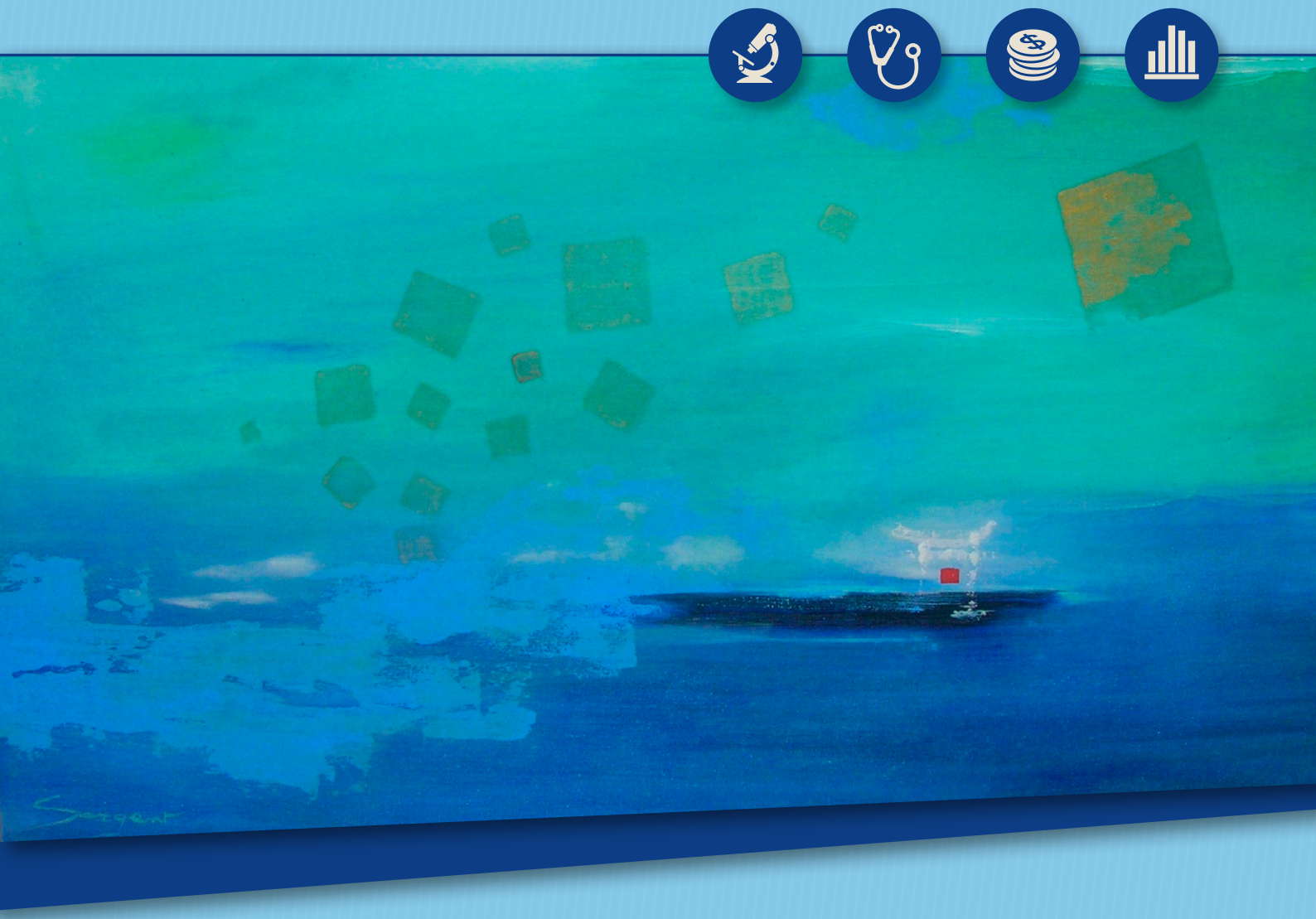
HEALTH FINANCING GUIDANCE NO 3

DEVELOPING A NATIONAL HEALTH FINANCING STRATEGY: A REFERENCE GUIDE



Joseph Kutzin
Sophie Witter
Matthew Jowett
Dorjsuren Bayarsaikhan

World Health Organization

HEALTH FINANCING GUIDANCE NO 3

DEVELOPING A NATIONAL HEALTH FINANCING STRATEGY: A REFERENCE GUIDE

Joseph Kutzin
Sophie Witter
Matthew Jowett
Dorjsuren Bayarsaikhan

World Health Organization

Developing a national health financing strategy: a reference guide / Joseph Kutzin, Sophie Witter, Matthew Jowett, Dorjsuren Bayarsaikhan
(Health Financing Guidance No 3)

ISBN 978-92-4-151210-7

Printed in **[add country – for customs purposes]**

NUMBERS WILL BE INSERTED

TABLE OF CONTENTS

List of Figures

List of Boxes

AUTHORS AND CITATION

Authors:
Joseph Kutzin, Coordinator Health Financing, Dept. Health Systems Governance and Financing, WHO Geneva
Sophie Witter, Professor of International Health Financing and Health Systems, Queen Margaret University, Edinburgh, UK.
Matthew Jowett, Senior Health Financing Specialist, Dept. Health Systems Governance and Financing, WHO Geneva
Dorjsuren Bayarsaikhan, Senior Health Financing Specialist, Dept. Health Systems Governance and Financing, WHO Geneva

Citation:
Please cite this paper as follows:
Kutzin J, Witter S, Jowett M, Bayarsaikhan D. Developing a National Health Financing Strategy: A Reference Guide. Geneva: World Health Organization; 2016. (WHO/HIS/HGF/HFDiagnostics/17.3; Health Financing Diagnostics & Guidance Series No3.); IRIS LINK TO BE ADDED ONCE E-PUB APPROVED

LINK

ACKNOWLEDGEMENTS

The author acknowledges comments and suggestions provided by WHO colleagues and other experts during the development of this reference guide. Financial support from the UK Department for International Development (DFID) under the Program for Improving Countries' Health Financing Systems to Accelerate Progress towards Universal Health Coverage.

For further information about our work on health financing policy please visit our website:
www.who.int/health_financing

HOW TO USE THIS DOCUMENT

This document is based on WHO's experience providing support on health financing policy to its Member States over many years. As a Reference Guide, it uses an outline for a health financing strategy, but its primary aim is to highlight the different aspects of health financing policy which need to be analysed and addressed by countries. Any successful health financing strategy is rooted in an analysis of current performance problems in the health sector; conducting such an analysis is the focus of a separate document, and hence this Reference Guide should be used in conjunction with it:

McIntyre D. & Kutzin, J. Health financing country diagnostic: a foundation for national strategy development. Geneva: World Health Organization; 2016. (WHO/HIS/HGF/HFDiagnostics/16.1; Health Financing Diagnostics & Guidance Series No1). Available at http://www.who.int/health_financing

1. INTRODUCTION

1.1. HEALTH FINANCING AND UNIVERSAL HEALTH COVERAGE

Universal health coverage (UHC) means that all people in a society are able to obtain the health services that they need, of high-quality, without fear that the cost of paying for these services at the time of use will push them into severe financial hardship. UHC has become a major policy priority in many countries, and a significant and growing focus of attention at the international level, forming one of the targets of Sustainable Development Goal 3.[1,2,3,4]

Consistent with the core messages of the World Health Report 2010, many countries have committed to UHC and are as a result reviewing, analysing, and modifying health financing arrangements in their countries. Experience shows that progress towards UHC needs not only strong political commitment but also a coherent strategy which ensures that the different aspects of the health system are aligned and coordinated with each other in order to address core performance challenges effectively. A coherent and well-aligned strategy for health financing reform can play a key role in this process.

WHO's thinking on the development of health financing strategies is rooted in its approach to health financing policy, as illustrated in Figure 1 below.

This approach combines a normative set of goals that are embedded in the concept of UHC (equity in utilization or service use relative to need, financial protection, and quality) with a descriptive framework of the functions and policies that are part of all health financing arrangements. As our normative position, making progress towards the goal of UHC *should* therefore drive reforms in health financing. As reflected in Figure 1, health financing reforms can also influence progress towards the UHC goals indirectly through a set of intermediate objectives: equity in the distribution of health system resources, efficiency, and transparency and accountability.[5]

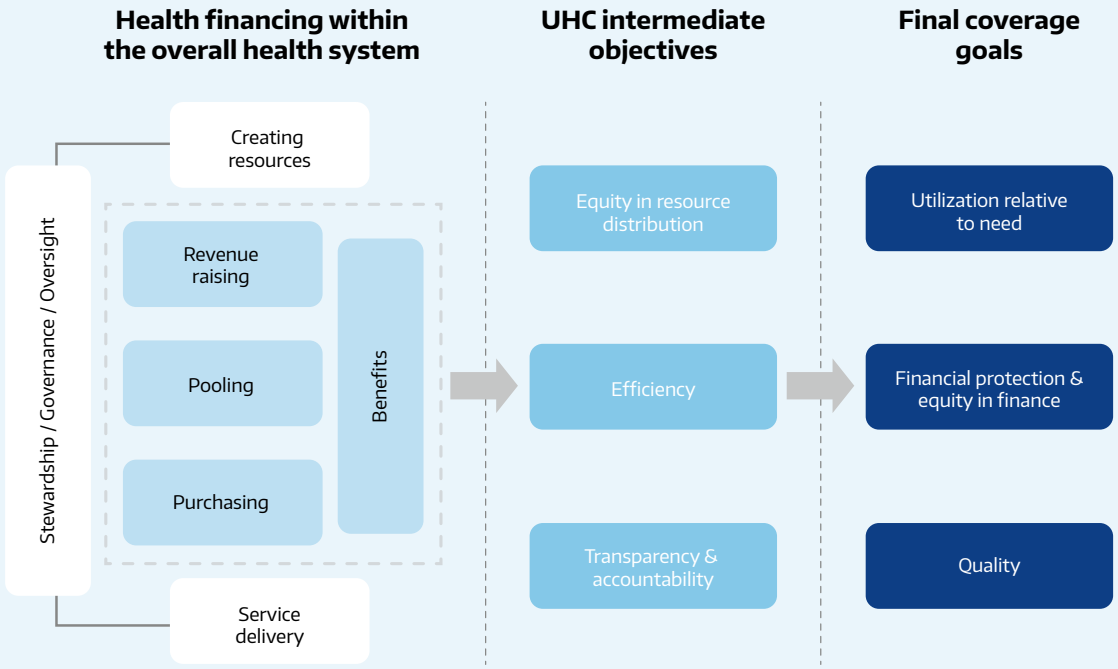
The UHC goals and intermediate objectives depicted in Figure 1 are generic and broad; to provide a clear agenda for country-specific reforms it is essential to first conduct a diagnosis of current health system performance, the specific ways that underperformance manifests itself, and the underlying causes. Based on this a health financing strategy can be defined to address the specific causes of underperformance.

JOWETTM: DO WE HAVE IRIS LINK?

1 Declaration for Universal Coverage. Bangkok, Thailand. January 2012
2 Universal Coverage Declaration. Mexico. April 2012
3 United Nations. 2012. UN Assembly resolution supporting universal coverage. http://www.un.org/News/Press/docs//2012/ga11326.doc.htm
4 United Nations. (2015) Transforming Our World: The 2030 Agenda for Sustainable Development. New York.

5 Kutzin, J (2013). "Health financing for universal coverage and health system performance: concepts and implications for policy." *Bulletin of the World Health Organization* 91:602-611. http://www.who.int/bulletin/volumes/91/8/12-113985/en/

Figure 1: UHC goals and intermediate objectives influenced by health financing policy



1.2. WHAT IS A HEALTH FINANCING STRATEGY?

The specific scope and content of a health financing policy, strategy, or plan, and the terminology used, differs in each country. There is also significant variation in terms of the degree of detail included, the process used in their development, and their legal status. This document provides guidance on the development of a *health financing strategy*, our preferred term, which we consider to live somewhere between high level documents which outline a vision for the health sector, and implementation documents which provide detailed plans. In our view a health financing strategy:

- is based on a diagnosis of how a country's health system currently performs relative to stated goals and objectives, which are usually framed in terms of UHC; this diagnosis identifies both the specific ways that problems manifest themselves and their underlying causes, internal and external to the health system.
- focuses on the entire population of a country, and the national health system, not just a single component or a single scheme within it. It takes a comprehensive view of all functions, policies, linkages and alignments across the health system.
- identifies a set of detailed country-specific objectives, together with a prioritized set of actions which address the problems identified, within a specified time period (e.g. 5 to 10 years); it also considers how reforms need to be sequenced.
- includes an evaluation strategy to ensure both public accountability and mid-course corrections.

