit or non-profit schemes. There may also be complementarity between private and public sources e.g. an individual's health insurance contributions that are matched by a public subsidy (as in China). The issues raised by the question can apply both to the flows from revenue sources to pools (e.g. whether different sources are pooled together to fund a benefit package) and also to the flows from pools/purchasers to providers (this latter will also be reflected in Question 4.2). Promised benefits/entitlements and the way that funds flow to or for this is of great importance to analysing the issues raised by this question.

Refer to Stage 1 which may tease out some of these issues. Questions in Section 7 address a similar issue, but in the specific context of disease-specific or other public health programmes.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

LEVEL 1: EMERGING

There is no coordination of fund flows from different revenue sources.

A common example is that each revenue source flows to its own distinct pool, and taken together, they are not explicitly organized to fund a common benefit. It may also be observed in payments from a social health insurance fund to providers do not account for direct government budget funding to the same providers. Other examples include governments at different levels funding different budget line items, the lack of a well-defined minimum benefit framework that indicates funding sources, and RBF operating as a vertical initiative uncoordinated with other funding streams.

LEVEL 2: PROGRESSING

Complementarity exists among some revenue sources, but there is no population-wide (universal) framework of health benefit entitlements indicating the specific role of different funding sources/streams.

For example, there is some pooling of budget allocations and SHI contributions but only for a small part of the population, and other mechanisms such as donor-funded RBF are not well-integrated with or defined in a way which complements other flows; there is no clear or explicit complementary role defined for voluntary/private sources to what is funded from public revenues.

LEVEL 3: ESTABLISHED

A benefit framework exists for most of the population with funding responsibilities clearly defined across different revenue streams, but private prepayment still not well-integrated.

Examples of complementarity are where SHI contributions for formal sector employees are pooled with budget transfers to fund a common benefit for most of the population; or where RBF/P4P mechanisms are designed and implemented in a where which recognizes and is complementary to "base payment" funding flows, for e.g. budget funding of salaries.



LEVEL 4: ADVANCED

There is explicit complementarity of different revenue sources to fund a defined benefit package for the entire population.

Examples include the health budget and SHI contributions jointly funding benefit entitlements for all citizens, possibly with an explicit (but small) role for individual prepaid contributions. Another example is where a SHI scheme covers variable costs, with the government budget directly funding fixed costs such as salaries; if copayments are defined as necessary for certain (partially) publicly funded services, these are clearly organized to be complementary. A third example would be where the benefit framework and public funding responsibilities for it leave explicit gaps in either service coverage or cost coverage (i.e. co-payments) that establish the space for complementary voluntary health insurance (as compared to VHI that covers the same services and costs as are also covered by the public benefit framework). Overall, a key feature of an advanced situation would be the existence of a publicly guaranteed benefit package framework with explicit indication of how different funding sources combine to provide this on behalf of the entire population.

QUANTITATIVE INDICATORS

The indicator "Government subsidy to social health insurance as% of social health insurance" provides a sense of how budget and payroll tax revenues are used in a complementary way. This should be used in combination with data regarding population coverage in the SHI scheme. Country-specific information is available on the accompanying dashboard <u>here</u>.



Question 4.1 (allocneeds):

To what extent is the payment of providers driven by information on the health needs of the population they serve?

BACKGROUND TO THE QUESTION

This question is concerned with the way in which funds flow from purchasers to service providers; it does not focus on the allocation of funds at the intermediate level i.e. from national to subnational purchasers for example through geographical allocation formula, which is captured in Question 3.2 (redistlim). The way in which providers are paid is one of the most powerful ways to influence the performance of providers, from several perspectives including the quality (see Question 4.3) and efficiency (see Question 4.4) of services provided.

Specifically, this question looks at whether information on the health needs of the population served by a provider is used to influence the financial allocations they receive; if not, then there may be significant misalignment between the needs of the population being served and funds received for some providers relative to others.

II WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Specifically, look for the type of allocation mechanisms used, particularly for budget funds; input-based budgets are often driven by infrastructure and staff numbers or norms which may, but most likely does not, reflect population health needs. Using simple capitation as the basis for allocations reflects population size, and further adjustments which reflect health needs directly or indirectly will positively increase alignment. Finally, some form of variable, volume, activity or performance related allocation can further increase alignment between financial allocations and population health needs.

