

## CHAPTER 7 HEALTH FINANCING MODULE

### 7.1 Overview

#### 7.1.1 Chapter Outline

This chapter presents the health financing module of the assessment tool. Section 7.1 defines health financing and its key components and describes the process of resource flows in a health system. Section 7.2 provides guidelines on preparing a profile of health financing for the country of interest, including instructions on how to customize the profile for country-specific aspects of the financing process. Section 7.3 presents the indicator-based part of the assessment. Section 7.4 provides guidance on how to synthesize your findings and presents suggestions for possible solutions to the most common problems in health system financing.

#### 7.1.2 What Is Health Financing?

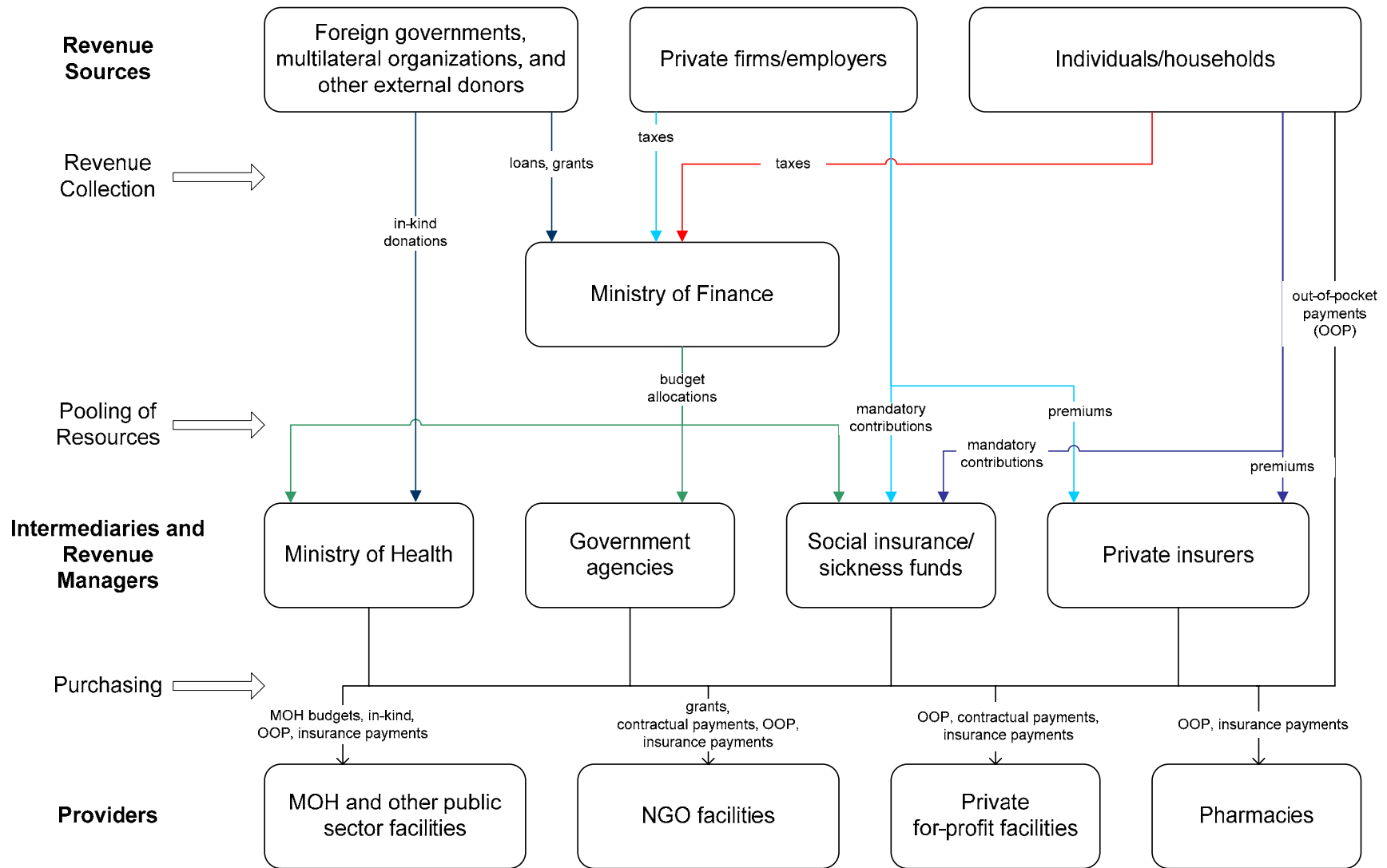
The World Health Organization (WHO) defines *health financing* as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system.” It states that the “purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO 2000). The rest of this section draws from PHR (1999) and Mossialos and Dixon (2002). Health financing has three key functions (illustrated in Figure 7.1 and defined below): revenue collection, pooling of resources, and purchasing of services.

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

#### Tip!

Definitions of health financing terms can be found in the following glossaries—

- European Observatory's Health Systems and Policies (2006) Glossary
- World Bank Health Systems Development—Glossary (World Bank 2006)



Notes: Figure 7.1 presents the most common flows of health system resources; some countries may have other options of health system financing. "Other Government Agencies" can include the Ministry of Education and Ministry of Defense.

**Figure 7.1 Health Financing Flowchart**

*Pooling of resources*, the second main aspect of health financing, is the accumulation and management of funds from individuals or households (pool members) in a way that insures individual contributors against the risk of having to pay the full cost of care out-of-pocket in the event of illness. Tax-based health financing and health insurance both involve pooling. Note that fee-for-service user payments do not involve the pooling of resources. Some fees, however, may be set to “cross-subsidize” certain services or groups by charging more than the cost of production for a service or a group to allow less than the cost to be charged for another service or to another group.

*Purchasing* of health services is done by public or private agencies that spend money either to provide services directly or to purchase services for their beneficiaries. In many cases, the purchaser of health services is also the agent that pools the financial resources. Purchasers of health services are typically the Ministry of Health (MOH), Social Security agencies, district health boards, insurance organizations, and individuals or household (who pay out of pocket at time of using care). Purchasing can be either passive or strategic; passive purchasing simply follows predetermined budgets or pays bills when they are presented, whereas strategic purchasing uses a deliberate approach to seeking better quality services and low prices.

For good performance of the health system, the financing agents need to generate an appropriate amount of revenues relative to what is possible in the country; pool risk effectively; create appropriate incentives for providers; and allocate resources to effective, efficient, and equitable interventions and services. These functions should be managed efficiently, minimizing administrative costs.

Resources on health financing, including selected articles and references to specialized literature, are provided in the bibliography for this chapter.

## **7.2 Developing a Profile of Health Financing**

This section presents a basic model of health financing and discusses common country context issues, related to decentralization, that the assessment team needs to consider in developing an understanding of the financing process.

### **7.2.1 How Does Health Financing Work?**

Figure 7.1 shows a general model of the flow of health care resources from sources of funds to health service providers. The assessment team should redraw the flowchart as needed to reflect country-specific characteristics of the health financing process. The payment mechanisms presented by the arrows that connect the various levels of financing assessed are in the last part of the indicators section. The assessment team is encouraged to customize Figure 7.1 for the country of interest after completion of the indicator-based assessment of health financing (Section 7.3). Customizing will facilitate the process of synthesizing the findings from this module (Section 7.4).

The Ministry of Finance is typically the central revenue collector of funds for the public health care system. The Ministry of Finance receives funds from foreign donors (in the form of grants or loans) and from private firms and individuals (in the form of taxes). The pooling of resources, the next step in health financing, is conducted by intermediaries and revenue managers, who could be the MOH and other government agencies such as the Ministry of Education (in charge of medical education institutions) and the Ministry of Defense (in charge of military health facilities); social insurance and sickness funds; community-based insurance schemes; and private insurance entities.