A health financing strategy can be a stand-alone document which refers to and is consistent with wider national health policies, strategies, and plans. More preferable is for a health financing strategy to be part of, and integrated within, a national health policy or other strategic health sector document that includes a service delivery plan. It may even be, perhaps in the most ideal of circumstances, embedded within a country's overall national development plan. The important point is that a health financing strategy should not be developed in isolation. Health financing consists of the arrangements that a country has for:

- revenue sources and contribution mechanisms ("revenue raising")
- pooling of funds
- purchasing of services
- policies on benefit design, rationing, and the basis for entitlement
- governance of the above functions and policies

Each of these is discussed in more detail in Section 4 of this document; further details can also be found in additional references.[6,7,8] Whilst each health financing function is considered separately in the following chapters it is important, indeed critical, to think about how each fits with the others, and how all fit together in the context of a health system. This approach facilitates the development of system reforms which cut across different functions and health coverage schemes, and in turn supports the development of a comprehensive health financing strategy.

Put another way, a health financing strategy should define changes to be implemented over a period of time, such as the next 5-10 years, to revenue raising, pooling, purchasing, benefit design, and overall system architecture and governance. These policy changes would aim to address the root causes of problems observed in the health system i.e. shortcomings in the attainment of UHC in terms of the final coverage goals and intermediate UHC objectives. These changes would be considered feasible in terms of implementation, and would at same time lay the foundation for future improvements.

1.3. HOW THIS REFERENCE GUIDE IS ORGANISED

The main purpose of this Reference Guide is to support countries to develop a comprehensive health financing strategy which supports progress towards universal health coverage. Following this introductory section, the document is organised into three further sections:

- **Chapter 2:** considers some of the work required prior to the development of a health financing strategy, in particular the conduct of a situation analysis of current performance in the health sector, together with a diagnosis of the underlying causes. Issues related to the process of developing a health financing strategy are also discussed.

6 Kutzin, J (2001). "A descriptive framework for country-level analysis of health care financing arrangements." *Health Policy* 56(3):171-204.

7 Kutzin, J (2008). "Health financing policy: a guide for decision-makers." Health Financing Policy Paper. Copenhagen, Denmark: World Health Organization, Regional Office for Europe, Division of Country Health Systems. http://www.euro.who.int/__data/assets/pdf_file/0004/78871/E91422.pdf

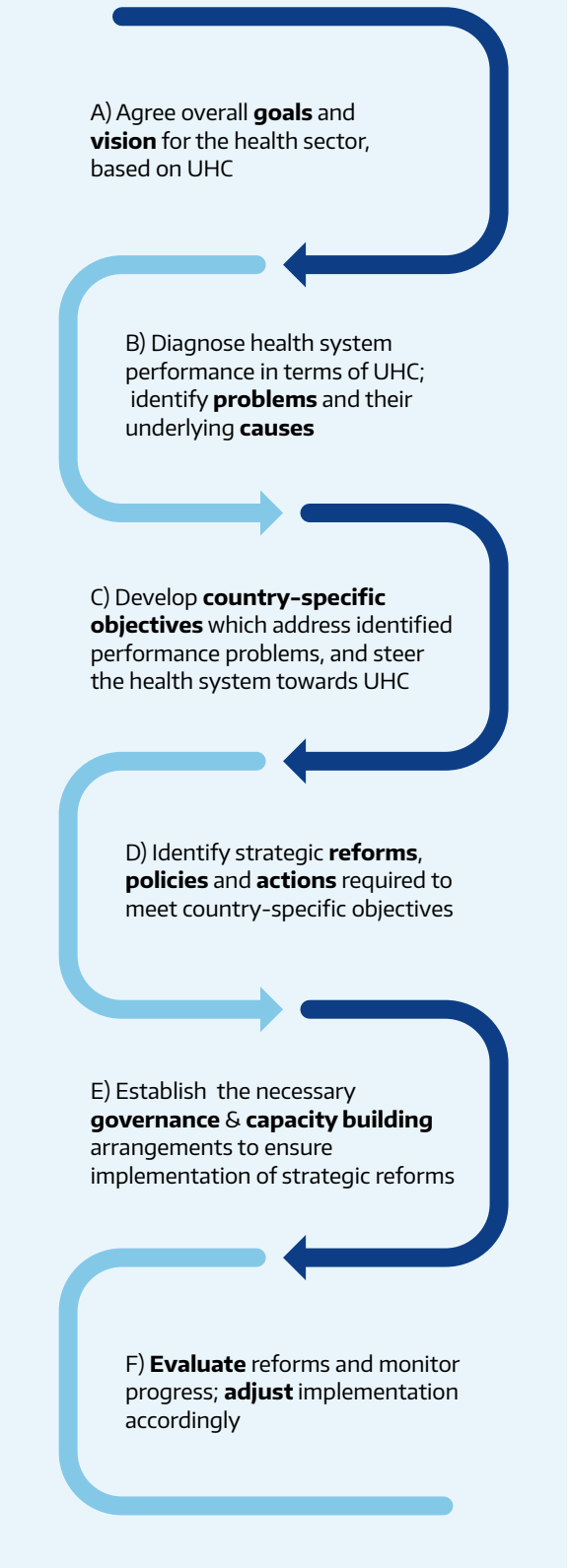
8 Mathauer I, Carrin G. 2010. The role of institutional design and organizational practice for health financing performance and universal coverage. Discussion paper 5. World Health Organization.

- **Chapter 3:** provides an indicative outline of a health financing strategy based on three sections: i) "Background, diagnosis and objectives" ii) "Strategic interventions" iii) "Governance, evaluation and monitoring, capacity building". In each section key issues considered important for a comprehensive health financing strategy are highlighted; however, national decision-makers are encouraged to adapt the document to the specific situation and context in their country.

- **Chapter 4:** for each of the three sections further background, context and detail on each issue or topic is provided, including the underlying concepts and common challenges faced, structured around the core health financing functions.

Whilst it is assumed that the goals embedded in the definition of universal health coverage form the basis for health financing reforms, the purpose of this guide is to promote comprehensive strategy design, not to recommend or promote any particular health financing strategy or reform. However, it is possible to define a set of guiding principles to ensure that a strategy which aims to support UHC is consistent with the evidence of what works (see Box 1).

Figure 2: Key steps in the development of a health financing strategy



Box 1: Guiding principles for health financing reforms in support of UHC

a) Introduction

Health financing reforms cannot simply be imported from one country to another given the unique context of each country and its starting point in terms of health financing arrangements; the underlying causes of performance problems differ in each country and it is these causes which the reforms proposed in a health financing strategy must address. However, there are lessons from international experience that allow a number of guiding principles for reforms which support progress towards UHC, to be specified. These do not constitute a "how-to" guide, but rather a set of "signposts" that can be used to check whether reform strategies (and more importantly, reform implementation) create an appropriate incentive environment and hence are pointing and moving in the right direction in terms of objectives and goals in Figure 1. These principles, or signposts, are presented below for each of the health financing sub-functions and policy areas:

1) Revenue raising

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

2) Pooling revenues

- Enhance the redistributive capacity of available prepaid funds
- Enable explicit complementarity of different funding sources
- Reduce fragmentation, duplication and overlap
- Simplify financial flows

3) Purchasing services

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

4) Benefit design and rationing mechanisms

- Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)
- Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries
- Align promised benefits, or entitlements, with provider payment mechanisms

2. PREPARING FOR A HEALTH FINANCING STRATEGY

2.1. CONDUCTING A SITUATION ANALYSIS

A health financing strategy will only be useful, and successful, if it is based on and responds to a detailed analysis of both the current performance problems in the health sector and their underlying causes. Detailed guidance on how to conduct such a situation analysis has been developed separately by WHO,[9] built around five core sections as follows:

- Section 3 "Key contextual factors that influence health financing policy and attainment of policy goals"
- Section 4 "Overview of health expenditure patterns"
- Section 5 "Review of health financing arrangements"
- Section 6 "How are we doing? Analyzing UHC goals and intermediate objectives"
- Section 7 "Overall assessment: priorities for health financing reform"

Each section provides detailed guidance on how to analyse current arrangements, identify performance problems, and also to understand and identify the underlying causes. The document covers a wide range of issues which include describing and analysing, for example:

ASPECTS OF SYSTEM DESIGN AND OPERATION

- overall health financing architecture, the flow of funds within the health system, and the agencies responsible for revenue raising, pooling, and purchasing
- the source of revenues for the health sector and the specific contribution mechanisms; trends in absolute and relative levels of public, private, external, and total health expenditures
- revenue pooling arrangements: for example are there single or multiple risk pools? Are there mechanisms for cross-subsidy and fund equalization across population groups, geographical areas etc?
- resource allocation rules, including details of how funds flow differently, in terms of amounts, across geographical locations and health facilities (hospitals, health centres and clinics)
- purchasing arrangements, such as the specific payment mechanisms, the number of purchasers, information systems and governance arrangements for purchasing, and the incentive environment created for providers
- explicit rules on patient cost-sharing (e.g. user fees), exemptions for certain population groups or services, and services not covered from prepaid funds
- public financial management rules and systems, including how funds are planned and budgeted, transferred, used, reported on and controlled, which affects how much autonomy public providers have
- reporting requirements (e.g. to Parliament, civil society, media) for the use of public funds by health financing agencies

9 McIntyre, D and J Kutzin (2016). Health financing country diagnostic: a foundation for national strategy development. WHO/HIS/HGF/Technical Report/16.1. Geneva: World Health Organization. http://www.who.int/health_financing/tools/diagnostic

ASPECTS OF SYSTEM PERFORMANCE

- the provision and use of health services (equity of distribution and use, access issues and especially financial barriers) relative to the health needs of the population, income groups and other indicators of vulnerability (such as sex or ethnicity), and location (urban and rural)
- evidence on overall financial protection as well as equity concerns (e.g. level and distribution of catastrophic and/or impoverishing out-of-pocket payments)
- the performance of health service providers (both public and private), including any evidence on the effect of purchasing arrangements on health service quality and efficiency
- public awareness about health service benefits entitlements, their payment obligations if any, and the extent to which these are realized in practice (e.g. is there evidence of informal out-of-pocket payments?)

The aim of the situation analysis is to set out clearly the way the health financing system is organized and performing, and in particular to reach plausible conclusions about the *causes* of underperformance, based on available documentary and data evidence as well as discussion with key stakeholders. This will include a review of achievements, shortcomings, and areas for improvement, taking into account contextual factors and also identifying those causes which are amenable to change through health financing reforms.

2.2. THE PROCESS OF DEVELOPING A HEALTH FINANCING STRATEGY

It is the responsibility of national governments to develop and implement a health financing strategy which reflects and contextualizes the UHC concept in their particular setting, and which is owned by those responsible for its implementation. The nature of the issues means that success requires the engagement of the government agencies responsible for health and for finance, typically a Ministry of Health (MoH) and Ministry of Finance (MoF), though the specific names of these responsible agencies may differ slightly. In addition, other government agencies/ministries may also be involved depending on country circumstances, such as those responsible for Local Government, Labour, Social Security, Education, and so forth. In many settings, effective policy dialog must also involve legislative bodies (Parliamentarians) as well as non-government partners such as the associations of health professionals, patient groups, and other civil society organizations, in an open consultation about problems, priorities, possible reforms and roles and responsibilities.

Approaches to formulating a health financing strategy for UHC often include the establishment of a multisectoral task force, steering committee or technical working group with a clear terms of reference and timeline; this can help to broaden the expertise and ownership in the process. Experience suggests that it is essential to have at least some full-time dedicated staff (possibly local consultants) working under the guidance of the steering committee and responsible to carry forward the strategy to completion, as progress is difficult if no one is really freed from their routine responsibilities. A steering

committee may be comprised of high-level decision-makers such as ministers and senior officials from government who are mandated to provide oversight. In some countries, thematic sub-working groups may be helpful to focus on the development, assessment and prioritisation of options under headings such as 'resource mobilisation and needs', 'increasing equity and coverage' and 'more efficient purchasing and provision'.

An inclusive process involving civil society groups, non-governmental organizations, health care professional associations, academic institutions, development partners, health insurance bodies (where relevant), private sector representatives and sub-national level authorities in steering committee and working groups helps to strengthen a strategy and move it beyond largely technical content. Broad ownership is required not only because of the need for political commitment and consensus, but also because intersectoral actions are likely to be needed. For example, reforms to health financing policy can have implications for human resource development plans and education plans. Moreover, the discussion of reform options requires political and wider considerations, in addition to technical ones.