LEVEL 1: EMERGING

Historical patterns or input-based norms used without reference to data on population health needs.

No evidence of use of data on service use or population size in allocations to providers; entirely or predominantly historical pattern plus/minus an increment in line with overall budget availability. In the public sector, budget allocations would be based on inputs such as the number of hospital beds or staff and tends to be paid as rigid line-item budgets. For reimbursements of non-government providers, this is simply paying whatever is claimed by the providers (e.g., unmanaged fee-for-service) without analysing the data to understand patterns and influence in a desired direction (e.g. to promote more preventive services).

LEVEL 2: PROGRESSING

There is some use of simple measures of need within payment mechanisms in at least some schemes or government budget allocations.

For example, simple (unadjusted) capitation has been introduced for a part of provider payments as the size of the population served is a crude measure of need, and or epidemiological and service use data inform explicit choice regarding the amounts made available for primary health care relative to higher-level referral care. However, this may only apply to one or two schemes or programmes, or to only some line items (e.g. excluding personnel). One may also find use of pay-for-performance (P4P, RBF, PBF) mechanisms to steer service use and resource allocation towards some high priority services (e.g. immunization), though not on a national basis.



LEVEL 3: ESTABLISHED

More sophisticated mechanisms of adjusting for health needs, service mix and provider performance are incorporated into payment methods and applied to most prepaid funding in the system.

For example, capitation formulae include age and sex adjustors and or consider service use and needs (such as disease burden or poverty rate of a catchment area). Measures of the relative severity of case mix (e.g. use of DRGs for case-based payment weights) informs allocations across and within (inpatient) facilities. These mechanisms apply within the schemes (including government budgets that flow directly to providers) that account for most public funding in the system but may not yet fully include personnel. There may also be nationwide use of P4P/RBF/PBF mechanisms to steer service use and resource allocation to needs-related prioritized services (e.g. immunization, communicable disease services, RMNCH).

Level 4: Established

The main provider payment methods used in the health system involve methods that incorporate data on population health needs, risk factors, provider performance and service mix.

Payment methods with needs-adjustors are applied to most of the prepaid funds in the health system, including for personnel. The adjustors (e.g. for capitation or risk-adjusted global budgets or reimbursements) go beyond age and sex and incorporate other individual characteristics (e.g. historical utilization data, disability status, relative deprivation measures, relative severity). Price incentives for high-priority services (based on need, such as immunization) exist within the core payment system or as an add-on P4P element.



Question 4.6 (prvdauton):

To what extent do providers have financial autonomy and are held accountable?

BACKGROUND TO THE QUESTION

This question complements earlier questions, in particular Question 4.2, Question 4.3 and Question 4.4, which considers the incentive environment for providers. It also links closely to Question 6.2, as the rules governing autonomy in the public sector are core to PFM. In order to respond to financial incentives, providers need autonomy i.e. authority over spending decisions, to respond to local needs as they change and as opportunities arise. With greater provider autonomy comes responsibility and the need for accountability mechanisms to ensure that performance improves in line with UHC goals.

The key to driving improvements in provider performance is to find a balance between payment system financial incentives, the autonomy given to providers over spending decisions, and the appropriate accountability measures. Where provider's lack the decision-making authority, or indeed the necessary skills and capacity, financial incentives will not have the desired impact. Where these elements are in place, but accountability mechanisms are weak, again performance may change in the way intended, for example revenue generation may be prioritized over patient financial protection. Regular review and adjustment are likely to be required.

In the private sector, the issue of financial autonomy is less central as providers are autonomous by status. However, where public purchasers can contract private providers, holding them to account is of critical importance.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

LEVEL 1: EMERGING

Public providers have no or extremely limited autonomy and cannot respond to financial incentives through the payment system.

Providers have no financial or management authority; all decisions on spending or reallocation must be approved by higher-level administrative offices, a situation common in health systems which rely heavily on central command-and-control. Where private providers are contracted, very limited accountability measures (e.g. reporting requirements) are in place, making it difficult to assess performance.

Levels: 2 Progressing

Public providers are given greater managerial and financial autonomy, but accountability mechanisms are weak.