The MOH receives the government budget funds allocated for health from the Ministry of Finance, but the level of government decentralization dictates whether all or only part of the government health budget goes directly to MOH (see Section 7.2.2 in this chapter and the Core Module in Chapter 5 for a more detailed discussion of decentralization issues). The MOH often receives a large share of donor contributions for health as in-kind contributions (e.g., medicines and technical experts). Other ministries or government agencies can also receive central government funds for expenditures on health: for example, the Ministry of Education to fund university teaching hospitals and the Ministry of Defense for medical facilities that are under its umbrella. Social and private health insurers receive contributions in the form of insurance premiums from individuals or households and from private firms that purchase or subsidize insurance premiums for their employees. Social health insurance (SHI) organizations also receive government funds, either as direct subsidies (usually when the SHI scheme is not self-sustaining financially, which is often the case with nascent schemes) or as premium payments for individuals who are eligible for government-subsidized SHI contributions (usually children, the elderly, military recruits, civil servants, or the indigent or unemployed).

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

- *Line item budgets* are allocated for each functional budget category, such as salaries, medicines, equipment, and administration.
- *Global budgets* are allocated to health facilities and typically depend on the type of facility, historical facility budget, number of beds (for hospitals), per capita rates, or utilization rates for past years.
- *Capitation* is a payment method that allocates a predetermined amount of funds per year for each person enrolled with a given provider (usually a primary care provider, such as family physician) or resident in a catchment area (in the case of hospitals, for example); usually there is a defined package for services covered by providers under such schemes.
- *Case-based payment* combines the estimated costs associated with all interventions typically prescribed for the treatment of a given condition and involves a set payment to providers for each patient treatment episode by condition, according to a predetermined payment schedule based on estimated total cost.

- *Per diem payment* is a predetermined payment that providers receive for each patient-day of hospital stay; the amount of the payment usually varies by type of hospital department.
- *Fee for service (or user fee)* is the out-of-pocket payment that patients make for each health care service at the point and time of use.

### **7.2.2 Health Financing in Decentralized Systems**

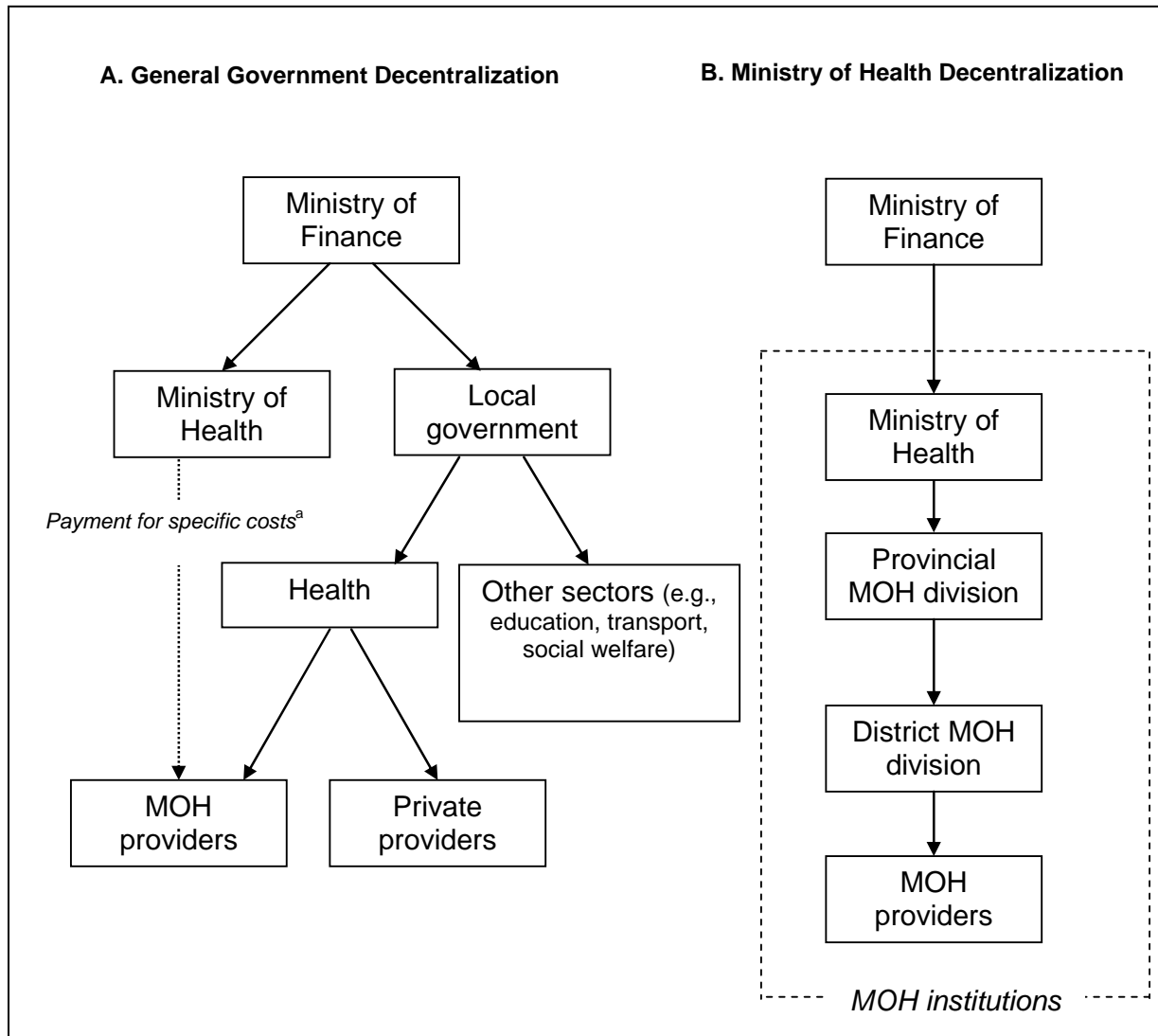
The level of decentralization of the general government or the public health care sector is an important factor that can influence the patterns of resource flows through the health system, as well as key issues related to, for example, service provision (such as the allocation of resources across programs or budget categories) and provider incentives for quality of services.

Part A of Figure 7.2 shows the basic flow of government funds for the public health care sector under general government decentralization. A portion of government funds allocated for the public health care sector are distributed from the Ministry of Finance to the MOH, for general programs administered by the MOH. The Ministry of Finance also allocates “grants” to decentralized political units (such as local government administrations or district councils), who then decide how much of these funds are allocated to health, among other sectors.

The funds from the Ministry of Finance to local government administrations are typically block grants determined by a number of criteria such as share of total population or burden of disease. Block grants may or may not include earmarks for health. If they do not, health competes at the local government level with other sectors for budget resources. Alternatively, the Ministry of Finance might pay certain recurrent costs of public health facilities such as the salaries of public health sector employees, in which funds flow directly from Ministry of Finance to MOH providers, and local governments do not have discretion over this part of health system financing.

Part B of Figure 7.2 illustrates the flow of government funds for the public health care sector under MOH decentralization. In this type of system, funds flow to providers through a hierarchy of MOH administrative units, though salaries can sometimes be paid directly from the Ministry of Finance. When funds are allocated wholly within the health system without regard to local government decisions, the main resource negotiations are first between the central MOH and districts or regions and second between the central MOH and the Ministry of Finance.

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



<sup>a</sup>In certain decentralized systems, MOH may continue to pay for certain costs at health facilities such as health worker salaries and vaccines.

**Figure 7.2 Flow of Government Funds for the Public Health Sector in Decentralized Systems**

### 7.3 Indicator-based Assessment

The indicators assessed in this module are organized in the two components described in Chapter 2. Component 1 has general health financing indicators, data for which can be obtained from the data file titled “Component 1 data” (available on the CD that accompanies this manual and discussed in Chapter 5.2) or from the Internet if you do not have access to the CD. Component 2 combines a desk-based assessment and stakeholder interviews to collect information on additional health financing indicators. Stakeholder interviews should complement the information collected from a review of documents and provide important information that may not be available through document review.

Although the indicators in Component 1 are measurable indicators, the indicators in Component 2 are often descriptive questions about, for example, the process or practices related to a government policy.

Note that this module is longer than the other modules in the assessment. Not all indicators may be relevant in your country, however; look for the screening questions placed throughout this section because they will guide you to skip over indicators that you may not need to assess. If you have limited time and are not able to cover all indicators, refer to Box 7.1 for guidance on how to prioritize your assessment work.