The strategy development process should use the best available knowledge, expertise, and data. It may need to initiate additional health financing analytical work beyond the initial situation analysis – for example, studies dealing with fiscal space, stakeholder mapping, benefit package reform and the resource implications of various options, cost-effectiveness analysis, studies on efficiency and provider payment, and the development of an evaluation framework. However, some data gaps will always be found and commissioning of studies should not be excuse for postponing changes which are needed and for which there is clear evidence and consensus. It may work well to start with an understanding of the challenges and the areas for likely priority actions needed and to shape these into a detailed draft outline for the health financing strategy. Then, additional studies may be commissioned to address identified knowledge gaps or explore alternative policy options in more depth. In turn, these can be used to inform specific parts of the strategy, rather than waiting to complete all analytical work before working on a strategic framework.

Finalizing and approving a health financing strategy may require several rounds of consultations with stakeholders, particularly those who involved in implementation. Approval of the strategy from the highest political and decision making levels in the form of presidential decree, parliament or cabinet decisions may also be needed.

3. INDICATIVE OUTLINE OF A HEALTH FINANCING STRATEGY

This chapter provides an indicative outline for a health financing strategy, based on three sections as follows:

i. Background, diagnosis and objectives
ii. Strategic interventions
iii. Governance, evaluation and monitoring, capacity building

Whilst the ordering of issues and the emphasis given to each section will vary depending on a country's specific situation, we outline below the key questions and issues we consider important for a strategy to be comprehensive.

SECTION 1:
BACKGROUND, DIAGNOSIS AND OBJECTIVES

3.1. INTRODUCTION

- Brief country overview, development perspectives and contextualization of the health financing strategy within the country`s overall national health policy and plan, and service delivery strategy.
- Make reference to how this strategy is embedded within the wider socio-economic context, and major health challenges facing the country. Summarize the UHC goals and show how they fit with political commitments and broader national goals.
- Brief description of the process of development of the strategy and explanation of health financing strategy purpose, duration and structure.
- In addition to framing the document in relation to other key health sector documents, the underlying process used to compile and complete the strategy, as well as approval processes and any legislative requirements, should also be detailed.
- A preface or foreword from a leader in the health sector or in government, who can emphasize the national importance of the document, helps to give credibility to the document.

3.2. SITUATION ANALYSIS AND LESSONS LEARNED

- Summarise the way in which health financing is currently organised in the country.
- Summarise the main findings of the analysis of the performance of current health financing arrangements. Note in particular the main achievements and problems/ shortcomings identified, and how we know (the specific manifestations of achievements and shortcomings). These can be usefully categorized according to the UHC goals and intermediate objectives.
- Also from the situation analysis, summarise the key contextual factors (i.e. from outside the immediate control or influence of the health system) that affect what can be realistically implemented and achieved through health financing reforms

in the country. This includes in particular the fiscal context/outlook for the country, but also other issues as relevant such as decentralization of public administration, public financial management rules, nature of the country's political system, etc.

- Finally (again from the situation analysis), summarize the main identified causes of performance problems, highlighting those that are potentially actionable through financing reforms. These causes of underperformance provide the basis for prioritization within the health financing strategy, and can be usefully organized by health financing functions and policies (revenue raising, pooling, purchasing, and benefit design), as well as problems of misalignment (e.g. lack of coherence) of these with each other and with the UHC goals. Mapping the existing flow of funds through the system as well as the institutional responsibilities for implementing the health financing functions can help provide this overall perspective.

3.3. COUNTRY-SPECIFIC OBJECTIVES

- This section follows from the diagnosis of problems and their causes in the situation analysis. Whilst the objectives of the health financing strategy should relate to broad health system goals, such as "ensuring financial protection", these "high-level goals" are not sufficient and should be used only as categories. Within these, country-specific objectives need to be defined to address the underlying causes of under-performance.
- The objectives prioritised in the strategy should be justified in terms of the main performance problems identified in the situation analysis and diagnosis of underlying causes. Priority areas for reforms, to address the causes of under-performance relative to the UHC goals and intermediate objectives may also be indicated here; they are also the main focus of the following section.
- Where feasible, the objectives should be specified to the extent that they are measureable and thus can be tracked as indicators of progress. Some objectives may be more qualitative in nature, however, and should still be identified here.

SECTION 2:
STRATEGIC INTERVENTIONS

In relation to each of the priority objectives identified, strategic interventions need to be identified. This takes us to the core of the strategy: what is it that will change to address the main causes of performance problems, and what needs to happen for this change to occur? At this point we suggest referring to the different functions of health financing as this is where policy is focused, and where specific actions are identified. In the boxes below, we highlight what we consider to be key issues around each of the health financing functions, which arise in relation to typical objectives defined in health financing strategies. As noted previously, this document is not prescriptive in terms of proposing specific reforms; we merely emphasize that the reforms chosen should be justified in terms of a plausible impact on the identified causes of under-performance and consistency with global knowledge about what works and does not work in health financing. For the latter, the

guiding principles for reform identified earlier in Box 1 can be used to ensure that strategies are consistent with global experience, even as the specific features of each strategy are "home-grown".

3.4. REVENUE RAISING

GUIDING PRINCIPLES

- *Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)*
- *Increase predictability in the level of public (and external) funding over a period of years*
- *Improve stability (i.e. regular budget execution) in the flow of public (and external) funds during any given year*

- Define specific reforms to revenue raising policy based on the identified causes of under-performance and guided by the principles outlined above. Consider reforms which would lead to an increased reliance on public funding sources; for each option assess its feasibility given likely fiscal scenarios and the global evidence of what does and does not work. Options may include improvements to existing mechanisms as well as the introduction of new ones; for each option selected, its' link with the underlying cause of the problem or policy challenge identified should be made clear.
- Ensure realism by engaging with MOF to obtain data and estimates of past, current and projected revenue sources, both domestic and external. Medium Term Fiscal and Expenditure Frameworks should be used where available along with any available studies of fiscal space.
- In those countries where external aid flows are significant include measures to improve predictability, for example moving external flows "on budget", whilst bearing in mind that domestic resources may be offset i.e. reallocated elsewhere, as a result.
- Improvements in budget execution, in other words the timely release of funds in line with approved budgets, should enhance predictability in the flow of public revenues to the health sector. Note that reforms in revenue raising will be closely linked to actions planned by Finance/ Treasury authorities (e.g. to improve tax administration more generally), and they should be closely involved in the development of any such proposed reforms.

3.5. POOLING REVENUES

GUIDING PRINCIPLES

- *Enhance the redistributive capacity of available prepaid funds*
- *Enable explicit complementarity of different funding sources*
- *Reduce fragmentation, duplication and overlap*
- *Simplify financial flows*

- Define specific actions to reform pooling arrangements based on the identified causes of under-performance and guided by the principles above. For those reforms included in the strategy, the way in which they address identified problems in existing pooling arrangements should be made clear. Similarly, their expected impact in terms of addressing these challenges should be highlighted.
- Measures to enhance the redistributive capacity of available prepaid funds, or pooling / health coverage arrangements,

should not be limited to explicit insurance schemes but should also consider issues arising with public budget arrangements, particularly in countries with significant fiscal decentralization.

- Different funding sources can be explicitly combined or pooled to address inequities arising from fragmented pools between insured and uninsured populations; one such example is the transfer of general budget funds to a national health insurance scheme as subsidised contributions for priority population groups, where these funds are combined with payroll contributions into one pool.
- For each of the options to reduce fragmentation and enhance redistributive capacity, the potential political barriers should be made clear to ensure realism. Options may include the merger of separate coverage schemes, or measures to harmonize policies across schemes e.g. benefit entitlements, patient co-payments, provider payment mechanisms.

3.6. PURCHASING SERVICES

GUIDING PRINCIPLES

- *Increasing the extent to which the allocation of resources to providers is linked to the health needs of the population they serve, information on provider performance, or a combination (i.e. strategic purchasing)*
- *Moving away from the extremes of either rigid, input-based line item budgets or completely unmanaged fee-for-service reimbursement*
- *Moving towards a unified data platform on patient activity, even if there are multiple health financing / health coverage schemes*
- *Avoiding open-ended commitments in provider payment arrangements*

- Define specific actions to reform purchasing arrangements based on the identified causes of under-performance and guided by the principles above, for example by adding a small payment to primary care units that achieve defined immunization targets. More generally, the aim is to develop more active / strategic purchasing of health services through the improved use of information on population health needs and provider performance.
- Also analyse provider payment mechanisms from the provider perspective, for example how different financial flows (from one or multiple schemes or funding sources) affect the incentive environment for service providers. Based on this perspective, weigh the options for reforms to existing provider payment mechanisms and the mix of purchasing agencies in terms of the likely impact. Changes in the incentive environment should support improvements in the quality, effectiveness, equity, and efficiency of services, as well as the management of expenditure growth.
- Given that all single payment mechanisms create positive and negative incentives, identify the combination of measures (e.g. mixed payment systems, administrative control/utilization review mechanisms) to mitigate potentially negative implications (e.g. over- or under-use of services).
- Consider any complementary changes needed to make purchasing more strategic, such as reforms to the information systems used for provider payment, greater managerial autonomy for providers over their internal resources, and public financial management (PFM) reforms to institutionalize within national budget processes, including better alignment of payment incentives across schemes.

- Options for reforms to governance arrangements for existing or newly proposed purchasing agencies should be assessed in terms of whether they improve accountability, and promote a system which learns and adapts to evidence and changing circumstances, for example in terms of the mix of provider payment methods used.
- Consider the potential to contract non-state providers with public funds and the mechanisms needed to hold them accountable.
- For all proposed reforms, their link with the identified causes of problems arising from current purchasing arrangements in the country should be clearly stated, as should the expected impact of the reforms.

3.7. BENEFIT DESIGN, RATIONING, AND THE BASIS FOR ENTITLEMENT

GUIDING PRINCIPLES

- *Improving the population's awareness of their entitlements and obligations (who is entitled to what services, and what, if anything, are they meant to pay at the point of use)*
- *Aligning promised benefits, or entitlements, with provider payment mechanisms*

- Proposed reforms should address the identified causes of under-performance in terms of existing entitlements and obligations, and be guided by the principles above. An example might be the elimination of user fees for pregnant women and children under five in rural health centres, and the widespread publicizing of these entitlements, to address evidence of underutilization due to expected cost, and/or evidence of financial protection problems.
- Consider reforms to existing population entitlements to services (or "guarantees" or "benefits"), the basis for entitlement to these benefits, the conditions attached to those entitlements (e.g. adhering to a referral system), and means of rationing access to the defined services (e.g. patient cost-sharing through user fees or co-payments), in order to support progress towards universal health coverage. This may include making some or all services entitlements more explicit.
- Changes in the basis for benefit entitlements may include a shift towards entitlement based on contributions (made either by, or on behalf of, a "covered" person), or conversely towards entitlement derived from some other basis such as citizenship, residence, income/poverty status.
- Given that no system can provide everything to everyone, clearly define, explain and communicate proposed changes to rationing mechanisms such as patient cost-sharing, referral requirements, waiting lists, and service exclusions. Furthermore, clearly describe and explain the criteria used for inclusion or exclusion of services, such as cost-effectiveness analysis, equity in service use, and/or financial protection for very high cost but life-saving interventions.
- The process (including responsibilities) for periodic (e.g. annual) review and revision should also be specified in the strategy. For example, any proposed change to benefits may be subject to both cost-effectiveness and budgetary impact analysis, and may include a process for broader stakeholder input.
- Weigh the pros and cons of *targeting* benefits to certain population groups

(e.g. the poor) or for certain services (e.g. communicable disease treatment) or facilities (e.g. remote/rural clinics). Concretely, this often means considering the trade-off between the accuracy of the targeting mechanism and the administrative feasibility and cost of the targeting process. Explore possibilities to take advantage of any existing targeting mechanisms which exist in other social sectors.