Public sector facilities are granted partial financial autonomy with control over certain revenues e.g. retained patient co-payments, and for these funds they have their own back or Treasury account. However, rules governing the use of these funds are either overly restrictive or place no conditions at all, raising concerns about either inadequate flexibility or insufficient accountability. Where there is widespread contracting of private providers by public purchasers, reporting and accountability requirements are clearer although it remains difficult to obtain quality information, in terms of how funds are used, on a regular and timely basis.



LEVEL 3: ESTABLISHED

Public providers are granted further increases in managerial and financial autonomy and compliance with accountability requirements is progressively improving.

Public providers have spending authority over an increased proportion of funds received, for example from patient co-payments, health insurance scheme reimbursements, and performance-based allocations, but not over their core budget. They can manage their discretionary funds flexibility, but with strong and enforced accountability measures, in terms of both financial and activity reporting. In the private sector, there is good compliance overall with the reporting requirements, but further improvements are needed. There is increased decision-making over support (non-clinical) staff.

LEVEL 4: ADVANCED

Providers enjoy substantial managerial and financial autonomy, have clear incentives to improve performance and are held accountable for their performance.

In the public sector, providers have control over their budget including but not limited only to additional income e.g. from patient co-payments and can reallocate across budget lines without pre-approval. Often, mechanisms are in place that allow them to directly receive, manage, and account for all sources of funds. Provider-level managerial authority and involvement in staffing decisions is significant. This is accompanied by clear, comprehensive reporting requirements and oversight mechanisms are in place for large providers and or provider networks) e.g. boards. Payment incentives are regularly reviewed and assessed, and overall these translates into performance improvements. Private sector providers comply with accountability requirements which are also regularly reviewed. Purchasers can measure provider performance across the health system.



Question 7.3 (scrtyprep):

Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?

BACKGROUND TO THE QUESTION

Financing emergency preparedness is a critical function of the overall public sector. Mechanisms need to be in place in the case that emerging threats materialize. This capacity can be proxied by financing related to the International Health Regulations (IHR). The IHR represent the commitment of States Parties to collectively prepare for, and respond to, events that may constitute a public health emergency of international concern according to a common set of rules (e.g. COVID-19). Preparedness functions that support health security are often underfunded or are financed and organized in isolation from the rest of the financing system (e.g. through extra-budgetary mechanisms). Additionally, the multisectoral nature of these functions requires explicit coordination. This question looks at what type of financing arrangements in the country exist to support implementation of preparedness functions, as laid out by the core IHR capacities. These capacities and indicators include the following: Legislation and financing, IHR coordination and NFP Functions, Zoonotic events and the human-animal interface, Food safety, Laboratory, Surveillance, Human resources, National health emergency framework, Health service provision, Risk communication, Points of entry, Chemical events, Radiation emergencies.

While revenues are clearly necessary to finance these functions, they often represent a marginal amount in relation to overall health spending. These functions rely on public financing and therefore need to be clearly incorporated into health sector budgeting processes. Effective budgetary mechanisms need to be flexible and effective in ensuring funding reaches the front lines.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Progress on this issue means that funds are available and financing mechanisms are in place to implement the health security-related capacities laid out in the International Health Regulations (IHR) across all levels of government and relevant ministries. It is important that the budget allocated for IHR capacities is flexible to adapt as needs change and can be distributed and executed in a timely manner. These functions rely heavily on existing health system functions and must be clearly incorporated into health sector budgeting processes that are coordinated across ministries and governments. Specifically, consider:

- How are resources managed by the public sector when a public health emergency occurs?
- Is there a mechanism that allows for resources to be rapidly distributed in response to a public health emergency?
- When a public health emergency occurs, does the country know where it can immediately access most of the financing needed to respond?
- How does the country ensure the coordination of funding allocated to a public health emergency response?



LEVEL 1: EMERGING

There is no budgetary allocation available or identifiable to finance the implementation of IHR capacities

Financing for IHR is handled through extrabudgetary means, revenues are not allocated to fund these functions, and there are no institutional mechanisms in place to ensure accountability for implementation.

LEVEL 2: PROGRESSING

A budgetary allocation, or substantial external financing, is made for some of the relevant sectors to support IHR capacities but are not fully implemented.