Note that answering a screening question “no” may indicate that an important aspect of health financing is missing; you should consider investigating the reasons why and defining some potential recommendations or interventions to address this problem. For example, if the country has no private health insurance market, a possible recommendation might be that donors assist with the process of developing private insurance in the country.

**Box 7.1**  
**Prioritizing Indicators**

If you are able to complete only part of this module because of limited time or resources, do the following—

- First, assess indicators 1 through 6, because data for them are readily available in the CD database that accompanies this manual or from Internet sources.
- Second, assess indicators numbered 7, 10, 11, 14, 15, 18, and A1 (in Annex 7A).
- Third, if possible, assess all remaining indicators to get a more comprehensive picture of health system financing in the country.

### **7.3.1 Topical Areas**

The indicators in this module are grouped around the three main functions of health financing that were illustrated in Figure 7.1: (A) revenue collection: amount and sources of financial resources; (B) pooling and allocation of financial resources; and (C) purchasing and provider payments.

#### **A. Revenue Collection: Amount and Sources of Financial Resources**

This group of indicators looks at how much is being spent on health care in the country and how much of this spending comes from public, private, and external donor sources. The health system performance criteria addressed by these indicators are access, equity, quality, and sustainability. All indicators in this group are Component 1–type indicators.

#### **B. Pooling and Allocation of Financial Resources**

For the purposes of this rapid assessment, the indicators on pooling and allocation of financial resources focus on the government health budget and health insurance.

- **Government budget allocation.** These indicators look at the MOH budget trends, the process of health budget preparation at various levels of health system administration, and the distribution of central and local government funds across different types of spending categories, services, and regions. The health system performance criteria

assessed in this group of indicators are sustainability, equity, efficiency, access, and quality.

- **Health insurance.** These indicators investigate the different types of insurance schemes (if any) operating in the country of interest, such as social, private, or community-based health insurance schemes. The health system performance criteria assessed in this part of the module are efficiency, equity, access, sustainability, and quality.

### **C. Purchasing and Provider Payments**

This set of indicators analyzes the process by which funds are paid by purchasers to providers of health services. The performance criteria assessed in this part of the module are access, efficiency, equity, sustainability, and quality.

#### **7.3.2 Detailed Descriptions of Health Financing Indicators**

Table 7.1 groups the indicators in this module by topic.

**Table 7.1 Indicator Map—Health Financing**

<b>Component</b>	<b>Topical Area</b>	<b>Indicator Numbers</b>
Component 1	Revenue collection: amount and sources of financial resources	1–6
Component 2	Pooling and allocation of financial resources— <i>Government budget allocation</i>	7–14
	Pooling and allocation of financial resources— <i>Health insurance</i>	Not applicable—indicators included in Annex 7A only
	Purchasing and provider payments	15–18
—	Annex 7A. Health Insurance: Coverage, Funding, and Policy Issues	A1–A4

### 7.3.2.1 Component 1

For all indicators that are part of Component 1, you may want to do regional comparisons, where possible (some regional averages are provided in Annex 5A). Regional comparisons are often used to suggest where a country fits in relation to neighbor countries or countries in the same region with similar economic and population profiles. Regional comparisons, however, may not necessarily offer good benchmarks when a country has important differences in, for example, standards of living, per capita incomes, structure of health system, and extent of donor contributions.

#### A. Revenue Collection: Amount and Sources of Financial Resources

##### 1. Total expenditure on health as % of GDP

**Definition, rationale, and interpretation**

The percentage of gross domestic product (GDP) spent on health is a measure of the share of a country's total income that is allocated to health by all public, private, and donor sources.

A standard measure used for international comparisons, this indicator typically ranges between 2 and 15 percent of GDP spent on health. An extremely low percentage of GDP spent on health suggests that not enough resources are mobilized for health, that access to health care is insufficient, and that the quality of services is poor. An extremely high expenditure suggests a widespread use of high technology and likelihood of inefficiencies. There are, however, no commonly accepted benchmarks or targets for an appropriate percentage of GDP that a country should spend on health.

*Module link:* Core Module, indicators 12 (GDP per capita) and 14 (total health expenditures per capita)

**Suggested data source**

WHO (2006). *The World Health Report 2006* <www.who.int> or most recent.

##### 2. Per capita total health expenditure, at average exchange rate (USD)

**Definition, rationale, and interpretation**

This indicator reflects the average amount of resources spent on health per person. It is another standard measure that can indicate whether spending on health is adequate to achieve appropriate access and quality. According to the report of the Commission on Macroeconomics and Health (WHO 2001), providing minimal essential health care services would require expenditure in 2007 of at least 34 U.S. dollars (USD) per capita per year in low-income countries. Countries with relatively low per capita spending (e.g., below USD 30 per capita) are likely to have poor access, a low quality of health care, or both.

*Module link:* Core Module, indicator 14 (total health expenditures per capita)

**Suggested data source**

WHO (2006). *The World Health Report 2006* <www.who.int> or most recent.

---

### 3. Government expenditure on health as % of total government expenditure

---

**Definition, rationale, and interpretation** This indicator illustrates the commitment of government to the health sector relative to other commitments reflected in the total government budget. The allocation of government budget to health is subject to political influences and judgments about the value of health spending relative to other demands for public sector spending. A relatively large commitment of government spending to health (e.g., above 20 percent) suggests a high commitment to the sector.

**Suggested data source** WHO (2006). *The World Health Report 2006* <[www.who.int](http://www.who.int)> or most recent

**Notes and caveats** Trends over time are a more reliable measure of the reliability of government spending on health, as a share of total government spending, than any single year. (See indicator 7c.) Note as well that if the country has a Social Security scheme, its funding for health is included as government funding, even though a large share of it comes from private sources (individual and employee mandatory contributions).

---

---

### 4. Public (government) spending on health as % of total health expenditure

---

**Definition, rationale, and interpretation** This indicator is a measure of the relative contribution of central and local government, relative to total health spending. If the percentage is relatively low (i.e., below 40 percent) it can reflect (1) a low tax capability of the country's government, (2) a philosophy of a limited role for government in health (i.e., that public spending should not play a large role in financing or providing health services for the population), or (3) both. A low value for this indicator also means that the government has limited ability to act to address equity issues.

**Suggested data source** WHO (2006). *The World Health Report 2006* <[www.who.int](http://www.who.int)>

**Notes and caveats** Trends over time are a more reliable measure of the reliability of government spending on health as a share of total health spending than any single year.

---

---

### 5. Donor spending on health as % of total health spending

---

**Definition, rationale, and interpretation** The share of total health spending financed by donors measures the contribution of international agencies and foreign governments to total health spending. A very high donor contribution to a country's total health spending (e.g., above 10 percent) is a concern for financial and possibly institutional sustainability if the donor contributions are withdrawn.

Compare this indicator to government health spending as a percentage of total health spending (indicator 4) to assess the sustainability implications of the share of donor spending. Very high donor health spending suggests that the government would have to increase its health spending by a large proportion to replace donor contributions, should they be withdrawn, to avoid placing the burden on private spending.

---

---

**5. Donor spending on health as % of total health spending**

---

**Suggested data source**

WHO (2006). *The World Health Report 2006* <[www.who.int](http://www.who.int)>

---

**Notes and caveats**

Because donor contributions are in foreign currencies and the country's government spending is in local currency, this percentage can be affected by fluctuations in exchange rates.

Because donor contributions can fluctuate with political situations, they can be subject to frequent changes in amount, target of spending assistance, or both.

Therefore, trends over time are a more reliable measure of the reliability of donor spending on health (and of the country's dependence on donor spending), than any single year.

---

---

**6. Out-of-pocket spending as % of private expenditure on health**

---

**Definition, rationale, and interpretation**

This indicator represents the expenditures that households make out of pocket at the time of using health care services and purchasing medicines, relative to total private spending on health. Out-of-pocket expenditures exclude payment of insurance premiums, but include nonreimbursable insurance deductibles, co-payments, and fees for service.