3.8. ALIGNMENT ISSUES

- Central to the success of a health financing strategy is that it is not focused **only** on one issue such as raising revenues, nor does it consider each function and policy in isolation from the others. Hence, each of the above aspects of the strategy needs to be considered in terms of how it fits, or is aligned with the others, in other words "the pieces need putting back together". Examples include:[10]
  - *Aligning revenues with the benefit package* i.e. ensuring adequate funds to deliver statutory entitlements / benefits to avoid false promises. Signs of misalignment include extensive unofficial payments, delays or non-payment of salaries, shortages of other supplies.
  - *Aligning changes in promised benefits with purchasing*. Even with a good analysis of the budgetary implications of a proposed expansion of benefits, the promised expansion is unlikely to be realized without explicit mechanisms to pay providers and hold them accountable for delivery of these services. Such a link between purchasing and benefits is explicit in well-designed performance-based funding reforms.
- To convey the overall health financing reform strategy and the "fit" of the different aspects of the reform together, it can be useful to create a diagram of the flow of funds under the proposed reform, from the sources through the pooling and purchasing intermediaries and ultimately to providers. Within this, the allocation criteria and provider payment mechanisms can be identified. Another useful visual aid is to map the proposed organization of the health financing functions (the agency or agencies responsible for implementing each function) and the coverage arrangement(s) for the population. Taken together, the flow-of-funds and function-coverage maps provide a useful overview of health financing arrangements. Comparing this to similar charts for the existing system (see 1b above) is a good way to depict the proposed health financing reform.

10 For more examples of key alignment issues, see pp 389-396 of: Kutzin, J, C Cashin, M Jakab, A Fidler, N Menabde (2010). "Implementing health financing reform in CE/EECCA countries: synthesis and lessons learned." In Kutzin, J, C Cashin, M Jakab, eds. *Implementing Health Financing Reform: Lessons from Countries in Transition.* Copenhagen, Denmark: World Health Organization, on behalf of the European Observatory on Health Systems and Policies.

SECTION 3:

GOVERNANCE, EVALUATION AND MONITORING, CAPACITY BUILDING

3.9. GOVERNANCE & IMPLEMENTATION ARRANGEMENTS

The strategy should outline any changes which are recommended to health financing governance arrangements, including, for example (alternatively, these may be included as part of the reforms described in Section 2):

- Changes in the roles of institutions at both central and decentralized levels,
- Any changes to laws and regulations which may be needed to support the reforms outlined above, including the strengthening of regulatory capacity to manage the market of either/both service providers and insurers.
- Actions to improve transparency and accountability in the sector, including greater beneficiary participation and awareness.
- Improving public financial management rules and systems so that resources flow reliably and in a timely way, can be used effectively, are aligned with the proposed health financing and particularly the provider payment reforms, and are properly accounted for, reported upon, and monitored.
- The strategy should also identify next steps and complementary actions to enhance the probability of effective implementation (for the strategy, this is just to identify the next steps, not to implement them). For example, these steps might include:
  - Developing an implementation plan for the health financing strategy, including the sequencing of the reforms.
  - Public awareness-raising and communications to ensure the changes are well understood and supported by all key actors.
  - Conducting a stakeholder analysis to identify potential political obstacles as well as opportunities to move to implementation, as well as other work to identify risks and then to develop strategies to reduce or mitigate them.

3.10. EVALUATION PLAN AND MONITORING

An initial evaluation plan should be derived from the strategy with the aims of learning from the implementation process, ensuring public accountability, and enabling "mid-course corrections" to implementation. This should not be designed as a one-off exercise but rather as concurrent research that accompanies the implementation process.

- evaluation is more than just tracking indicators; it consists of applied policy research designed to understand the effects of implemented reforms, the extent to which reforms are working, and why.
- a health financing strategy should be built on a set of hypotheses that if the proposed reforms are implemented, the identified causes of underperformance will be at least partially addressed; the evaluation plan should follow directly from these hypotheses at the core of the strategy. If it becomes clear that there is no plausible link between the reform in the strategy and the causes of underperformance, then the strategy needs revisiting.

- both qualitative and quantitative approaches to evaluation should be considered. In general, statistically representative quantitative analysis takes longer to produce, and given the importance of timing particularly in the early stages of implementation when new reforms may come under pressure to show impact; relevant and timely information is also important to inform rapid adjustments in implementation, for example if there are unintended consequences.
- proposed methods and responsibilities for the evaluation research should be included in the plan. This would indicate, for example, whether evaluation would be conducted in-house by a dedicated unit of the Ministry of Health or would be commissioned externally from local consultants or independent institutions for example.
- plans for public reporting (e.g. to Parliament and civil society) on lessons learned from the evaluation studies should also be included.

The health financing strategy should also specify indicators for each of the objectives and reforms, that will be tracked over time to monitor progress. These should include:

- objectively verifiable, quantitative indicators for each of the objectives in the strategy (linked to the UHC goals and intermediate objectives), to be assessed on a routine basis (annually, but keeping in mind that the effect of certain interventions may not be observed for several years). Targets for these indicators should also be defined.
- qualitative indicators of reform implementation should also be identified where relevant. Together with quantitative indicators these will help to track implementation progress.
- the source of information for each indicator and how frequently new data becomes available should also be noted, as should responsibilities for collection to ensure collaboration between the national statistical agency and those managing the health information system.

3.11. BUILDING CAPACITY

There may also be specific capacity building needs which are required to make the implementation successful, and these should be identified in the strategy. Common examples are:

- Strategies to strengthen capacity for health financing policy analysis,
- Skills in applied policy research (evaluation), as well as skills and systems for monitoring.
- Institutional development priorities, for example, building the skills required for the effective purchasing of health services.
- Links with other capacity building plans, such as the human resources for health strategy.

3.12. CONCLUSIONS

This section summarises the main elements of the strategy, and how each aims to address the problems identified, and hence how the strategy will contribute to making progress towards UHC goals.

4. UHC & HEALTH FINANCING: UNDERLYING CONCEPTS & CONTEXT

This section provides broader reflections on the different elements of a health financing strategy outlined in Chapter 3.

SECTION 1:
BACKGROUND, DIAGNOSIS AND OBJECTIVES

4.1. HOW HEALTH FINANCING CAN SUPPORT PROGRESS TOWARDS UHC – INTERMEDIATE OBJECTIVES AND FINAL COVERAGE GOALS

The ideas and approach presented in this Reference Guide are rooted in WHO's health financing policy framework reviewed earlier and described in more detail elsewhere.[11,12] First, specific policy goals are embedded within the definition of UHC, namely that all people receive the services they need (referred to in the diagram as utilization relative to health needs, and elsewhere as equity in service use), financial protection and equity in finance, and service quality.

The core question for a health financing strategy (and indeed, an overall health system reform strategy) is this: how and within what timeframe should a country change its health financing arrangements (i.e. policies around revenue raising, pooling, purchasing, benefit design, and overall governance of the system) in order to influence progress towards the final coverage goals of UHC? Reforms to health financing policy can influence these goals directly, but they also exercise influence indirectly, through the intermediate objectives of equity in resource distribution, efficiency, and transparency and accountability as shown in Figure 3.

There is no model or blueprint for the design of health financing reforms in order to support UHC. However, the final coverage goals and intermediate objectives of UHC, individually or combined, should guide and facilitate health financing reforms, while the principles described in Box 1provide evidence-informed "signposts" to steer reforms in a direction consistent with progress towards UHC.

4.2. KEY CONTEXTUAL FACTORS

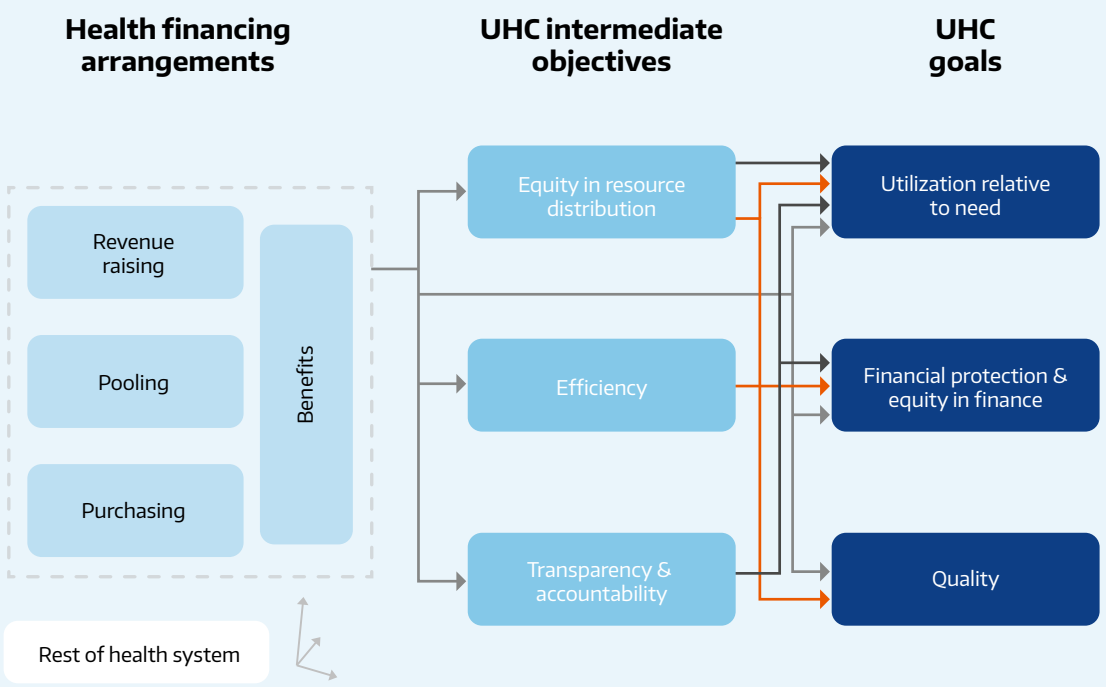
Health financing reforms involve the modification of health financing arrangements and architecture, and the flow of funds from revenue sources to beneficiaries. Accordingly, a health financing strategy needs to review existing arrangements in order to identify both the major problems, as well as interventions to address them. At the same time, the feasibility

11 Kutzin, J (2013). "Health financing for universal coverage and health system performance: concepts and implications for policy." *Bulletin of the World Health Organization* 91(8):602-611. http://www.who.int/bulletin/volumes/91/8/12-113985/en/

12 Kutzin, J (2001). "A descriptive framework for country-level analysis of health care financing arrangements." Health Policy 56(3):171-204.

WE HAVE USED THE SOURCEFILES YOU SEND TO THE FIGURES - THE ARROWS AND TEXT ARE A BIT DIFFERENT FROM WORD-DOC. WHICH ONE SHOULD BE USED?

Figure 3: Health financing policy and UHC: pathways



of implementing certain measures, as well as what health financing reforms can attain, will depend on a number of contextual factors that emanate from outside the health system. Many of these are country specific (e.g. the nature of the political system, population density) but some are relatively generic in the sense that they are factors that emerge in nearly all countries, and should be part of the situation analysis. In particular, three of these are identified in WHO's Health Financing Country Diagnostic:[13] fiscal capacity, the structure of public administration, and public sector financial management rules. Main issues for each are summarized below.

- **Fiscal capacity:** the capacity of government to increase public spending on health depends both the priority given to health in resource allocation decisions, and the overall level of public spending. The first of these can be influenced by the health authorities through their ability to "make the case" for a greater share of available public funds. The second is contextual, depending on issues such as national income, tax capacity, debt and budget deficits. Those involved in developing the health financing strategy need to engage closely with the national Finance authorities to ensure that scenarios for public spending on health included in the strategy are consistent with the overall outlook for public spending for

13 McIntyre, D and J Kutzin (2016). Health financing country diagnostic: a foundation for national strategy development. WHO/HIS/HGF/Technical Report/16.1. Geneva: World Health Organization. http://www.who.int/health_financing/tools/diagnostic

the government as a whole,[14] and that any proposals for new revenue raising mechanisms are agreed with Finance.

While the Ministry of Health is not responsible for overall tax, revenue and borrowing policies of the government, a number of resources exist that can help those working on the health financing strategy engage more effectively with their colleagues in Finance.[15,16,17,18,19] This dialog is essential, because enhancing fiscal capacity is likely to be a requirement in many contexts to implement sustainable health financing reforms to make progress towards UHC.

- **Structure of public administration:** all countries distribute decision-making and implementation responsibilities across levels of government to varying degrees. The extent of decentralization or federalism, and the types of decisions and actions to which it applies, again emanate from outside the sector but have important implications for health financing reforms. For example, where most public revenues are raised centrally but authority to spend is with states or provinces, an important issue for health financing – and policies related to pooling in particular – relates to the mechanism used to allocate these revenues to the sub-national spending units. More generally for a health financing strategy, it is essential to have a good understanding of precisely what decisions and actions are taken at what level of public administration and what the consequences of this context are for health policy objectives such as equity in the level of public spending per capita by region. Even if the health sector cannot directly influence such government-wide decisions, understanding the rules can help in the design of sector-specific policies to mitigate some of the consequences, and more generally to ensure that the health financing reform proposal can be implemented within the existing system of public administration.