This only exists at the national level and is not fully implemented at all levels of government

LEVEL 3: ESTABLISHED

Budgetary allocations for IHR capacities are made across relevant sectors to support implementation but there is no clear coordination across sectors in their execution.

There is sufficient budget allocation for IHR capacities at national and subnational levels across sectors including (health, veterinary, agriculture, and all other relevant ministries or sectors); budget allocations are based on clear evidence and related needs.

LEVEL 4: ADVANCED

Sufficient budget for IHR capacities is distributed, executed, and coordinated in a timely manner across all relevant ministries and levels of government.

These funds are well coordinated and integrated with the overall health financing system.

I QUANTITATIVE INDICATORS

WHO oversees the IHR SPAR assessment, in which all countries self-assess on several areas related to the International Health Regulations. Look at how the country performs on indicator "C.1.2 Financing for the implementation of IHR capacities" which assesses how the public health response to emergencies is financed, in terms of whether there is an explicit budget allocation for IHR, whether it is multisectoral, and whether funds are distributed to subnational entities

Supporting notes to the SPAR assessment further elaborate that "States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process. Budget is an itemized summary of expected income and expenditure of a country over a specified period, usually a financial year, whereas financing and funding refers to money which a government or organization provides for a particular purpose. In other words, budget is what is planned for, and financing is what is actually provided."

Country-specific information is available on the background indicators dashboard <u>here</u>. Ratings use a 1-5 scale where one is low, with scores represented as 20%, 40%, 60%, 80% or 100%. No supporting text or analysis is available for countries. Furthermore, to move away from exclusive self-evaluations, the IHR Review Committee has developed an approach for voluntary external evaluations involving domestic and international experts. This is known as the Joint External Evaluation (JEE) tool published in 2016. The purpose of the JEE is to measure country-specific status and progress in achieving the IHR targets and has the same indicator as SPAR.

The Guidance document for SPAR assessments (13) and the JEE 2nd edition manual (14) provide useful references.



Question 7.4 (scrtyresp):

Are public financial management systems in place to enable a timely response to public health emergencies?

BACKGROUND TO THE QUESTION

This question differs from 7.3 as it looks at whether and how health financing arrangements and mechanisms allow for and facilitate a timely <u>response</u> to public health emergencies. Central to this is that funds can be used flexibly and where necessary reallocated rapidly in support of the response to public health emergencies. Having a strong public financial management system will enable a rapid and comprehensive response to an emergency. This also encompasses whether health budget formulation supports alignment with a timely response to public health emergencies, as well as whether there is flexibility in spending to reallocated in the context of changing needs and demands. This question has similarities with Question 6.2 but focuses specifically on the capacities om public financial management required to respond to public health emergencies.

WHAT MATTERS AND WHAT DOES PROGRESS LOOK LIKE?

Progress on this issue would mean that necessary funds are flexible and can be reallocated rapidly for the response to a public health emergency. This involves having a strong public financial management system that ensures the speed, transparency, and accountability of funds for public health emergencies that are coordinated across levels of government and relevant ministries. Specific questions to ask regarding the progress level:

- How are resources managed by the public sector when a public health emergency occurs? How are they gathered and disseminated from both public and private actors?
- Is there a mechanism that allows for resources to be distributed for responding to a public health emergency in a timely manner?
- When a public health emergency occurs, does the country know where it can immediately access most of the financing needed to respond to the emergency?
- Does each relevant ministry or public entity have a budget line in place for activities related to responding to public health emergencies?
- How does the country ensure coordination of funding related to response to public health emergencies?

LEVEL 1: EMERGING

Funding to respond to public health emergencies is identified but public financial management system does not allow for effective or timely disbursement during a public health emergency.

Funds are allocated and distributed in an ad hoc manner during a public health emergency. Extra-budgetary funds are created that are not coordinated with the overall public financing management system.

LEVEL 2: PROGRESSING

An emergency public financing mechanism exists that allows for structured reception and rapid distribution of funds in response to public health emergencies

In this context, the government has established these pathways; however, they are not operational and fully funded.



LEVEL 3: ESTABLISHED

Financing for public health response is identified for immediate mobilization when needed at all levels of government for relevant sectors in advance of a public health emergency.