*Module link:* Core Module, indicator 16 (Out-of-pocket expenditures as percent of private expenditures)

If out-of-pocket spending represents a large share of private health spending (e.g., above 80 percent), pooling of private resources is limited. It means that most of the time households need to produce funds at the time of seeking care, which can be a barrier to accessing care and can threaten the financial status of the household (e.g., push some into poverty).

In lower income countries, out-of-pocket spending usually represents a very high or nearly all of total private spending on health.

---

**Suggested data source**

WHO (2006). *The World Health Report 2006* <[www.who.int](http://www.who.int)>

---

### 7.3.2.2 Component 2

While Component 1 indicators covered revenue collection (topical area A), Component 2 indicators will cover the pooling and allocation of financial resources (topical area B), and purchasing and provider payments (topical area C).

#### **B. Pooling and Allocation of Financial Resources**

For the purposes of this rapid assessment, the indicators on pooling and allocation of financial resources focus on the government health budget allocation and health insurance.

***Government budget formulation and allocation.*** In most countries, several government ministries have health services or activities included in their budgets (e.g., Ministry of Defense for military health, Ministry of Education for medical education). For purposes of the rapid assessment, the following section concentrates only on the MOH budget because that is available to the whole population and is usually the major source of recurrent health spending (see Box 7.2 for definitions).

#### **Box 7.2**

##### **Definition of Recurrent and Investment Budget**

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

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

**7. Ministry of Health budget trends**

- a. Do MOH expenditures keep pace with inflation and with population growth? Inflation (measured by the consumer price index) and rate of population growth are indicators included in the Core Module.
- b. Does the country have any mandated level of public spending on health as percentage of total public spending? If not, is the MOH share of the total government recurrent budget increasing or decreasing?
- c. What percentage of the total public health budget is for capital investments?
- d. What is the trend in difference between the authorized budget and actual expenditures?

**Definition, rationale, and interpretation**

These four indicators related to trends in MOH budget spending are common measures to indicate whether the MOH budget is a sustainable source of funding for the health sector.

- a. If annual actual or planned expenditure is not increasing at the same rate as the annual general price level *plus* the rate of population growth, then there is a real decrease (decline in purchasing power) of resources allocated by the MOH. It cannot provide the same level of services to people that it provided in the previous year(s).
- b. If the MOH share of total government budget is decreasing, this trend indicates a decrease over the years in commitment of the government to fund health.
- c. Capital investment includes assets such as physical infrastructure and medical equipment. In low-income countries, capital expenditures can be as high as 40–50 percent of the total public health care budget if, for example, the physical infrastructure is being created or restored after years of conflict. Knowing how much capital investment occurs, in comparison with recurrent costs, is important to ensure that capital is not wasted or is not draining off funds needed for other inputs (e.g., if many new health facilities are built but no funds are available to staff them and supply medicines).
- d. If actual is less than planned or authorized expenditure, then the budget is unreliable and unpredictable as a source of funds for health. In this case, salaries tend to be paid late and medicine allotments tend to be less than needed. Actual expenditures are rarely higher than planned expenditures (if they are, budget controls and financial management are most likely the problem).

**Suggested data source**

Government budgets

**Notes and caveats**

In countries with sector-wide approach (SWAp) funding from donors, the funds from donors are often channeled through the MOH budget. In this case, examine changes in SWAp funding amounts when assessing MOH budget increases or decreases.

**Table 7.2 MOH Budget Trends: Authorized or Planned and Actual Expenditures**

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

**8. Process of MOH budget formulation**

- a. Are MOH budgets developed based on last year’s or historical totals, or are budgets developed based on estimates of resources required to meet the population’s health needs?
- b. Is budget planning done centrally or is the budgeting process bottom-up, beginning at the district or local level (i.e., accumulation of district or local budget planning requests)?

**Definition, rationale, and interpretation**

a. When budgets are historically based, they usually allocate funds based on the number of hospital beds or health workers without regard to the occupancy rate of different hospitals or different utilization rates of the clinics across the country; they simply reflect the amount of funding from the previous year, with a possible adjustment for inflation or changes in overall government spending. “Needs-based” MOH budgets, conversely, are built each year from estimates of the population’s health service delivery needs (along with needs for public health prevention; disease control; information, education, and communication; and other programs) according to epidemiological and health profiles in the various localities in the country.

Over time, historical budgeting does not reflect changing needs, and it becomes out of step with funding requirements. Thus, it tends to lead to inefficiency with more funding allocated to some functions than needed and less to others.

Needs-based budgets are more likely to reflect actual use and funding requirements for population and inflation changes and, subsequently, are more likely to lead to allocation of funds to facilities, districts, and regions where the funds are needed. Similarly, needs-based budgeting can point to underused hospitals and other facilities that can be closed or consolidated.

b. Historical or needs-based budgets can be developed centrally, with little input from local levels and facilities, or they can be developed from the bottom up, with budget requests coming from districts to regions, provinces, or states, and then to the central MOH and finally to the Ministry of Finance.

**8. Process of MOH budget formulation**

- a. Are MOH budgets developed based on last year's or historical totals, or are budgets developed based on estimates of resources required to meet the population's health needs?
- b. Is budget planning done centrally or is the budgeting process bottom-up, beginning at the district or local level (i.e., accumulation of district or local budget planning requests)?

Bottom-up budgets, if based on local resource requirements for the health needs in that area, are more likely to reflect actual health funding needs. If these budgets are done well and eventually approved and executed, funds are more likely to be allocated effectively and specific local services more likely to be sustainable.

**Suggested data source**

MOH budgets, stakeholder interviews

**Stakeholders to interview**

MOH and Ministry of Finance officials

**Issues to explore**

Although bottom-up budget preparation approach may exist as a policy, examining the practice to see if local input actually influences central MOH decision-making is important.

**Tip!**

Note that the following indicators on MOH and central or local government budget (indicators 9 through 14) refer to recurrent cost budgets, unless indicated otherwise.

**9. MOH budget allocation structure**

**What structure does the MOH use to allocate its budget? Line items? Programs? Other?**

**Definition, rationale, and interpretation**

Line-item budgets allocate funding by object class (e.g., salaries, electricity, fuel, medicines, rent). Program budgets allocate funding by program or service delivery area (e.g., Expanded Program on Immunization, TB, HIV/AIDS prevention and treatment, maternal health care or broadly defined primary health care [PHC], prevention, or curative and inpatient hospital care).

Line-item budgets provide no way to monitor and track the effectiveness or sustainability of spending allocated according to the service delivery and health outcomes that a health budget is funded for. Program budgets do provide a way to track whether spending is achieving the intended results. Program budgets also provide a way to evaluate whether funding is being used efficiently for priority services and health policy initiatives.

**Suggested data source**

MOH budgets

**Stakeholders to interview**

MOH officials

**9. MOH budget allocation structure**

**What structure does the MOH use to allocate its budget? Line items? Programs? Other?**

**Issues to explore**

What criteria do Ministry of Finance officials require and rely on for approval of MOH budgets? Does the MOH have any evaluation process to assess whether the budget is allocated appropriately to achieve policy and program goals in the five-year health plan?

**Screening question:** Do local government authorities have responsibilities for health in systems in which general government is decentralized? Does the central government allocate to local government administrative authorities funds that are specifically earmarked for health? If the answer to both questions is “no,” then proceed to indicator 12.

**10. Central and local government budget allocations for health in decentralized systems**

- a. How does the central government allocate funds for health to lower level administrative units such as states, regions, provinces, and districts?**
- b. Do local government units have local taxing authority? If so, do they appropriate funds for health? Do they have any other method of local public funding for the health sector?**

**Definition, rationale, and interpretation**

a. Alternative methods of allocating central funds to local levels have different incentives for the local levels to use those funds for health. Block grants from the central government are the most common forms of allocating funds to local levels in systems where general government administrative authorities are decentralized.

If grants are earmarked for health and if those earmarks are adjusted for the locality’s health needs (e.g., adjusted for population or socioeconomic indicators), the funds are more likely to be spent on health, reflect equity considerations, and maintain (or improve) the local population’s access to health services.

b. If local governments also have taxing authority and can raise and allocate additional funds for health, this capacity increases the possibility of sustainable and adequate health funding.