- **Public sector financial management (PFM):** the successful implementation of health financing reforms will be affected by the organization and management of public financing at national and sub-national levels. Proposed reforms need to be consistent with existing public financing laws and regulations or may need to initiate changes in public financial management, for example the degree of financial autonomy given to local governments or health facilities. A major challenge in many settings is the alignment of reforms to move towards output-oriented strategic purchasing

14 Ideally, these are available domestically from the Finance Ministry and incorporated into a multi-year planning document, such as a Medium Term Expenditure or Fiscal Framework. There are also relevant external data sources that provide projections for key economic variables including GDP and government revenues, notably the World Economic Outlook database of the International Monetary Fund (IMF) (https://www.imf.org/external/pubs/ft/weo/2016/02/weodata/weoselgr.aspx) or the IMF's most recent country-specific Article IV Consultation reports (http://www.imf.org/external/pubs/cat/shortres.aspx?TITLE=&auth_ed=&subject=Article+IV+consultation+reports&ser_note=All&datecrit=During&YEAR=&Lang_F=All).

15 Durairaj V, Evans DB. 2010. Fiscal space for health in resource-poor countries. Geneva: World Health Organization, World Health Report 2010, Background Paper No. 41.

16 Heller P. 2006. The Prospect of Creating 'Fiscal Space' for the Health Sector. Health Policy and Planning 21(2): 75-79.

17 Tandon A. Cashin Ch. 2010. Assessing public expenditure on health from a fiscal space perspective. Health, Nutrition and Population Discussion paper. World Bank.

18 Clements BJ, Coady D, Gupta S. 2012. The economics of Public Health Reform in Advanced and Emerging Economies. Washington DC. International Monetary Fund.

19 Barroy, H, S Sparkes, E Dale (2016). Assessing fiscal space for health expansion in low- and middle-income countries: a review of the evidence. WHO/HIS/HGF/HFWorking Paper/16.3. Geneva: World Health Organization. http://www.who.int/health_financing/documents/assessing-fiscal-space/

where PFM rules on budget formation and expenditure control have long led to input-based line-item budgets with very limited autonomy for public providers and limited scope to contract non-state providers with public funds. In other settings, low levels of budget execution constrain public spending more than even low levels of budget allocations. As with fiscal capacity, close engagement between health and finance authorities is essential to address PFM bottlenecks that may affect all of government but raise particular challenges for the health sector.[20,21,22,23]

4.3. DEVELOPING COUNTRY-SPECIFIC OBJECTIVES

Once a diagnosis of health system performance has been conducted, the next step is to formulate a set of **country-specific objectives** which reflect the performance issues facing a particular country's health system. This step is critical in the process of developing a health financing strategy, as it forms the basis for defining the detailed policy responses which address identified performance problems and their underlying causes. The clear connection between the diagnosis of problems, the formulation of specific priority objectives, and the subsequent definition of detailed policies, is the key to making improvements in overall health system performance. Ideally, the objectives should be sufficiently specific so that they are **measurable** and hence can be tracked as part of monitoring progress over time.

The UHC goals and intermediate objectives sit at a broader level, and remain the same across countries, and over time. When used as categories or a checklist to ensure completeness, they can facilitate the development of country-specific objectives. Thus, for example, a country-specific objective may be to raise the level of per capita outpatient service use in rural areas to within 10% of the level that exists in urban areas over a five-year period. This fits within the generic UHC goal of improving equity in service use, while relating to a country-specific manifestation of a problem on this goal – in this case, geographic inequities.

An explanation of *why* the specific objectives in a country's strategy have been selected, and *how* by addressing them health system performance is expected to improve, is key to making the strategy more robust and easier to communicate. By including evidence from the health system performance diagnosis, or from international experience, the strategy will be more rigorous and convincing. Similarly, the identification of potential risks and adverse consequences will also strengthen the strategy, especially if ideas are included about how to mitigate such problems if and when they arise.

20 World Health Organization (2016): Public Financing for Health in African: from Abuja to the SDGs. Joint report of the Health Systems Governance and Financing Department WHO Headquarters and the Health Systems Strengthening Department of the WHO Regional Office for Africa. WHO/HIS/HGF/Tech.Report/16.2. Geneva: World Health Organization. http://www.who.int/health_financing/documents/public-financing-africa/.

21 Andrews, M, M Cangiano, N Cole, P de Renzio, P Krause, R Seligmann (2014). This is PFM. CID Working Paper No.285. Cambridge, Massachusetts: Center for International Development at Harvard University. https://www.hks.harvard.edu/centers/cid/publications/faculty-working-papers/this-is-pfm

22 WHO PFM and health webpage with descriptions and links: http://www.who.int/health_financing/topics/public-financial-management/

23 World Bank PFM web page with descriptions and links: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPUBLICSECTORANDGOVERNANCE/0,,contentMDK:23090543~pagePK:148956~piPK:216618~theSitePK:286305,00.html

SECTION 2:
STRATEGIC INTERVENTIONS

The next step is to define the strategic interventions which are expected to result in improvements to the health system, in line with the priority country-specific objectives identified. In the paragraphs below we discuss WHO's approach to health financing policy, the underlying concepts, and each of the health financing functions which we propose using to as the basis for defining interventions. Throughout, we discuss some of the common challenges facing countries.

4.4. REVENUE RAISING: SOURCES AND CONTRIBUTION MECHANISMS

It is important to first consider the agencies that collect revenues, the contribution methods used, and the initial sources of funding. Apart from revenues that originate from abroad (e.g. external funds from donors), and revenues deriving from natural resources[24] owned by the state (e.g. oil, gas, diamonds), the population is the ultimate source of all funds for the system, whether in the form of direct out-of-pocket payments for services, insurance contributions, or taxes that people and firms pay to their governments. However, most focus is on the revenue raising mechanisms used because this is where most of the policy, particularly equity, considerations lie. An overview of the major revenue sources and contribution mechanisms is presented in Figure 4.

The categorization of these contribution mechanisms is based on important policy distinctions, as discussed in the "revenues of financing schemes" chapter of the 2011 System of Health Accounts.[25]

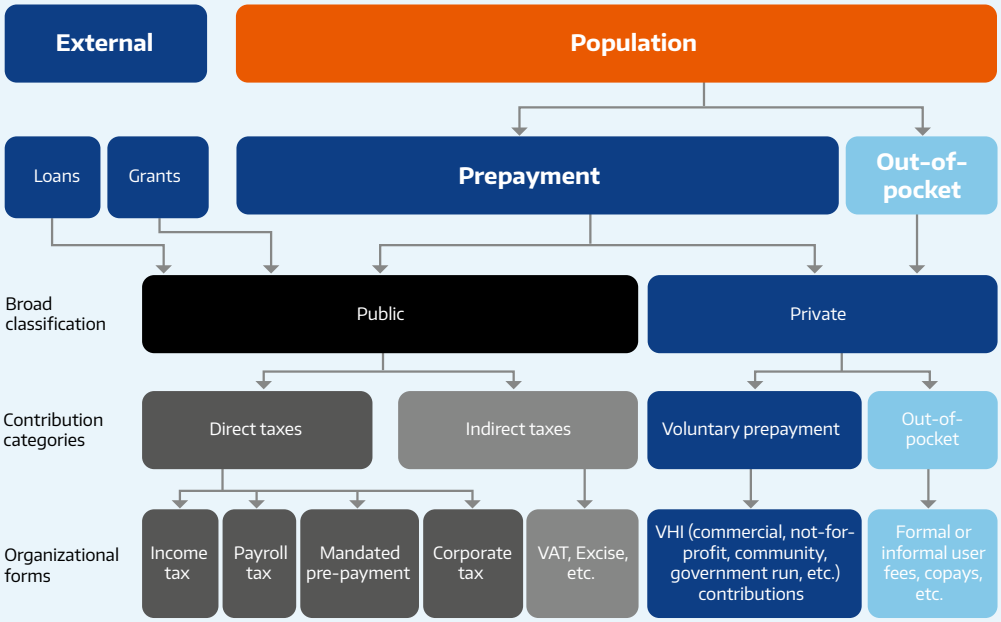
i) **Domestic versus external revenue sources:** Most countries, including most that are low- or middle-income, rely predominantly on domestic revenues, hence country specific analysis and the development of objectives and strategies needs to focus principally on the domestic financing system. However, in those (mainly low-income) countries where foreign sources are significant (including a few where these revenues are the main source for the health system), analysis and policy related to the level, flow and use of external sources should be incorporated into the strategy, including consideration of likely changes to the levels of such funding. This is a challenging task as external grants tend to be unpredictable with many donors unable to commit over longer timeframes. Reasonable assumptions based on an assessment of trends and discussions with key donors may have to be made. The analysis can also be a useful entry point for dialogue with international funding agencies.

ii) **Prepaid versus out-of-pocket revenue sources:** "Prepaid" means that the contributions that individuals make, whether public or private, are not made at the time of service use but prior to

24 Revenues derived from natural resource are not really a "contribution method" but still an important source of public funding in some countries.

25 OECD, EU, WHO. 2011a. Classification of the revenues of health financing schemes. A System of Health Accounts. 2011 Edition: 195-203.

Figure 4: Major revenue sources and contribution mechanisms



this, and typically prior to any identified need to use health services. These may take the form of various types of taxes, and either compulsory or voluntary health contributions. They are distinguished from out-of-pocket spending (OOPS) which, conversely, are made at the time of service use.

iii) **Public (compulsory) versus private (voluntary) revenue sources:** From a health financing policy perspective, it is useful to equate public with compulsory, because each is not only prepaid but mandatory and therefore not subject to the problem of adverse selection[26] which plagues voluntary health insurance markets. "Compulsory" in this sense does not mean that individuals are obliged to make a direct contribution for health insurance. It merely signifies that the revenue source is either what is commonly recognized as a tax (e.g. income tax, value-added tax) or a mandatory contribution (e.g. a requirement to buy health insurance).[27] Voluntary sources may be prepaid (voluntary purchase of health insurance) or direct payments at the point of use (OOPS).

Taxation is a broad category, and within this it is useful to make a further between "direct" and "indirect" taxes. Direct taxes are levied directly on individuals and firms, as with income tax (individual or corporate) or payroll tax (the term used by public finance

26 Akerlof, G (1970). "The market for "lemons": quality uncertainty and the market mechanism." *Quarterly Journal of Economics* 84(3):488–500.

27 It is worth noting that although a government mandate to purchase health insurance, but without defining a specific rate of contribution, is also a compulsory mechanism that is equivalent to a tax from a health policy perspective, it may not be treated as part of "fiscal space" by a country's finance authorities or the IMF.

economists for the mandatory contribution rate typically levied on employers and employees under a social health insurance arrangement). Indirect taxes are levied on the trade or consumption of goods and services, for example value-added tax (VAT), and excise taxes (e.g. on tobacco or alcohol).

Another useful policy distinction is between revenues that are *earmarked* for health and those for which the use is discretionary. For earmarked funds, their use is specified in advance of collection. For example, earmarked taxes on vehicles can generate revenues to compensate for the costs of health services associated with road accidents. The VAT levy in Ghana which supports the National Health Insurance fund is another such example. And it is worth noting that social health insurance contributions (payroll taxes) are another form of earmarked tax. Discretionary revenues do not have a fixed use and go into a general government fund which is allocated annually as part of the routine budget and fiscal framework.

As noted above, **private (voluntary) sources** may be either prepaid or paid at the point of service use. Voluntary prepayments can be made to various types of insurance funds, irrespective of the ownership and management arrangements for these funds. While common forms of voluntary health insurance (VHI) are managed by private companies on either a for-profit or not-for-profit basis, there are also examples of VHI that are managed by NGOs, the members of the scheme, or communities. Indeed, there are examples of government-run and managed VHI schemes. What distinguishes voluntary prepayment is not the ownership or organizational form of the VHI fund, but rather that the decision to prepay is not mandated by government, but instead is a choice made by individuals or firms.

The other mechanism for private, voluntary contribution of health revenues is *out-of-pocket spending* made at the point of service. These OOPS can come in many forms and the following categorization may be useful:

- **Official patient** cost-sharing, sometimes called user fees, co-payments, coinsurance, or deductibles. These are payments required by the terms of a public or private financing scheme.[28]
- **Informal payments**, which are payments made at the time of (or immediately prior to) service use and are beyond the amounts required under official cost-sharing arrangements. These include so-called "under-the-table" payments to health workers as well as payments for (or the purchase of) inputs needed for patient care that should have been provided by the system, such as medicines, surgical supplies, provision of food, and direct nursing care by family members.
- **"Pure private"** out-of-pocket spending for services and inputs for which there is no prepayment. Examples include payment for services of a private doctor or the purchase of medicines, so long as these are not covered by any prepayment mechanism.

