Health Financing Progress Matrices for UHC

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I. Key Structure of the Model
1. Process and progress

Qualitative assessment of the overall financing system
- Quantitative models often fail to provide contextual stories

Examines the policy process and progress to achieve the UHC intermediate objectives and final coverage goals
- Agreement on final outcomes/goals of health financing for UHC (e.g., financial protection measures) does not necessarily inform policy makers of LMICs how to move toward achieving the UHC goal

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

Kwon: HF Progress Matrices
2. Parsimonious

Good model needs to be parsimonious

This model does not aim to cover all possible aspects of health financing
- Initially targets about 50 questions in total to grasp the essential/key aspects

This model does not aim to compare the performance of health financing of countries:
Inter-temporal comparability is important while Cross-country comparability is not
3. Structure and logical framework

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

Each question is based on Guiding Principles in national health financing strategy (Kutzin, Witter, Jowett, and Bayarsaikhan, 2017)
II. Application to Countries:
Lao PDR, Myanmar, Tanzania
1. Overview of Health Financing Arrangements (by WHO country offices)
1) Lao PDR

- The major health coverage arrangements, outside Vientiane Capital:
  - **General budget** for staff, equipment and capital at public facilities
  - **Vertical programmes** for HIV, TB, malaria, immunization, etc.
  - **National Social Security Fund** for civil servants and formal private sector workers and their dependents
  - **National Health Insurance** covering the rest (the informal sector)

- Major revenue sources:
  - **Household out-of-pocket** spending accounts for 46.2% of CHE
  - **Government**: 32.8% of current health expenditure (CHE):
    - Central 29.1%; Provinces 60.5%; National H Insurance 10.4%
  - **Donors**: 16.7% of CHE, largely focused on vertical programs, but the share is expected to decline due to donors’ transition
  - **Social health insurance** only 2.4% of CHE

- Provider payment methods:
  - Input-based line item budgets for staff, equipment and capital
  - Capitation for National Soc Security Fund for both OPD and IPD
  - Capitation (OPD) and case-based payments (IPD) for NHI
2) Myanmar

- 74% out-of-pocket
- 21% MOH
- 2% other public
- 3% External funding (currently underestimated but now revised data collection for coming NHA by using SHA 2011 frame)

(Source: Myanmar National Health Accounts)

Catastrophic spending by households:

- 16% of Myanmar households spend over 10% of their total expenditure to health
- 5% of Myanmar households spend over 25% of their total expenditure to health

(Source: World Bank, 2018)
3) Tanzania

• **Three main schemes:**
  - Public system with automatic coverage for all citizens
  - Social health insurance system for civil servants (NHIF)
  - Community health insurance funds (CHFs) organized at district level, but will be at regional level in the future

• **Major revenue sources:**
  - General taxes
  - Payroll contributions for a small portion of the population
  - External assistance
  - User fees

• **Provider payment methods:**
  - Input-based line item budgets dominant in the public system
  - Capitation payments from the “health basket funds“ (external on-budget support)
  - Fee-for-service under the NHIF

• **Benefits:**
  - Benefits vary by scheme with very generous entitlements under NHIF compared to all the others
  - Within CHFs, entitlements can vary
2. Common Challenges
1) Revenue Raising

The level of public funding is low, and budget allocation to health is not sufficient.

As a result, OOP pay for health care is still high.

Government budgets have low predictability, and there are frequent delays in budget execution.
2) Pooling

The three countries have very fragmented financing arrangements compounded by vertical programs.

Separate schemes exist for formal sector workers and poor/informal workers, although they account for a small share in total health expenditure.

Lao PDR is an exception as it decided to move to a single pool (although risks, benefits and provider payments are not coordinated across pools).

External assistance is often off budget, although there is a trend to move toward its integration with budget.
3) Purchasing and payment

Input-based budgeting is dominant, contributing to inequities within countries among different geographic units.

Provider accreditation and contracting systems are particularly weak.

Some donors use RBF, but fiscal autonomy of public providers is very limited.

Countries experience problems in the purchasing of and access to medicines.
4) Benefits and entitlement

Process and criteria for decisions on benefits and entitlements are not clearly defined.

Governments attempt to prioritize services to target populations/needs, but the alignment of benefits to revenue/funding is still weak.

Policies to help the public have clear understanding and awareness on benefits/entitlements is needed.
5) Public financial management (PFM)

PFM overall is very weak (with the exception of Tanzania where various measures are being implemented to improve PFM system).
- Even when reasonable PFM rules/policy exists, they are not fully implemented.