In general, experience to date suggests that in the early years of decentralization, funding for health and especially for priority PHC services may decline or become unreliable, thus affecting access and sustainability. If wealthier local governments provide additional health funding from their own budgets, inequality across districts or regions can increase.

**Suggested data source**

Central and local government budget data, stakeholder interviews

**Stakeholders to interview**

MOH, Ministry of Finance, and Ministry of Local Government  
Local government officials, local health administrative units

**Issues to explore**

Describe the combination of sources of funding for health at the local level (central government grant, local government tax-financed budget, MOH contribution toward salaries and other expenses). Review recent funding trends in central government allocation to local administrations to see if this mechanism promotes reliable funding for health and equity of distribution of central government health funding across the country.

---

**11. Percent of government health budget spent on outpatient/inpatient care**

---

**Definition, rationale, and interpretation** This is a general indicator for the sustainability of outpatient care funding through the MOH budget. The MOH budget allocated to inpatient care often crowds out funding for outpatient care (and thus PHC services), especially in a tight MOH budget situation.

Although public spending for inpatient care is generally higher than for outpatient care, no standard benchmarks exist to define an appropriate, sustainable, or efficient ratio between these two main categories of services. Trends are likely to be more important for interpreting the implications of the ratio than funding in any one year. If the share allocated in the MOH budget for outpatient services declines over time, or periodically, it means that outpatient care is being cut in favor of inpatient spending. This cutback, in turn, can reflect either a decreasing priority of outpatient care for the government or changes in the disease profile of the population that require more inpatient care.

---

**Suggested data source** MOH budgets (you may have to do this estimate manually, with assistance of MOH staff), National Health Accounts (NHA) if available

*Module link:* Health Service Delivery Module, indicator 17 (primary care or outpatient visits per person per year)

---

**Stakeholders to interview** MOH officials, staff involved in NHA if available, representatives of donor agencies who may be taking the lead in outpatient or hospital services

---

**Issues to explore** Donor funding is frequently targeted toward PHC and related outpatient care services. Examine whether this targeting is the case and whether the government MOH budget may thus provide less funding for PHC and other outpatient care because it is relying on donors to cover those costs.

---

**Notes and caveats** Although a common indicator for spending by level of health services distinguishes between PHC and hospital care, comparing spending on *outpatient* and *inpatient* services instead is preferable to account properly for PHC services that are provided at outpatient departments of hospitals (and to avoid overestimating the expenditures on inpatient hospital care). In addition, the definition of *outpatient care* is more straightforward than the definition of *PHC*, which varies widely across countries, and a standardized NHA measures outpatient and inpatient care expenditures.

If obtaining data on the breakdown between inpatient and outpatient government spending is difficult, consider instead the percentage of the budget allocated to hospital and non-hospital facilities as a proxy for this indicator.

**12. Percent of government health budget allocation in rural/urban areas**

<b>Definition, rationale, and interpretation</b>	The proportion of the government health budget spent in rural and in urban areas, relative to the proportion of the population living in rural and urban areas (from Core Module) is a common indicator of how equitably public health resources are allocated. Typically, the proportion of public spending on health in urban areas is high relative to the proportion of the urban population. In addition, since the cost per capita of serving dispersed populations in some rural areas may be higher, such patterns of resource allocation further exacerbate inequities of access between rural and urban populations.
<b>Suggested data source</b>	MOH budget You may need to analyze the budget and spending estimates allocated manually, in consultation with MOH budget officials. See if any studies have been done (e.g., sponsored by donor organizations) that provide this information.
<b>Stakeholders to interview</b>	MOH officials Representatives of donor agencies who may be taking the lead in urban–rural health inequities, poverty initiatives, or both
<b>Issues to explore</b>	You can subtract spending on tertiary hospitals before disaggregating spending between rural and urban areas. Tertiary hospitals are in urban areas but expected to provide specialized services to both rural and urban residents.

**13. Percentage of the government health budget spent on—**

- a. Salaries of health workers?
- b. Medicines and supplies?
- c. Other recurrent costs (e.g., administrative costs at central and district levels, in-service training)?

<b>Definition, rationale, and interpretation</b>	The amount and shares of funding for salaries and medicines are the most relevant categories to assess for purposes of a rapid assessment.  Generally, as much as 70–80 percent of MOH budgets is allocated to salaries and benefits, most of it for health worker salaries and benefits. When the budget is not sufficient to cover the costs of medicines, people have to pay for medicines separately at the public health facility or at a local private pharmacy, and health workers do not have the wherewithal to treat patients. This shortfall affects the quality of care, as well as equity.
<b>Suggested data source</b>	MOH recurrent cost budget  <i>Module link:</i> Pharmaceutical Management Module, indicators 3, (government expenditures on pharmaceuticals) and 19 (value of government procurements for drugs)
<b>Stakeholders to interview</b>	MOH officials, particularly staff who have been involved in NHA estimates (where available).

**13. Percentage of the government health budget spent on—**

- a. Salaries of health workers?
- b. Medicines and supplies?
- c. Other recurrent costs (e.g., administrative costs at central and district levels, in-service training)?

**Issues to explore** Even if a high proportion of the MOH budget is allocated to salaries, it may not be sufficient to provide adequate pay to health workers. Examine also whether salaries are paid on time and regularly. Compare the distribution of spending to that of other countries with similar per capita income level, if possible.

**Notes and caveats** This group of indicators is most easily measured from a line-item MOH budget or an NHA that included this breakdown. If neither is available, the calculations must be done manually in consultation with MOH budget officials.

See also the Pharmaceutical Management Module (Chapter 10).

**14. Local level spending authority**

- a. Do MOH health facilities have autonomy in making recurrent cost expenditures such as procurement of supplies, gasoline, and medicines, and hiring of supplemental personnel?
- b. Does a system exist at the central, district, or facility level for tracking and auditing budget expenditures?

**Definition, rationale, and interpretation**

- a. Having authority to make decisions about allocating spending to the service delivery costs at the facility level is important to assure that funds are prioritized and spent for needed items. This authority can be granted in line-item budgets if the facility manager can reallocate among the designated expenditure categories (e.g., from supplies to transportation for outreach). It can also be made available in global budgets, which is generally the most effective method. With a global budget, facility managers have the discretion to allocate the total funds across uses according to their service delivery needs.
- b. Systems to track and audit expenditures against budget authorizations are essential to good financial management and accountability, and can be key to efficient management and allocation of resources.

**Suggested data source** Key informant interviews  
*Module link:* Pharmaceutical Management Module, indicator 16 (procurement processes)

**Stakeholders to interview** MOH central and local level administrators and managers

**14. Local level spending authority**

- a. Do MOH health facilities have autonomy in making recurrent cost expenditures such as procurement of supplies, gasoline, and medicines, and hiring of supplemental personnel?
- b. Does a system exist at the central, district, or facility level for tracking and auditing budget expenditures?

**Issues to explore** Exploring the different administrative and service delivery levels of the system separately on this issue is important because different levels of facilities (e.g., health post, clinic, secondary, or tertiary hospital) may have different rules for autonomy and expenditure tracking.

**Notes and caveats** In decentralized systems, different jurisdictions (zones, districts) may have different policies regarding budget flexibility and cost control measures for ensuring proper use of budgeted expenditures.

---

**Health insurance.** Three major types of health insurance may be available in the country—

- Social health insurance (SHI): a mandatory government-organized program that provides a (usually) specified benefit package of health services to members. Usually funded by payroll deductions from the employee and the employer and paid into a separate health insurance fund.
- Community-based health insurance (CBHI): a voluntary program that provides (usually) a specified benefit package of health services to members who pay premiums to a community-based and community-managed health fund.
- Private for-profit health insurance: a voluntary program of a specified benefit package of health services offered by private commercial insurance companies. Paid for by premiums (and often co-payments and deductibles) that members pay to the insurance company.

**Screening Question:** Do SHI, CBHI, or private for-profit health insurance exist in the country? If yes, refer to the set of indicators in Annex 7A; otherwise proceed to Topic C (Purchasing and Provider Payments).