28 These are considered voluntary even when health service users are required to pay them under the rules of a particular health financing arrangement.. The distinction with a payroll tax is that such a tax is codified in law and must be paid by all required to do so (e.g. all former sector workers and their employers). A co-payment or user fee may be part of a law, but if someone does not use the services, they do not have to pay.

The role of domestic private sources, such as user fees and voluntary prepayments, also needs to be considered, both in terms of their likely impact on future revenues and their consequences for making progress towards policy objectives.

The distinction of funding sources and contribution mechanisms along these dimensions is useful for characterizing how the health system is funded. Different mechanisms have well-documented implications for health policy objectives.[29,30] Decisions about changes to revenue raising mechanisms (expansion, contraction or introduction of new sources) should be supported by projections of how current public revenues sources are likely to evolve over the next 5-10 years (see discussion under fiscal capacity in the previous section), together with estimates of evolving health sector needs over this period. If a costed health sector plan or a Medium Term Expenditure Framework (MTEF) is available, this can form the basis for an estimate of future needs. The process will necessarily be iterative, in order to reconcile revenue scenarios with estimates of need. The temptation to reduce the process to an accounting "gap-filling" exercise should be avoided however, as this can mistakenly convey the message that the health financing problems will be resolved simply by providing a target level of revenues, while the evidence suggests that countries with similar levels of health spending attain different levels of progress towards UHC.[31] A narrow focus on meeting expenditure targets is not only misguided but also risks diverting attention away from critical reforms in pooling and purchasing that are likely to be of much greater importance for building the system in the longer run.

Overall, it will be important to consider how much additional revenue will result from new sources, as well as judging them against wider criteria such as efficiency i.e. how much the funds cost to collect, their stability over time (an important feature for planning purposes), how equitable they are i.e. whether they likely to fall most heavily on richer or poorer households, and whether they are likely to have any adverse consequences (e.g. distorting the labour market) or positive consequences (e.g. reducing consumption of harmful products like tobacco and alcohol).

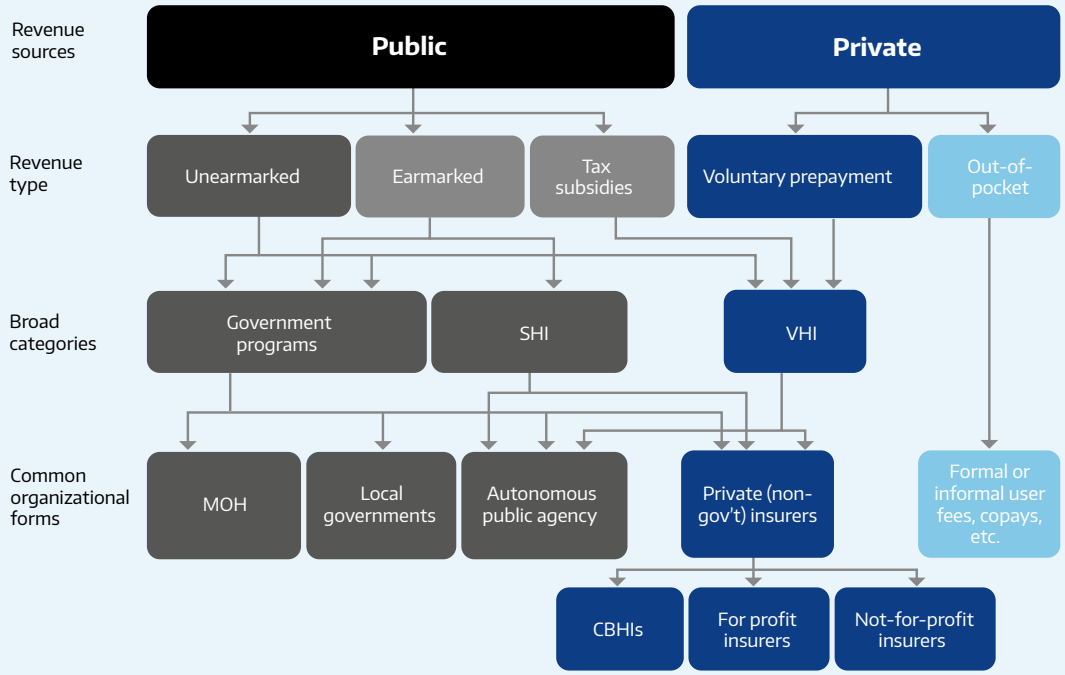
Feasibility is also an important consideration when proposing new revenue sources in a health financing strategy. As noted in the earlier section on fiscal context, the Health Ministry is not a final decision-maker on such issues, and hence engagement with key stakeholders such as the Ministry of Finance or the Customs and Revenue body, is essential to assess their willingness to introduce new funding sources such as earmarked taxes? And any analysis of the revenue potential of a new earmarked tax (as should be balanced by the recognition that the revenues may not be purely additive; government may decide to reduce some amount of discretionary revenues allocated to the health sector in response

29 McIntyre, D and J Kutzin (2011). "Revenue collection and pooling arrangements in financing." In Smith, RD and K Hanson, eds. *Health Systems in Low and Middle Income Countries: an Economic and Policy Perspective*. Pp 77-101. Oxford, UK: Oxford University Press.

30 Jowett, M and J Kutzin (2015). Raising revenues for health in support of UHC: strategic issues for policy makers. Health Financing Policy Brief No.1. WHO/HIS/HGF/Policy Brief/15.1. Geneva: World Health Organization. http://www.who.int/health_financing/documents/revenue_raising/

31 Jowett, M, M Petro Brunal, G Flores, J Cylus (2016). Spending targets for health: no magic number. WHO/HIS/HGF/HFWorking Paper/16.1. Geneva: World Health Organization. http://www.who.int/health_financing/documents/no-magic-number/.

Figure 5: Common revenue flows from sources to pooling entities



to the new earmarked source.[32] Hence, it is essential that even where a strategy includes a new revenue source, the focus of attention (and engagement with the national finance authorities) remains on the "big picture" – the overall level of public financing that the health sector can expect.

The process of developing the health financing strategy should include an options appraisal process which takes all of these considerations into account.

4.5. POOLING REVENUES

In its most generic sense, pooling of funds refers to the accumulation of prepaid revenues on behalf of a population. Funds for health services are pooled by a wide variety of public and private agencies, including national ministries of health, decentralized arms of ministries of health, local governments, social health insurance funds, private for-profit and not-for-profit insurance funds, NGOs, and community organizations. An overview of revenue pooling is provided in Figure 5.

Figure 5 illustrates that the distinction between public and private revenue sources is not necessarily the same as between public and private pooling agencies; similarly, social health insurance agencies may (and often do) receive funds from general tax revenues in addition to payroll tax contributions.

32 For more information on earmaking revenues for health, see http://www.who.int/health_financing/topics/earmarking-revenues-for-health/.

Indeed, there is a large and growing number of countries in which the direct link between the revenue raising mechanism (for example making a payroll contribution), and the nature of the pooling arrangement has been broken,[33,34] often playing a central role in efforts to make progress towards UHC.[35] Examples also exist of government relying on private agencies to manage a publicly funded resource pool and, conversely, examples of voluntary prepayment schemes managed by government agencies. Such "cross-flows" illustrate the range of reform experiences and are a prime reason why it is important for the development of health financing policy to distinguish between revenue raising and pooling.[36]

In addition to the organizational and flow aspects depicted in Figure 5, other critical aspects of pooling need to be considered in policy analysis and design:

- Compulsory/automatic versus voluntary participation/coverage in a pool
- Single or multiple pools
- Territorially distinct or overlapping
- Competition versus monopoly
- Competition for clients versus competition for contracts
- Choice (by individual or firm) or assignment to a pool
- Pools covering a comprehensive package or different pools for different services
- Existence (or not) of a redistribution mechanism across pools

As suggested by this extensive list of features, pooling can be quite complex with many possible combinations. Taken together, these characterize what can be called the market structure of pooling in a country. A few examples are provided here to illustrate:

- **Canada:** a single compulsory, territorially distinct funding pool exists in each province covering the cost of a comprehensive benefit package for the entire population.
- **Netherlands:** participation is compulsory, the population can choose among competing private insurers as their provider of the defined comprehensive package, and also opt to buy supplementary[37] health insurance on a voluntary basis. A sophisticated redistribution mechanism exists across the pools.
- **India:** a government-funded health insurance scheme known as "RSBY" is designed for households below a defined income threshold, who are entitled to enrol and receive insurance coverage for inpatient care with no patient cost-sharing up to a maximum annual threshold of expenditures incurred by the scheme on behalf of each covered person. Under this program, private insurers compete for a government contract to be the pooling agency for either entire states or defined geographic territories within a state.

33 Mathauer, I, M Theisling, B Mathivet, I Vilcu (2016). "State budget transfers to health insurance funds: extending coverage in low- and middle-income countries of the WHO European Region." International Journal for Equity in Health 15:57 DOI: 10.1186/s12939-016-0321-0.

34 Vilcu, I, L Probst, D Bayarsaikhan, I Mathauer (2016). "Subsidized health insurance coverage of people in the informal sector and vulnerable population groups: trends in institutional design in Asia." International Journal for Equity in Health 15:165 DOI: 10.1186/s12939-016-0436-3.

35 Lagomarsino, G, A Garabrant, A Adyas, R Muga, N Otoo (2012). Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *The Lancet* 380(9845):933-943.

36 This is also why the classic historical models of health financing, Beveridge and Bismarck, are of little technical value in health financing policy design.

37 Insurance that covers either services or providers not included in the mandatory system.

- **Rwanda:** in the "community-based health insurance" (CBHI) system participation is compulsory. Pools are organized in territorially distinct sub-districts to which the local population is assigned and which are managed by the local community. Redistribution mechanisms mean that funds flow between pools within a district, between districts, and from the national level, as well as from both private and social health insurance funds into the national CBHI pool.
- **Kyrgyzstan:** coverage is automatic for the entire population, leading to a national pool managed by an autonomous public entity called the Mandatory Health Insurance Fund (MHIF). The MHIF also manages a separate, contributory-based pool that is compulsory for certain population groups, providing complementary benefits in the form of reduced co-payments and an outpatient drug package.

Agencies that redistribute funds between pools (e.g. distributing the "premium income" of insurance funds, or distributing central budget transfers across provinces or districts) also provide a pooling function. As with contribution mechanisms, the ways in which funds are pooled have implications for policy objectives. Therefore, understanding pooling arrangements within a health financing system is essential for a good analysis and consideration of policy options.

4.6. PURCHASING SERVICES

Purchasing refers to the allocation of financial resources to health service providers. Three important considerations for the analysis of a country's purchasing arrangements are:

- Provider payment mechanisms
- Market structure for purchasing
- Organizational arrangements between purchasers and providers.

Provider payment mechanisms: The way that providers are paid creates incentives that influence their behaviour. Several types of payment mechanisms (or methods) exist, and often co-exist within the same system or indeed as part of an overall payment mechanism. Important dimensions of provider payment mechanisms include:

- Passive versus active/strategic purchasing
- Payment rates determined before or after the use of services
- Prospective versus retrospective payment of providers
- Existence and composition of complementary administrative mechanisms

Given the definition of purchasing used here, what is sometimes called active or, increasingly, **strategic purchasing** can be defined as the transfer of revenues to providers based on *information* on either the health needs of the population served and/or the performance of the providers. Passive purchasing involves simply transferring the resources to the providers without a consideration of such information. This is not an "all-or-nothing" proposition as there are many examples of arrangements that combine a passive mechanism (e.g. providing a budget or salary driven by historical norms) with a strategic element (e.g. an additional payment for providing high priority services such as attended deliveries or meeting defined targets for childhood immunization or cervical cancer screening). Another way of thinking about what constitutes a strategic approach to purchasing is that there are *mechanisms*

to hold providers accountable for their activity or results associated with the payments that they receive.

Provider payment mechanisms can be characterized by both when payment rates are determined and when providers are actually paid. In most cases, payment rates are prospectively determined by government or a purchasing agency, but there are cases in which providers determine the price for their services and the purchaser simply pays all or part of this (as occurs in many health insurance schemes in the USA, for example). Most systems use some type of prospectively determined mechanism but with important differences in the timing and units of service covered by the payment methods.