For example, the functionality of the emergency public financing mechanism is ensured for the mobilization of funds when needed but funds are not released in a timely or transparent manner.

LEVEL 4: ADVANCED

Financing can be executed and monitored in a timely and coordinated manner at all levels for all relevant sectors, with an emergency contingency fund in place to respond to public health emergencies.

Public financial management systems are established and well-coordinated with the rest of the public sector. Speed, transparency, and accountability of all funds is ensured in response to a public health emergency.

QUANTITATIVE INDICATORS

WHO oversees the IHR SPAR assessment, in which all countries self-assess on several areas related to the International Health Regulations. Look at how the country performs on indicator "C.1.3 Financing mechanism and funds for the timely response to public health emergencies" which assesses whether a funding mechanism for emergency response is in place and executed rapidly to relevant sectors and levels of the system.

As noted in the previous question, supporting notes to the SPAR assessment further elaborate that "States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process. Budget is an itemized summary of expected income and expenditure of a country over a specified period, usually a financial year, whereas financing and funding refers to money which a government or organization provides for a particular purpose. In other words, budget is what is planned for, and financing is what is actually provided."

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The guidance document for SPAR assessments can be found <u>here</u> and the JEE 2nd edition manual <u>here</u>.



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 - THE HFPM SYNTHESIZES A WIDE RANGE OF DOCUMENTS ON HEALTH FINANCING AVAILABLE AT: https://www.who.int/health-topics/health-financing

ALL DOCUMENTS RELATED TO THE HFPM ARE AVAILABLE AT:

https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix/



5. Data collection template for country Assessments

This HFPM Data Collection Template is based on Version 2 of the Health Financing Progress Matrix country assessment released by WHO in November 2020. It should be used in conjunction with Edition 1 of the HFPM Country Assessment Guide.

Feedback and suggestions in relation to any aspect of this document are welcome and should be submitted using the <u>online form</u>.

Country			
Principal Investigator			
Date submitted for review	Day	Month	Year



Please summarize the main process followed in completing the assessment; this may include a summary of interviews with key informants, any meetings held with government steering or working groups, development partners, and review of key documentation, published and unpublished. Any additional Investigators should also be listed with the role played. Please write in the box below or alternatively complete the online form using this link.

Process	
followed	
Tonowea	



5.1. STAGE 1

KEY DESIGN FEATURE		
YEAR ESTABLISHED		
A) FOCUS OF THE SCHEME		
CODE A1)		
B) TARGET POPULATION		

KEY DESIGN FEATURE		
C) POPULATION COVERED		
D) BASIS FOR ENTITLEMENT / COVERAGE		
CODE D1)		

KEY DESIGN FEATURE		
E) BENEFIT ENTITLEMENTS		
CODE E1)		
F) CO-PAYMENTS (USER FEES)		
CODE F1)		

KEY DESIGN FEATURE		
G) OTHER CONDITIONS OF ACCESS		
CODE G1)		
H) REVENUE SOURCES		
CODE H1)		

KEY DESIGN FEATURE		
I) POOLING		
CODE 11)		
J) GOVERNANCE OF HEALTH FINANCING		
CODE J1)		

KEY DESIGN FEATURE		
K) PROVIDER PAYMENT		
CODE K1)		
L) SERVICE DELIVERY & CONTRACTING		

KEY DESIGN FEATURE		
CODEL1)		
CODE L2)		
CODEL3)		
Add reference documents		



5.2. Public financial management – Primary questions

	6. Public financial management							
Question 6.1 (pfmdiag)	Is there an	Is there an up-to-date assessment of key public financial management bottlenecks in health?						
			5500550000	5074849455				
EMI	ERGING		PROGRESSING	ESTABLISHED	ADVANCED			
No generic PFM ass outdated	essment exists or I assessment.	only an	Only a generic PFM assessment has been conducted which is up-to-date.	A rapid health-specific assessment was conducted in the last 2 years which examined some bottlenecks in health spending.	Extensive, up-to-date health-specific diagnosis/assessment conducted; key bottlenecks identified.			
References	used							