**C. Purchasing and Provider Payments**

This section investigates user fees and performance contracting for health service providers. Payment from the public sector to MOH health facilities and payments by health insurance entities to providers were already covered in the previous section.

*User fees* are a form of payment (usually a fixed charge) for services, supplies, and medications provided by health care facilities.

*Performance contracts* may be made between MOH and public or private providers. They relate health worker pay or facility allocations to performance (measured by, for example, indicators of quality of care, number of patients served, efficiency of resource use).

---

**15. Policies for user fee payments in the public sector**

- a. Do patients have to pay fees for outpatient care: visits, medicines, supplies (e.g., bandages), and laboratory and other diagnostic tests?
- b. Do patients have to pay for hospital inpatient care: fees for their stay (e.g., per day or per admission); fees for doctors' or nursing services; charges for medicines, supplies, and laboratory and other diagnostic tests?
- c. Do any policies remove the requirement for user fees for some patients using primary care services?<sup>1</sup> In particular, are fee exemptions or waivers provided for any—
  - Sociodemographic groups, such as children under age 5, students, elderly, military personnel, health care workers, or the poor?
  - Health care services, such as immunizations, services included in a basic benefit package (see Box 7.3), TB-DOTS, other chronic care?

**Definition, rationale, and interpretation**

The primary purpose of user fees in the public sector is to help facilities with cost recovery to improve quality and sustainability. Another function is to prevent unnecessary use of services because cost-sharing discourages over-utilization of health care or use of services at a higher level than necessary. At the same time, user fees can add financial barriers to the use of services, especially for the poorest, thus producing inequalities.

Fee waivers and exemptions can promote equity of financial access for the poor and can promote use of services by priority population groups or people with conditions requiring follow-up or continual care. Waivers and exemptions must be administered well and accurately, however, and they must not erode the purpose of user fees in the first place (helping to pay for the quality and availability of health services in the public sector, especially when MOH budgets are constrained). For example, many countries establish official user fees and then provide exemptions and waivers that cover 80–90 percent of PHC visits.

**Suggested data source**

MOH policy documents; key informants

*Module link:* Health Service Delivery Module, indicator 16 (user fee exemption and waivers); Pharmaceutical Management Module, indicator 38 (cost recovery methods)

**Stakeholders to interview**

MOH officials at central and local levels, facility managers

**Issues to explore in stakeholder interviews**

Are fees set nationally or locally? If locally, they may be more in line with the ability of the local population to pay the established level.

Investigate whether formal criteria exist and have been promulgated for identifying patients who are eligible for fee exemptions or waiver—especially whether clear eligibility criteria exist for waivers for the poor (such criteria are often controversial and difficult to establish).

Find out if the country has a mechanism to compensate facilities for the revenue foregone when exemptions are granted. If not, the incentives are for the facilities to give fewer exemptions.

Explore what effect user fees have on utilization of services for which fees are charged, especially on utilization by the poorest. Reviewing evidence-based data and evaluations or studies to assess this impact is especially important.

<sup>1</sup> Although fee exemption and waiver policies may exist for inpatient hospital care, this issue is primarily raised with respect to PHC services, especially priority services. For purposes of the rapid assessment, concentrate on PHC for question 15c.

**Box 7.3**  
**Basic Benefit Package**

A basic benefit package (BBP) is usually a defined group of essential and cost-effective services provided by government health facilities. BBPs of PHC services usually include the typical and routine services provided at lower level health facilities, such as maternal health services, preventive services for children (e.g., immunizations), services related to integrated management of childhood illness, and essential medicines. A BBP may cover selected hospital services when lower level facilities have made a referral. Typically, BBP services are free of charge for users.

**16. Allocation of user fee revenues**

- a. Are all or a portion of user fee revenues retained at the facility where they are collected?
- b. If so, are there guidelines for use of fee revenues? Describe the suggested or required uses of fee revenue retained at facilities (e.g., to buy additional medicines, to subsidize the poorest or give them fee waivers, to make infrastructure renovations, to provide staff bonuses). Is there community participation or oversight for the use of fee revenues?
- c. What is the average percentage that user fee revenue constitutes of non-salary operating costs for hospitals and for PHC facilities?

**Definition, rationale, and interpretation**

If revenues from user fees can be used at the facility where they are collected, this promotes incentives to collect them, and fee revenue can lead directly to improvements in quality and access to care.

User fees are typically established for purposes of increasing resources for non-salary operating costs, especially when MOH budget allocations to facilities for those purposes are low. If, on average, retained user fees constitute a substantial percentage of non-salary operating costs of facilities, then fees are likely to contribute significantly to the quality of services, as long as the MOH (or local government in a decentralized system) is not offsetting its budget allocation to the facility by the amount of user fees. Community participation in the use of fee revenues can increase the probability that they will be used to improve quality.

**Suggested data source**

Key informant interviews

*Module link:* Governance Module, indicator 29 (financial accountability of public authorities); Pharmaceutical Management Module, indicator 38 (cost recovery methods)

**Stakeholders to interview**

MOH officials at central, district, and facility levels

**17. Informal user fees in the public sector**

- a. Are informal user fees (widely) practiced in the public health sector?
- b. What is the typical form of informal fee payments?
- c. To what extent are informal user fees a financial barrier to use of services?

**Definition, rationale, and interpretation**

Informal user fees in the public sector are fees that are not officially sanctioned, often called *under-the-table payments*. They can exist in the form of cash, in-kind payments, or gratuities, and are often charged for access to scarce items such as medicines, laboratory tests, and use of medical equipment.

The amount of informal user fees that will be charged is difficult for patients to anticipate and can act as a barrier to care, just as formal fees do. Allocation of the revenue from informal user fees is subject to the discretion of the provider and, as opposed to revenue from official user fees, may not be used to increase the quality or access to public health services.

**Suggested data source**

Special studies; key informant interviews

**Stakeholders to interview**

Representatives of donor agencies, nongovernmental organizations (NGOs), and consumer advocacy organizations; users of health services (through focus group discussions)

**18. Contracting mechanisms between MOH and public or private service providers**

- a. **Within the public sector (either MOH or social health insurance providers—or both), are any contracting mechanisms or performance incentives used? If so, describe them. Distinguish between inpatient hospital care and PHC, if relevant.**
- b. **In the funding arrangements between the MOH and private health care providers, are any contracting or grant mechanisms or performance incentives in place? If so, describe them. Distinguish between inpatient hospital care and PHC and between private not-for-profit (NGO, faith-based organizations) and commercial providers, if relevant.**

**Definition, rationale, and interpretation**

Different provider payment methods give the providers different incentives for the quality and quantity of services they provide and the number of patients they serve. These incentives affect quality, access, and efficiency. Often the payment method is as important as the amount of payment.

Often, salaries are deemed to provide the least incentive for outstanding health worker performance. Salaries are, however, the most common method that MOHs use for public sector health workers. Sometimes MOH may assign MOH salaried health workers to NGO facilities as a form of in-kind grant to such facilities.

Performance contracts sometimes exist in the public sector that relate health worker pay, or facility recurrent cost budget allocations, to performance (e.g., percentage of children fully immunized, percentage of relevant patients receiving family planning counseling, percentage of cases with correct diagnosis). These performance criteria promote provision of services to attain coverage results the MOH has set.

Performance contracting (sometimes called *pay for performance*) is becoming more common in the arrangements between the public sector and private providers. Traditionally, public payments to NGOs and other not-for-profit providers have been in the form of a grant, without conditions for payment of the public funds. Careful choice of performance criteria can improve the provider incentives for quality, access for priority services or populations, and efficient use of resources.

**Suggested data source**

Key informant interviews

*Module links:* Core Module, section 5.3.4 (structure of government and private sector in health care); Governance Module, indicator 40 (partnerships with providers); Health Service Delivery Module, indicator 18 (private sector service delivery)

**Stakeholders to interview**

MOH officials and medical and nursing professional associations; NGOs and other private providers receiving government (e.g., MOH or Social Security) funds for service delivery

**Issues to explore in stakeholder interviews**

Assess with key informants whether alternative or revised payment methods or health worker incentives may be needed.