Common prospective provider payment methods include:

- Line item budgets
- Global budgets
- Capitation
- Salaries

Common retrospective provider payment methods include:

- Fee-for-service
- Case-based

Behind these broad categories can be significant variation in how payment rates are determined and provider payment mechanisms implemented. There is no clear mapping between these categories or the extent to which they constitute passive or active purchasing. For example, a line item or global budget for a hospital determined solely by the number of beds in the hospital, or solely on the basis of last year's budget plus (or minus) an across-the-board increase (decrease), would be an example of passive purchasing. On the other hand, a budget that is determined by the previous year's activity and case mix (e.g. a diagnosis-related groups (DRG)-weighted budget) takes advantage of data on provider activity and severity of cases treated, and is thus more "strategic". Similarly, reimbursing providers for every service they provide without consideration of either the quality or necessity of those services is an example of passive payment; paying fee-for-service for well-defined, high priority services (as in many examples of "results-based financing" or "pay for performance") is, on the other hand, an example of active purchasing. Thus, at the extremes of both prospective and retrospective methods are passive methods; historical (and often rigid) budgets with the amounts determined by input norms, and unmanaged, open-ended fee-for service reimbursement of whatever activity providers report.

Within **retrospective provider payment methods**, the unit of service to which the payment applies is important. For inpatient services many countries use case-based payment, usually on the basis of some variant of DRGs. This is distinguished from paying for each service provided individually (fee-for-service), or "in-between" methods such as payment per hospital day. A key distinguishing characteristic of these methods is the extent to which the unit of service for which providers are reimbursed is "bundled". For example, reimbursement for each service provided represents an unbundled payment mechanism, whilst paying a hospital per inpatient day or per admission represent increasingly bundled mechanisms. In general, the greater the extent of bundling the more financial risk is transferred from the purchaser to the provider.

In terms of the incentives generated by different payment methods, prospective methods tend to be good for expenditure control (for the purchaser) but not for productivity or responsiveness to patients. Conversely, retrospective methods can increase responsiveness to service users but encourage providers to generate more services, compromising cost control and potentially an increase in the fraudulent reporting of activity. Case-based reimbursement limits this to some extent by defining an amount the hospital will receive irrespective of the patient's length of stay or the inputs provided to the patient. But there remains an incentive to increase the volume of cases, and also an incentive to "skimp" on the inputs provided during each case.[38]

As a result, countries often rely on both mixed payment methods and complementary administrative mechanisms to curb the potentially harmful effects of payment incentives. These include efforts to verify the validity of provider-reported information and checks to ensure that cost-saving incentives do not harm the quality of care provided to patients. Within a health financing strategy, it should also be recognized that reform of provider payment mechanisms is not a one-time decision. Instead, processes should be incorporated for periodic review and adjustment of payment methods in order to respond to changing circumstances.[39] There is extensive reference material available to support both policy and implementation of provider payment reforms.[40,41,42]

Market structure: Similar issues to pooling arise because in most countries the same agencies that pool funds also purchase services. The consequences are different, however, and relate to the existing and possible future ways that a purchaser or purchasers can organize financial incentives for providers. Where there are multiple purchasing agencies paying a provider, each with different methods, aligning incentives to promote desirable behaviour is compromised because providers have scope to "shift costs" from one purchaser to another (as in the United States, for example).[43] In addition, where information systems for provider payment are not unified across purchasers, there is an added administrative burden placed on provider organizations, in turn contributing to inefficiency across the health system. Understanding the market structure of purchasing is hence essential to analysing the incentive environment and its influence

38 Ellis, RP (1998). "Creaming, skimping and dumping: provider competition on the intensive and extensive margins." *Journal of Health Economics* 17(5):537-555.

39 Langenbrunner, J, E Orosz, J Kutzin, M Wiley (2005). "Purchasing and paying providers." In Figueras, J, R Robinson, E Jakubowski, eds. *Purchasing to Improve Health Systems Performance*. European Observatory on Health Care Systems. Buckingham, England: Open University Press.

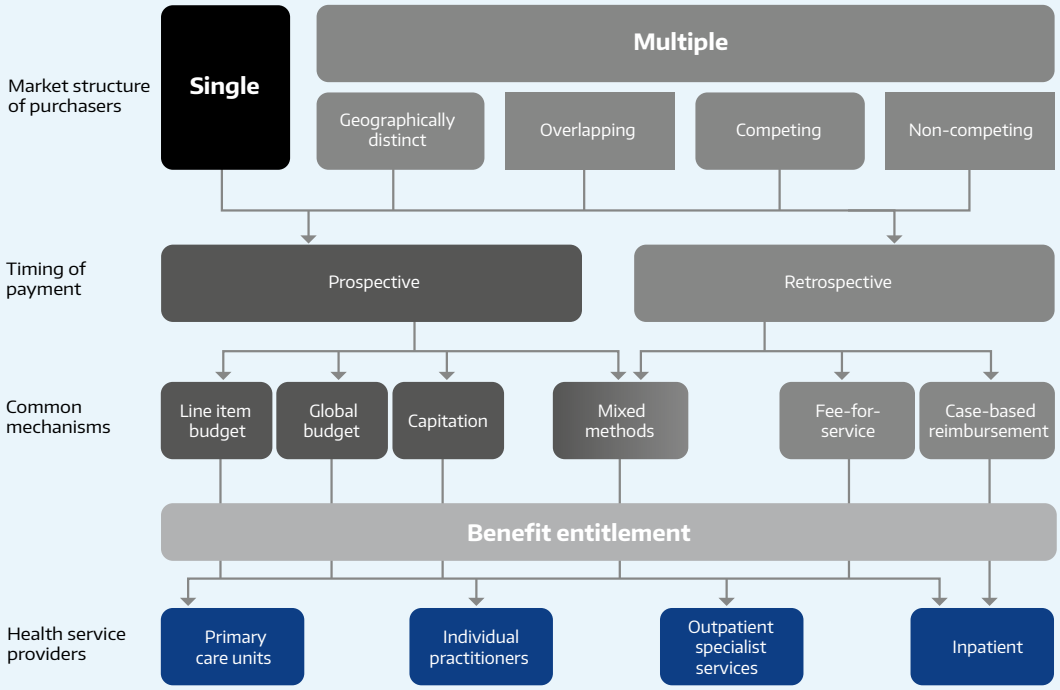
40 Cashin, C, ed. (2015). *Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage*. Joint Learning Network for Universal Health Coverage. http://www.jointlearningnetwork.org/resources/assessing-health-provider-payment-systems-a-practical-guide-for-countries-w.

41 Langenbrunner, JC, C Cashin, S O'Dougherty (2009). *Designing and Implementing Health Care Provider Payment Systems: How-To Manuals*. Washington, DC: The World Bank. https://openknowledge.worldbank.org/handle/10986/13806.

42 Özaltın, A, and C Cashin, eds. (2014). *Costing of Health Services for Provider Payment: A Practical Manual Based on Country Costing Challenges, Trade-offs, and Solutions*. Joint Learning Network for Universal Health Coverage. http://www.jointlearningnetwork.org/resources/costing-of-health-services-for-provider-payment-a-practical-manual.

43 Fahs, MC (1992). Physician response to the United Mine Workers' cost-sharing program: the other side of the coin. *Health Services Research* 27(1):25-45.

Figure 6: Overview of purchasing market structure and provider payment methods



on provider behaviour.[44] Figure 6 presents an overview of purchasing, with illustrations of common types of provider payment methods and market structures of purchasing agencies.

Purchaser-provider organizational arrangements: An important question to consider is whether providers should be organizationally distinct from purchasing agencies, or should be integrated. A useful way to approach this issue is to determine the extent to which providers (in particular public providers) currently have autonomy over their internal resource allocation processes. Frequently, when both purchasers and providers are government budgetary units, autonomy is limited, and a split cannot be said to exist. In such a context, efforts to improve performance by changing provider incentives through payment reforms may fail because providers are not in a position to respond to the new incentives (e.g. make decisions on human resources). This is an example of financing and provision arrangements being misaligned; ensuring alignment is an essential part of an effective health financing strategy. Reforms to do so typically involve increased autonomy of public providers with regard to the internal management of their resources, combined with a shift in the way that they are held accountable for their performance. Experience suggests that such a reform often involves substantial legal changes to enable it to go forward.

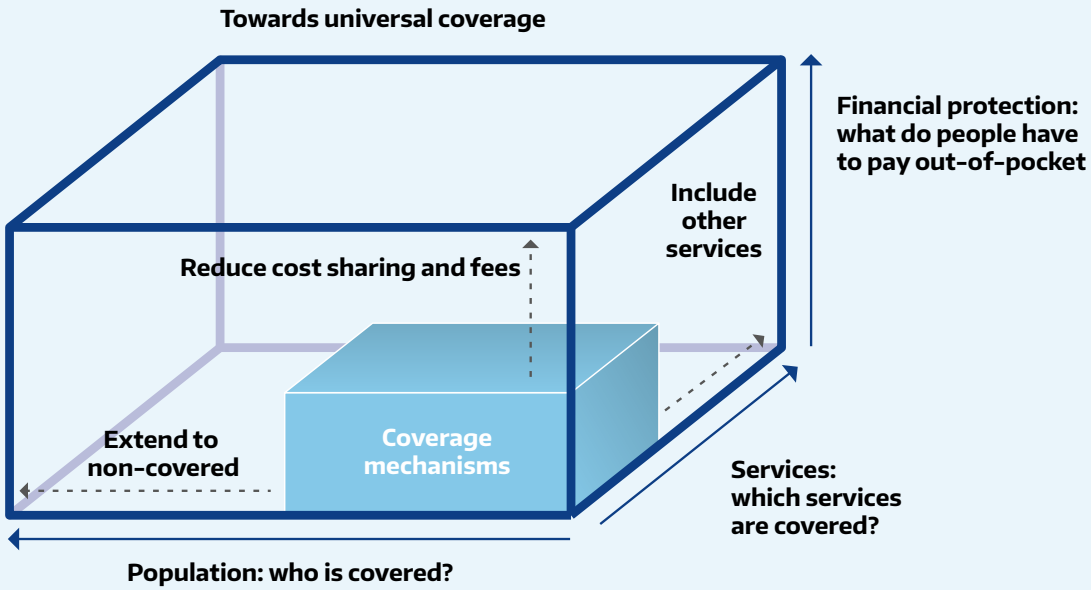
44 Another important aspect relates to the governance arrangements of (especially) public/mandatory purchasing agencies. This is discussed below in the section on governance.

4.7. BENEFIT DESIGN, RATIONING MECHANISMS, AND THE BASIS FOR ENTITLEMENT

All health financing systems involve, explicitly or implicitly, policies on benefits or entitlements together with the rules which accompany them, such as patients adhering to a gatekeeper system, public funds covering only generic medicines, or patients being required to pay a user fee for care at a health centre. Such rules *ration* health benefits to the population. *Patient cost-sharing* (often referred to as user fees or co-payments) is perhaps the most common form of explicit rationing, while non-availability of services or inputs in certain health facilities is perhaps the most common form of implicit rationing. It is worth noting that while the term "benefit package" is often associated with some form of explicit "insurance", all systems provide some type of benefits, whether implicit or explicit. Thus, the starting point for reform of a system is never the complete absence of benefits, though reforms may involve the establishment of an explicit package. Decisions on benefit design and rationing are reflected in the "cube" of population, service and financial coverage popularized in the WHR2010.

The cube highlights decisions on *what* to provide, for *whom*, and at *what out-of-pocket cost* to the patient; decisions on these issues are also decisions on what (or whom, or how much) **not** to cover. The cube, as depicted in Figure 7, is a highly simplified version of reality which aims to emphasize choices and trade-offs along these three dimensions. "Real" benefit design policy choices must account for the current situation in a country; for example inequality in population coverage (both service and financial coverage) is common and not reflected in the simplified cube. A health financing strategy which aims

Figure 7: Benefit design and rationing along the three dimensions of coverage



only to "expand the inner cube" is unlikely to address such equity challenges directly.[45]

Given that it is not feasible to provide all services and related products for everyone with public financing alone, health financing policy involves trade-offs and choices. Such choices should be informed by country-specific data and analysis, particularly evidence on the relative cost-effectiveness of different types of health service interventions, and the political priorities for population, service and cost coverage. Typically, these are choices *at the margin* i.e. changes to existing policies on population, service and financial coverage, rather than a complete overhaul of the existing arrangements.

In practice, policy choices tend to combine the three dimensions, and hence the questions have to be addressed simultaneously:

- who is covered for what services, and
- for the services covered for each person (or population group), what expenditure (if any) is required by the person at the time of use?

Framing the questions in this way, rather than as independent questions, helps to facilitate the understanding that different population groups may have different service entitlements (e.g. persons covered by different health coverage schemes), and/or that different services (for all or different population groups) may have different cost-sharing arrangements (e.g. exemptions for the poor, free services for children under 5 while others have to pay a user fee, free treatment of tuberculosis).