	6. Public financial management					
Question 6.2 (pfmallocprty) Do health	n budget	formulation and implementation su	pport alignment with sector priorities	and flexible resource use?		
EMERGING		PROGRESSING	ESTABLISHED	ADVANCED		
Health policy priorities are poorly de not reflected in the budget; rigid input item budget dominates.	t-based line-	Input-based line-item budget and ex-ante financial control still dominates; some piloting of programme-based budgets provides more flexibility in resource use, and performance information is increasingly used.	Use of performance information and implementation of programme-based budgets are becoming widespread, better directing budgets to sector priorities using mechanisms that are consistent with provider payment incentives, thereby providing greater flexibility in resource use.	Health sector priorities, medium term expenditure framework and annual budgets are fully aligned and structured around well-designed budgetary programmes, and stable, predictable funds are directed to health sector priorities and service providers.		
References used						

	6. Public financial management						
Question 6.3 (bdgtprcss)	Are processes in p	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?					
EMI	ERGING	PROGRESSING	ESTABLISHED	ADVANCED			
MoH, with no or very	cess often by-passes the limited dialogue between and MoF.	Budget process is consultative and transparent but to a limited extent, and input from health sector is minimal; MoH not consulted over midyear re-allocations.	Budget process is consultative and transparent but to a limited extent, and input from health sector is minimal; MoH not consulted over midyear re-allocations.	Budget process is consultative and transparent, based on dialogue between MoH and MoF, within a clear multiyear budgeting framework; all appropriate administrative levels are consulted and engaged.			
References	used						

6. Public financial management						
Question 6.4 (bdgtcntrl)	Are there measures to address problems arising from both under and over budget spending in health?					
ЕМЕ	ERGING	PROGRESSING	ESTABLISHED	ADVANCED		
comply with basic bud planning, insufficient streams, and few if ar	nentation frequently fails to dget discipline due to poor or unpredictable revenue ny measures are taken to s the issue.	Health budget implementation complies with basic budget discipline, but with still major shortfalls and significant underspending in health.	Limited under or over-spending on a yearly basis, but delays remain in fund releases for health service providers specifically.	Health budgets are fully executed and comply fully with budget discipline; significant underspending rarely happens.		
References ι	used					

	6. Public financial management					
Question 6.5 (expinfmon)	Is expenditu	re repo	orting in health comprehensive, tin	nely, and publicly available?		
EMI	ERGING		PROGRESSING	ESTABLISHED	ADVANCED	
No computerized sys expenditure monitor reporting system		rallel	Computerized system being developed and strengthened, but with limited or poor-quality routine data; financial reporting in health	A functioning financial information system in place but is not aligned with health sector accountability requirements	Financial management information system allows monitoring by multiple categories; information is publicly available and used to inform new budget decisions	
recor	nciliation.		remains fragmented.			
References	used					



5.3. Public financial management – Questions mapped from other assessment areas

	2. Revenue raising						
Question 2.2 (predict)	How predictable is public funding for health in your country over a number of years?						
EME	ERGING	PROGRESSING	ESTABLISHED	ADVANCED			
are large or significan	ward budgeting, and there nt year-to-year fluctuations ealth (and where relevant, al funding).	Although revenue and expenditure scenarios exist, predictability of the level of public funding for the health sector remains poor.	The level of public funding for the health sector is relatively predictable due to well-functioning budgetary processes.	The level of public funding for health is highly predictable.			
References (used						

2. Revenue raising						
How stable is the flow of public funds to health providers?						
RGING	PROGRESSING	ESTABLISHED	ADVANCED			
entral and sub-national sies where relevant, are ed as planned.	Health budgets are sometimes executed as planned.	Health budgets (including SHI fund) are usually executed as planned.	Flow of public funds to the health sector is highly stable.			
sed						
F	entral and sub-national sies where relevant, are ed as planned.	RGING PROGRESSING entral and sub-national lies where relevant, are ed as planned. Health budgets are sometimes executed as planned.	RGING PROGRESSING ESTABLISHED Intral and sub-national ides where relevant, are ed as planned. Health budgets are sometimes executed as planned. Health budgets (including SHI fund) are usually executed as planned.			