**Notes and caveats**

Distinguish between inpatient hospital care and PHC and between private not-for-profit (NGO, faith-based organizations) and commercial providers, if relevant.

### 7.3.3 Summary of Issues to Address in Stakeholder Interviews

This section includes a summary listing of the types of stakeholders to interview in assessing the indicators from Component 2 and the issues to address with each stakeholder. This process will help the assessors in planning the topics to discuss in stakeholder interviews, as summarized in Table 7.3.

**Table 7.3 Summary of Issues to Address in Stakeholder Interviews**

Profile of Stakeholders to Interview	Issues to Discuss with Stakeholder
MOH officials (including staff involved in NHA preparation)	Process of MOH budget formulation and allocation structure by government health budget spending in rural and urban areas; by levels of service (inpatient and outpatient care); and by categories of recurrent costs, user fee policies in the public sector (including exemptions), informal user fees, and basic benefit package of services
Ministry of Finance officials	Process of MOH budget formulation; ability of MOH to use allocated funds
Social Security officials	Details of SHI scheme: population coverage, funding mechanisms, and provider payment mechanisms
Ministry of Local Government, local government officials, local health administrative units	Relative priority of health in decentralized budget allocations; central and local government recurrent cost budget allocations for health, local taxation powers, local level budget spending authority, user fee policies in the public sector (including exemptions), and informal user fees
Representatives of donor agencies	Sustainability of donor support; changes in donor support (e.g., mix of project and in-kind, SWAp, general budget support); government health budget spending by levels of service (inpatient and outpatient care) and in rural and urban areas; user fees (especially informal user charges)
Private insurers	Details of private insurance schemes: population coverage, funding mechanisms, provider payment mechanisms
CBHI committees	Details of CBHI schemes: population coverage, funding mechanisms, and provider payment mechanisms
Representatives of medical and nursing professional associations, NGOs, and other private providers receiving government funds for service delivery	Provider payment mechanisms by government
Public health facility managers	User fee policies in the public sector (including exemptions), informal user fees
Representatives of PVOs, NGOs, the media	Overall perception of the government financing system, including user fees, fee exemptions, informal charges; rural and urban, outpatient and inpatient balances

### 7.4 Summarizing Findings and Developing Recommendations

Chapter 4 describes the process that the team will use to synthesize and integrate findings and prioritize recommendations across modules. To prepare for this team effort, each team member

must analyze the data collected for his or her module(s) to distill findings and propose potential interventions. Each module assessor should be able to present findings and conclusions for his or her module(s), first to other members of the team and eventually at a stakeholder workshop and in the assessment report (see Chapter 3, Annex 3J for a proposed outline for the report). This process is iterative; findings and conclusions from other modules will contribute to sharpening and prioritizing overall findings and recommendations. Below are some generic methods for summarizing findings and developing potential interventions for this module.

### **7.4.1 Summarizing Findings**

Using a table that is organized by the topic areas of your module (see Table 7.4) may be the easiest way to summarize and group your findings. (This process is Phase 1 for summarizing findings as described in Chapter 4.) Note that additional rows can be added to the table if you need to include other topic areas based on your specific country context. Examples of summarized findings for system impacts on performance criteria are provided in Annex 4A of Chapter 4. In anticipation of working with other team members to put findings in the SWOT framework (strengths, weaknesses, opportunities, and threats), you can label each finding as either an S, W, O, or T (please refer to Chapter 4 for additional explanation on the SWOT framework). The “Comments” column can be used to highlight links to other modules and possible impact on health system performance in terms of equity, access, quality, efficiency, and sustainability.

**Table 7.4 Summary of Findings—Health Financing Module**

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

<sup>a</sup>List impact with respect to the five health systems performance criteria (equity, access, quality, efficiency, and sustainability) and list any links to other modules.

### **7.4.2 Developing Recommendations**

After you have summarized findings for your module (as in Section 7.4.1 above), it is now time to synthesize findings across modules and develop recommendations for health systems interventions. Phase 2 of Chapter 4 suggests an approach for doing this with your team. In this section, we discuss a list of common interventions seen in the area of health financing that you may find helpful to consider in developing your recommendations.

### **A. Revenue Collection: Amount and Sources of Financial Resources**

If the country is heavily dependent on donor spending, consider policy initiatives or reforms to develop alternative methods for raising funding for health from domestic public and private resources. In immediate post-conflict or rebuilding state situations, these measures would typically be developed as longer term goals and phased in over a longer period than in other more stable states and economies. For example, initiatives may need to be undertaken to increase the MOH budget or to introduce user fees (with waivers for the poorest) in the public health facilities. SHI and CBHI initiatives may also be appropriate.

If out-of-pocket spending is a large share of health spending in the country and if that appears to be due to inadequate government funding (i.e., not deliberate ideological policy), consider—

- Alternative methods for cost-sharing along with initiatives to increase the MOH or SHI budgets or both (e.g., more evidence-based budget formulation process, stronger budget advocacy skills)
- Whether the use of informal user fees and design strategy for moving from informal to formal user fees is widespread

### **B. Pooling and Allocation of Financial Resources**

**Government Budget Allocation.** If MOH spending for inpatient and outpatient services appears to be inequitable or out of balance, consider whether—

- Alternative financing methods might be appropriate, such as forms of insurance for select populations or selected inpatient services or higher user fees with appropriate waivers and exemptions for higher levels of service
- Reallocation of existing MOH spending may be appropriate

If a substantially higher portion of the MOH budget is spent in urban areas (relative to the share of urban population in the country), policy initiatives or reforms for alternative financing methods and allocation of the MOH budget may need to be considered.

If government budget allocations for medicines appear to be inadequate, consider adoption of generic pharmaceutical policies and improved prescribing practices if appropriate. The purpose of these options would be to make the best use of available resources for medicines. (This issue is also covered in the Pharmaceutical Management Module, Chapter 10.)

If public sector facility managers do not have any authority for spending user fee revenues or government budget allocations, consider policy initiatives to increase facility management authority, such as fee retention policies or flexible budget allocations.

**Health Insurance.** If no or negligible public, private, or community-based insurance exists, consider whether the situation warrants greater investment in, or more analysis of, expanded risk pooling.

If substantial social insurance exists that excludes coverage for informal sector workers, consider alternative allocations of MOH budget spending to target excluded workers if their access to health care appears to be substantially lower than covered workers and households.

If a basic benefit package exists that provides selected services free of charge at the time of use, consider risk-pooling mechanisms for high-cost, high-risk services outside of the package.

### **C. Purchasing and Provider Payments**

If government contracting with private providers appears ineffective, inefficient, or hard to achieve despite government support for it, consider whether the form of provider payment or contracting needs to be altered to provide greater incentives.

If formal user fees appear to have a negative impact on utilization of PHC or other priority health care services in the public sector, consider—

- Strengthening the waiver and exemption systems
- Examining the process for setting the level of fees at PHC and hospital facilities
- Evaluating the perceived quality of health care services
- Exploring the willingness and ability to pay for different types and levels of health care services

### **D. Cross-Cutting Issues**

If policy initiatives are already under way to address major health care financing issues, consider whether (additional) evaluation design or implementation would be appropriate and if (additional) technical assistance would be appropriate.

Consider using neighboring countries in the region that perform better on key indicators of interest to policy makers as a site(s) to be analyzed to see if their methods are replicable; if so, consider these sites for study tours.

For any financing intervention proposed, consider—

- Evaluating the incentives it provides to both provider and to consumer
- Incorporating complementary quality; information, education, and communication; and other interventions that may remove the nonfinancial barriers that may be strong barriers to use of services

## Bibliography

Bennett, S., and L. Gilson. 2001. *Health Financing: Designing and Implementing Pro-Poor Policies*. London: DFID Health Systems Resource Center.

European Observatory on Health Systems and Policies. 2006. "Glossary." <<http://www.euro.who.int/observatory/glossary/toppage>> (accessed Sept. 22, 2006).