Benefit design and health financing policy: Policy on benefits and patient cost-sharing entails perhaps the most direct connection between the health system and the population. In this regard, it is helpful to think of the benefit package as those services, and the conditions under which they are accessed, that the purchaser(s) will pay for from pooled funds. This definition implies that what is not in the benefit package (fully or partially) must be paid for (fully or partially) by patients. This makes the link between benefits and cost-sharing explicit (i.e. partially covered services are subject to cost-sharing), as opposed to being isolated measures to ration services, raise extra revenues, or deter demand. In turn this helps to develop an integrated health financing policy framework. By including "conditions of access" in the definition, benefit design can be used as an policy instrument to help steer utilization in a desired manner (e.g. making entitlement to specialist care dependent on referral from primary care).

A range of issues arise when considering the (re)design of benefits. Attention is typically focused on deciding what services to include for coverage, along with attempts to balance technical approaches for population health needs assessment, technology assessment, the cost-effectiveness of interventions, and their budgetary implications, with the need to involve citizens and advocacy groups in the process. As with provider payment reform, benefit design is not a one-off decision, and part of policy design should include the processes, mechanisms and institutions that will be needed to make periodic (e.g. annual) adjustments to benefits over time.

Whilst such efforts are essential, in some cases the emphasis on the technical aspects of benefit package design can lead to a loss

45 Roberts, MJ, WC Hsiao, MR Reich (2015). "Disaggregating the universal coverage cube: putting equity in the picture." *Health Systems and Reform* 1(1):22-27.

of focus on the basic objectives of benefit package design and its connections to overall health financing policy. In particular, *benefit design is most closely related to the objective of promoting transparency in entitlements* (i.e. covered services and related products) *and obligations of the population* (e.g. making a co-payment, or adhering to a referral system), in other words the rules that must be followed to obtain entitlements. A prerequisite for a benefit package to be successful is therefore that people understand their entitlements and obligations, and policy design is not complete without the last step of converting the results of any technical exercise into language that the population can understand.

Basis for entitlement: A critical policy element (and choice) facing countries is the legal basis on which individuals are entitled to access publicly funded health services. The key distinction is between:

- Contributory-based entitlement i.e. entitlement to service benefits derived from a specific contribution made by or on behalf of covered individuals; and
- Non-contributory based entitlement i.e. entitlement to benefits derived from some other basis, such as citizenship, residence, or being part of a specific population group (e.g. persons below the poverty line). In such cases, the funding source is typically general government budget revenues.

The label of "insurance" is commonly applied to arrangements with contributory-based entitlement, and "social health insurance" where participation (and contribution) for specific population groups is mandatory by law. As noted above in the section on pooling, there are many examples of countries in which the government budget pays the contributions on behalf of specific population groups according to national legislation. In the Republic of Moldova in 2011, for example, transfers from general revenues on behalf of specific population groups (e.g. children/students, disabled persons, pensioners, persons receiving social support) accounted for about 55% of the revenues of the national health insurance fund.[46]

The term **"non-contributory"** refers to the basis for entitlement and should not be interpreted as implying that persons under such arrangements do not contribute to the public revenues that fund coverage. Because indirect taxes (e.g. VAT) are an important source of revenues in many countries, even persons not paying income or payroll taxes often do contribute to public revenues through their purchase of products subject to VAT. So the basis for entitlement should not be conflated with the source of revenues for the system. It merely refers to whether or not entitlement derives from a *specific direct contribution* made for that purpose, or whether it derives from some other basis.

46 Shishkin, S and M Jowett (2012). A review of health financing reforms in the Republic of Moldova. Health Financing Policy Paper 2012/1. Copenhagen, Denmark: WHO Regional Office for Europe.

SECTION 3:
GOVERNANCE, CAPACITY BUILDING, M&E

4.8. GOVERNANCE OF THE HEALTH FINANCING FUNCTIONS

While the health financing arrangements of all countries include revenue raising, pooling, purchasing, and benefit design, the organization of these responsibilities differs from country to country. A health financing strategy should consider changes within each of these, as well as the alignment of reforms across these functions and policies to ensure coherence. In addition, it also needs to consider policies that may be external to the actual functioning of those arrangements but that greatly influence how well they perform. This is the stewardship or governance (hereafter) aspect of the health system with specific application to financing policy.

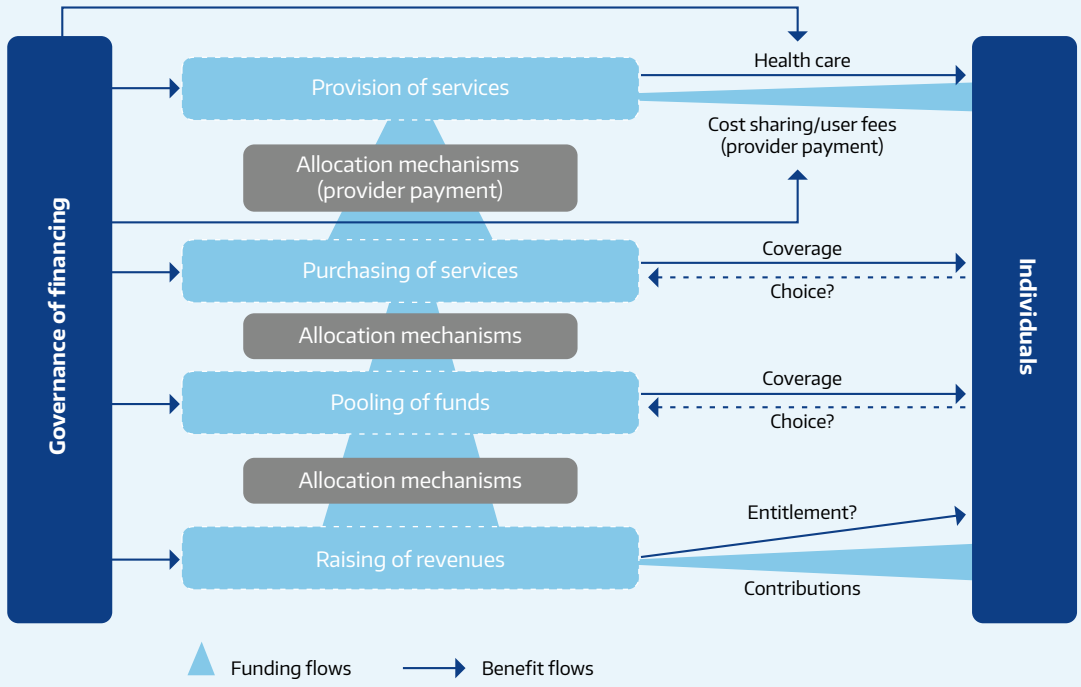
Concretely, the "governance" actions that can be considered here include *regulation, provision of information, and the arrangements to oversee* specific agencies in the health system. Some examples include:

- Regulations that prevent insurers from excluding persons on the basis of their health status
- Setting rules for risk adjustment between insurers or across geographic areas
- Requiring and establishing the conditions for a governing board of a national health insurance agency
- Requiring public reporting on the use of funds or performance of a national health service purchasing agency
- Informing persons who are exempted from user fees about their rights.
- More generally, an overall governance responsibility is policy coordination. This has to do with aligning the system with the UHC policy goals, improving coherence (or reducing contradictions) between the different aspects of the financing system, and between financing and service delivery.

Figure 8 summarizes generically health financing arrangements (the central pillar) and the different ways that the system interacts with the population. The black arrows from the "Governance of financing" rectangle refer to the actions that government may need to take to ensure that the reforms introduced to revenue raising, pooling, purchasing, and benefit design (and service provision) are aligned with defined policy objectives. The central "boxes" in the diagram (e.g. pooling) may each be seen as a market, and policy actions need to be defined to influence how those functions are performed. Concretely, the "governance" actions that can be considered here include *regulation, provision of information, and the arrangements to oversee* specific agencies in the health system. Some examples include:

- Regulations that prevent insurers from excluding persons on the basis of their health status
- Setting rules for risk adjustment between insurers or across geographic areas
- Requiring and establishing the conditions for a governing board of a national health insurance agency
- Requiring public reporting on the use of funds or performance of a national health service purchasing agency
- Informing persons who are exempted from user fees about their rights.

Figure 8: Health financing arrangements and the population[47]



– More generally, an overall governance responsibility is policy coordination. This has to do with aligning the system with the UHC policy goals, improving coherence (or reducing contradictions) between the different aspects of the financing system, and between financing and service delivery.

4.9. EVALUATION AND MONITORING PLAN

i) **Evaluation:** While monitoring and evaluation (M&E) are commonly seen as the same thing, these are separate activities which need to be clearly delineated. Much attention is given to defining indicators for monitoring; this is necessary but not sufficient. Indeed, the aim of this section of the strategy is to develop (or refine existing) mechanisms to learn from reform implementation, ensure public accountability, and to provide an "early warning system" to enable rapid adjustments to implementation that are often needed. Monitoring key indicators of performance is important for tracking progress, but monitoring alone cannot provide sufficient information to learn about the effects of the reforms. Indeed, tracking indicators over time can describe changes in progress towards UHC, but such **tracking cannot explain why** such changes occur. For that, evaluation (applied policy research) is needed.

47 Adapted from: Kutzin, J (2001). "A descriptive framework for country-level analysis of health care financing arrangements." *Health Policy* 56(3):171-204.

An evaluation plan should be an integral part of the health financing strategy. In principle, the strategy consists of a set of hypotheses based on the situation analysis and assessment of reform options. In particular, the hypothesis is that if the proposed sets of actions are implemented, the identified causes of underperformance will be (at least partially) addressed, and the country will make progress towards UHC. Thus, the evaluation plan follows directly from the content of the strategy itself.

The evaluation plan that is designed into the strategy should usually be considered initial or preliminary, because the specific methodology that will be appropriate depends critically on how implementation is to proceed. For example in Kyrgyzstan, reforms were phased in over a period of years on a geographic basis. This meant that in year one, reforms were implemented in 2 of the country's 7 regions. Two more regions were added the next year, and 3 more the next. This allowed for an evaluation design that could take advantage of this phasing, enabling a comparison of reforming with non-reforming regions in the first few years. Where the implementation strategy is not phased, a different methodology would be necessary. Thus, while the main directions of the evaluation plan should be defined in the health financing strategy, the specific methods to be used need to be defined in the reform implementation plan.

An important aspect of any evaluation is a detailed description of the implementation process and how it compares with the initial design. Understanding what was implemented, and how, is essential if there is to be an understanding of the causal effects of the reforms. In addition, keeping track of the implementation process is essential for detecting any problems, particularly in the early stages, that might require adjustments to enable reforms to go forward.

Ultimately, those leading the reform (typically the Ministry of Health) will be called to go before the public and explain how it is working and what is being achieved. Meeting this demand for public accountability can be greatly helped with robust evaluation studies. This will likely involve both longer-term quantitative studies and more qualitative "rapid appraisal" studies to ensure responsiveness to short-term political demands for information on progress.

For all of these reasons, evaluation is essential. Moreover, it needs to not be seen as something that comes some years after strategy implementation, but rather as an integral to the process. Accompanying implementation with concurrent evaluation can provide critical support to those leading health financing reforms.

ii) **Monitoring:** The health financing strategy should contain objectively verifiable and ideally quantifiable indicators for each of the objectives specified in the strategy The indicators can be mapped to the country-specific objectives categorized under the UHC goals and intermediate objectives. Sources of information for each indicator should be identified in advance. If possible, the existing routine health information system and national health accounts data should be used and strengthened, as should links to the national statistical agency. Additional studies and analysis can be undertaken to obtain more specific data and information where necessary.

4.10. DEVELOPING CAPACITY

Capacity development measures may also be required for a health financing strategy to be successful; for example, there may be a need to strengthen capacity in accounting and financial management at the local level, for reforms to be effective. Capacity development may also be needed to ensure the monitoring and evaluation of the health financing strategy. For example, supporting research centres in the use of policy and economic evaluation tools, building strong health information systems, or institutionalising the national health accounts tracking can all be required. Feedback loops and an iterative approach to implementation (recognising success and adapting to failures) will increase the chances of the strategy being successfully implemented.

World Health Organization

For additional information, please contact:

Department of Health Systems Governance and Financing
Health Systems & Innovation Cluster
World Health Organization
20, avenue Appia
1211 Geneva 27
Switzerland

Email: healthfinancing@who.int
Website: http://www.who.int/health_financing

9 789241 512107