MTFF (Medium Term Fiscal Framework) is not fully applied, and budget is not well aligned with health sector priorities.

Historical line-item budget is prevalent with very low flexibility and often with low budget execution.

The role of provinces is often important as MoF allocates budget to provinces, which then allocate across sectors.
6) Governance

Countries experience capacity problems in human resources and technology (including IT).

They need to improve transparency and participation in decision making for health financing, and public reporting should be improved to increase understanding by the general public and lower levels of institutions/agencies.

Improving the alignment of PFM rules/regulations and strategic purchasing/payment is urgent.
3. Progress in Health Financing Policy
Common Progress

Review of current situations, drafting of financing strategy, and increased awareness on the importance of health financing and UHC;

Consensus on the problems caused by fragmented pools and the adoption of policy measures to improve the efficiency and equity of pooling;

Improvement in the targeting of services/benefits to populations/regions in need;

Role of strategic purchasing is appreciated, along with more efficient payment system and increased communication among MoH, MoF, and health financing agencies.
1) Progress in Lao PDR

The roll-out of NHI in 2016 was a major step towards the expansion and consolidation of schemes:

- **Merging** of community-based health insurance (CBHI), Free MCH, and Health Equity Funds (HEF) has substantially increased population coverage and reduced fragmentation.

Reforms in **budget** formulation and execution have also improved the predictability and timeliness of funds, and brought external funds on-budget.

However, little progress has been made in **purchasing and payment**, with no formal contracting of health facilities, provider accreditation, and payment related to quality.

Enforcement of regulations on **pharmaceutical** procurement and use is also weak.
2) Progress in Myanmar

Very early stage of the development of health financing, and government has strong political commitment for health.

A key policy document “Strategic Directions for Health Financing” has been recently developed, which envisions to raise revenues through higher prioritization of health spending in public budget.

Earmarking of sin taxes and contributions from formal sector workers as well as improving budget execution processes are also seen as ways to increase fiscal space for health.

The policy document also envisions:
- establishing a single pool
- plans to establish an independent purchasing agency by Law (Myanmar Health Insurance Law/Myanmar UHC Law), of which draft is finished and now needs multi-stakeholder consultation.
3) Progress in Tanzania

Health Financing Strategy provides a common vision that all Tanzanians have the same basic entitlements and the poor are protected.

Pooling and purchasing have improved in CHF (Community Health insurance Fund) as pooling has shifted from district to regional level, benefits across CHFs are being harmonized, and common provider payment methods are put in place.

- Still separate schemes for different population groups and creating a single national pool remains politically challenging.

Direct health facility financing reform to ensure resources reach actual service providers through a direct disbursement by all funds to health facility bank account.

Generic medicines procurement and reimbursement are adopted.
4. Directions for Change
1) Lao PDR

The next major change will occur with the planned merger of formal sector schemes within NHI, including eventual harmonization of the benefit packages for the formal and informal sectors.

Along with this crucial change, strategic purchasing should be strengthened, such as provider accreditation and contracting of health facilities, medicines procurement and rational use.

Progress matrix will be used to set a baseline and identify policy priorities for the Health Financing Strategy for 2021-2025.
2) Myanmar

Myanmar will convert the Strategic Directions into legal government order documents.

Progress matrix will help identify priority next steps to develop and implement a Health Care Financing Strategy

- Governance arrangements for purchasing, working with other government agencies to design public financial management regulations that will be supportive of strategic purchasing arrangements, etc.
3) Tanzania

Findings of the Progress Matrix will be discussed in a wider stakeholder workshop and feed into the ongoing policy dialogue and technical support.

Next steps of reform include:
- strengthening provider capacity in financial management
- strengthening the Ministry capacity in governance to ensure strong national policies in health financing
- scaling up CHF
- strengthening budget policy dialogue to increase domestic public financing of health
III. Implementation Issues
1. Questions and scales

Two options

- Lengthy questions with simple scales such as “very underdeveloped”, “underdeveloped”, “developed”, “highly developed”: e.g., BMGF’s PHCPI (Maturity) model

- Short questions with lengthy scales containing more explanations: e.g., Scales can incorporate the quality dimension of policy (in addition to its existence)

Initial version of this model tries to frame both the questions and scales with some details (Optimal degree of details?)

- Questions themselves need to be understood clearly

-> Still concerns that some questions are too difficult/technical to be understood
2. Implementation

Some existing models are highly technical and too long, and experts complete the assessment
- Subject to bias of an assessor

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

Opportunity for government officers to review their system and contemplate the future policies:
- Basis for informed policy dialogue