Gottrett, P., and G. Schieber. 2006. *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: World Bank.

Mossialos, E., and A. Dixon. 2002. Funding Health Care: An Introduction. In *Funding Health Care: Options for Europe*, E. Mossialos, edited by A. Dixon, J. Figueras, and J. Kutzin. Open University Press. <[http://www.euro.who.int/observatory/Publications/20020524\\_21](http://www.euro.who.int/observatory/Publications/20020524_21)> (accessed Sept. 22, 2006).

PHR (Partnerships for Health Reform). 1999. *Alternative Provider Payment Methods: Incentives for Improving Health Care Delivery* PHR Primer for Policymakers Series. Bethesda, MD: PHR

Schieber, G., and A. Maeda. 1997. A Curmudgeon's Guide to Financing Health Care in Developing Countries. In *Innovations in Health Care Financing: Proceedings of a World Bank Conference, March 10–11, 1997*, edited by G. Schieber (World Bank Discussion Paper No. 365). Washington, DC: World Bank.

Sekhri, N., and W. Savedoff. 2005. Private Health Insurance: Implications for Developing Countries. *Bulletin of the World Health Organization* 83: 127–34.

WHO (World Health Organization). 2000. Who Pays for Health Systems? In *World Health Report 2000*. Geneva: WHO.

———. 2001. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: WHO.

———. 2006. *World Health Report 2006*. Geneva: WHO. <<http://www.int/whr/2006/en/>> (accessed Sept. 22, 2006).

World Bank. 2006. "Glossary." <<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,contentMDK:20218439~menuPK:459277~pagePK:148956~piPK:216618~theSitePK:376793,00.html>> (accessed Sept. 22, 2006).

## **Annex 7A. Indicators for Health Insurance Schemes**

This annex is to be completed only if health insurance schemes exist in the country.

If the community-based health insurance or private for-profit health insurance (or both) exists but covers very small populations or provides very limited coverage, it is not necessary, for purposes of this rapid assessment to spend much time gathering data about them. Noting that some small schemes exist is sufficient.

### ***Health Insurance: Coverage, Funding, and Policy Issues***

Use the guidelines for information and data collection provided in questions A1 through A4 to fill in Table 7A1 and to develop a profile of any of the three major types of health insurance that may be available in the country: social health insurance, private for-profit health insurance, and community-based health insurance. Note that not all three types of health insurance may be present in your country.

All countries face policy and implementation issues with respect to insurance. Elicit comments from key informants about (1) any issues they have faced with respect to services and population covered, the funding, provider payment mechanisms and subsidies used, and (2) any policy or implementation initiatives or reforms they are undertaking. Based on those discussions, identify for further exploration analysis or study issues that would improve the design or implementation of any of the three insurance types. For example, community-based health insurances are typically very small but of increasing interest to governments and international donors.

**Table 7A1. Characteristics of Insurance Schemes: Social Health Insurance, Community-Based Health Insurance, and Private Health Insurance**

<b>Indicator</b>	<b>Social Health Insurance</b>	<b>Community-Based Health Insurance</b>	<b>Private Health Insurance</b>
A. Population coverage <ul style="list-style-type: none"> <li>• Members: who is covered?</li> <li>• Percentage of total population covered</li> </ul>			
B. Services covered <ul style="list-style-type: none"> <li>• Types of services covered</li> <li>• Key exclusions</li> <li>• Waiting periods</li> </ul>			
C. Funding mechanisms <ul style="list-style-type: none"> <li>• Sources of funding</li> <li>• Government subsidies</li> </ul>			
D. Payment mechanism for providers <ul style="list-style-type: none"> <li>• Types of payment mechanisms used</li> <li>• Quality or accreditation requirements for provider payments</li> </ul>			

**A1. Population coverage of health insurance**

- a. Who belongs to the scheme?
  - Public employees?
  - Formal sector (non-public) employees?
  - Informal sector—urban and rural workers?
- b. What percentage of the population is covered?
- c. Who is entitled to benefits under the scheme?
  - Only those people who pay premiums?
  - People who pay premiums and all or some of their family members?

**Definition, rationale, and interpretation**

Generally, social and private health insurances cover primarily urban populations working in the formal sector for wages. Community-based health insurance is often developed by rural and urban informal sector populations who join together to help cover the costs of user fees in the public sector, the private sector, or both.

The percentage of the population covered by insurance indicates the proportion of the population with risk pooling that shares the costs of health care across the healthy and the sick. Membership in risk pooling adds financial protection against high costs of health care at the time of use and over time, compared with paying user fees to a provider at any time that the need for health care arises. It thus improves financial access and reduces the financial barriers to use of the health care services that the insurance covers.

**Suggested data source**

Key informant interviews

**Stakeholders to interview**

MOH, Social Security officials, private insurers, community-based health insurance committees

**Issues to explore**

If either of the two types of voluntary insurance (i.e., commercial private and community-based health insurance) have existed for several years, exploring their evolution over time is useful to see if population coverage has expanded.

**A2. Services covered by health insurance**

- a. Which services are covered by the insurance (e.g., a basic package of ambulatory PHC, hospital inpatient services)?
- b. Are any priority health services (e.g., child immunizations, family planning, childbirth, voluntary counseling and testing, antiretroviral therapy for HIV-positive patients) excluded from the benefit package?
- c. Is coverage provided for medicines and, if so, at what prices or co-payments?

**Definition, rationale, and interpretation**

The greater the range of health care services covered by insurance, the more financial protection that members have against high costs of health care. If an insurance plan requires members to pay a significant co-payment at the time of using a service, it will weaken the financial protection of the plan for members.

**A2. Services covered by health insurance**

- a. Which services are covered by the insurance (e.g., a basic package of ambulatory PHC, hospital inpatient services)?
- b. Are any priority health services (e.g., child immunizations, family planning, childbirth, voluntary counseling and testing, antiretroviral therapy for HIV-positive patients) excluded from the benefit package?
- c. Is coverage provided for medicines and, if so, at what prices or co-payments?

**Suggested data source**

Key informant interviews

**Stakeholders to interview**

MOH, Social Security officials, private insurers, community-based health insurance committees

**Issues to explore**

If co-payments for covered services are very high, exploring how those requirements may have affected utilization of covered services is important. Also important is finding out if the government offers priority services (e.g., immunization, family planning) services free of charge at the time of use (e.g., as part of a basic benefit package). In that case, one would not expect to find those services included in an insurance package.

**A3. Funding mechanisms and sustainability of health insurance**

- a. Is the insurance adequately funded, or does it consistently have losses?
- b. Does the government or any other entity (such as charities, NGOs) subsidize membership for any groups? (For example, does it pay the premiums for the indigent or elderly or contribute a general subsidy, such as from general tax revenue?)

**Definition, rationale, and interpretation**

- a. Although many factors affect the financial sustainability of insurance, a key factor is whether a scheme is underfunded (e.g., because of adverse selection of members, failure of members to pay premium installments, financial mismanagement).
- b. The poorest population groups are generally unable to afford either private commercial or CBHI premiums and are typically not covered by SHI because they are in the informal sector. If the government or charitable organization subsidizes or pays the premiums to cover the poorest, however, it extends the financial protection of insurance to them, thus increasing equity of financial access.

**Suggested data source**

Key informant interviews

**Stakeholders to interview**

MOH, Social Security officials, private insurers, community-based health insurance committees

**Tip!**

See Section 7.2.1 for definitions of the most common mechanisms that purchasers of health services use to pay providers.

---

**A4. Provider payment mechanisms under health insurance**

**What are the mechanisms used by insurance schemes to pay health service providers?**

---

**Definition, rationale, and interpretation** Different payment mechanisms provide different incentives to providers. For example, fee for service promotes responsiveness and quality but may lead to cost escalation and inefficiency. Capitation and case-based payment promote efficiency and sustainability but may be problematic for quality.

Quality assurance is promoted if only the providers who are accredited or licensed can be paid for services covered by the insurance plan.

---

**Suggested data source** Key informant interviews

---

**Stakeholders to interview** MOH, Social Security officials, private insurers, community-based health insurance committees

---