	3. Pooling revenues						
Question 3.3 (fragsolve)	What measures are in place to address problems arising from multiple fragmented pools?						
EMI	ERGING	PROGRESSING	ESTABLISHED	ADVANCED			
inequity and ine	sating measures to address fficiency arising from nentation.	Some measures in place to address inequity and inefficiency arising from fragmentation.	Substantial measures in place, though with room for improvement, to address inequity and inefficiency arising from fragmentation.	Compensation measures fully implemented to enable equity and efficiency challenges arising from pool fragmentation to be fully addressed.			
References	used						

			3. Poc	oling revenues	
Question 3.4 (revpool)	Are multip benefits?	le revenu		rganized in a complementary manne	r, in support of a common set of
EME	ERGING		PROGRESSING	ESTABLISHED	ADVANCED
There is no coordir different re	nation of fund flo	ws from	Complementarity exists among some revenue sources, but there is no population-wide (universal) framework of health benefit entitlements indicating the specific role of different funding sources/streams.	A benefit framework exists for most of the population with funding responsibilities clearly defined across different revenue streams, but private prepayment still not well-integrated.	There is explicit complementarity of different revenue sources to fund a defined benefit package for the entire population.
References	used				

4. Purchasing and provider payment						
Question 4.1 (allocneeds)	To what extent is the payment of providers driven by information on the health needs of the population they serve?					
EME	ERGING	PROGRESSING	ESTABLISHED	ADVANCED		
without reference to	input-based norms used data on population health eeds.	There is some use of simple measures of need within payment mechanisms in at least some schemes or government budget allocations.	More sophisticated mechanisms of adjusting for health needs, service mix and provider performance are incorporated into payment methods and applied to most prepaid funding in the system.	The main provider payment methods used in the health system involve methods that incorporate data on population health needs, risk factors, provider performance and service mix.		
References	used					

4. Purchasing and provider payment						
Question 4.6 (prvdauton)	To what extent do providers have financial autonomy and are held accountable?					
EMI	ERGING	PROGRESSING	ESTABLISHED	ADVANCED		
autonomy and can	ve no or extremely limited not respond to financial h the payment system.	Public providers are given greater managerial and financial autonomy, but accountability mechanisms are weak.	Public providers are granted further increases in managerial and financial autonomy and compliance with accountability requirements is progressively improving.	Providers enjoy substantial managerial and financial autonomy, have clear incentives to improve performance and are held accountable for their performance.		
References	used					

7. Public health functions and programmes						
Question 7.3 (scrtyprep)	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?					
EME	ERGING	PROGRESSING	ESTABLISHED	ADVANCED		
identifiable to finance	ary allocation available or the implementation of IHR pacities	A budgetary allocation, or substantial external financing, is made for some of the relevant sectors to support IHR capacities but are not fully implemented.	Budgetary allocations for IHR capacities are made across relevant sectors to support implementation but there is no clear coordination across sectors in their execution.	Sufficient budget for IHR capacities is distributed, executed, and coordinated in a timely manner across all relevant ministries and levels of government.		
References	used					

	7. Public health functions and programmes					
Question 7.4 (scrtyresp)	Are public financia	I management systems in place to	enable a timely response to public h	nealth emergencies?		
EMER	RGING	PROGRESSING	ESTABLISHED	ADVANCED		
Funding to respond to pu is identified but public f system does not allow disbursement during a pu	financial management for effective or timely	An emergency public financing mechanism exists that allows for structured reception and rapid distribution of funds in response to public health emergencies	Financing for public health response is identified for immediate mobilization when needed at all levels of government for relevant sectors in advance of a public health emergency.	Financing can be executed and monitored in a timely and coordinated manner at all levels for all relevant sectors, with an emergency contingency fund in place to respond to public health emergencies.		
References use	ed					

i	Please add in the box below any key messages from this section, which will support the overall assessment summary for presentation to policy makers
	Summary of assessment and recommendations for Public Financial Management

HEALTH FINANCING GUIDANCE NO 9



The Health Financing Progress Matrix (HFPM) is a standardized approach to assessing a country's health financing system. Primarily qualitative in nature, the HFPM considers health financing institutions, processes, policies and their implementation, assessing how aligned these are with universal health coverage. Country assessments highlight priorities for future action, allow progress to be monitored over time, and are used to build a Global Knowledge Database to facilitate learning between countries.



Further information is available at:

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