HEALTH FINANCING GUIDANCE NO 8

ASSESSING COUNTRY HEALTH FINANCING SYSTEMS

THE HEALTH FINANCING PROGRESS MATRIX

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TIMELINE

Initial conceptual development of the assessment took place during the first half of 2018, with revisions following an expert review meeting[1]. Country implementation of Version 1 as part of "proof-of-concept" testing followed in Afghanistan, Lao PDR, Myanmar, Peru and Tanzania through the second half of 2018. Initial experience from these countries was presented at the WHO Symposium on Health Financing for UHC 2018, Liverpool UK. A further seventeen countries then implemented Version 1, with the experience of Uganda and Tanzania presented at the African Health Economics Association 2019 Conference, in Accra, Ghana. The assessment tool was presented in numerous inter-agency meetings throughout 2019. Starting in early 2020, a systematic process of revising both the content of the assessment, and the development of detailed implementation guidance, were conducted. Edition 1 of the HFPM Country Assessment Guide, and a dashboard of publicly available quantitative indicators to support the assessment process, as well as a global knowledge database of country assessments, were also developed through 2020.

1 The report from this meeting is available upon request. Organizations represented at the meeting were: World Bank, Bill & Melinda Gates Foundation, The Global Fund, R4D, USAID Tanzania, Instituto de Estudios Peruanos (Peru), Abt Associates, LSHTM, Queen Margaret University (UK), KEMRO-Welcome Trust, P4H, Thinkwell, Seoul National University.

ABBREVIATIONS

AfHEA	The African Health Economics and Policy Association
AFRO	WHO Regional Office for Africa
AMRO	WHO Regional Office for the Americas
BR	Benefits and conditions of access
CHE	Current Health Expenditure
DFID UK	Department for International Development of the United Kingdom
DRG	Diagnosis Related Groups
EMRO	WHO Regional Office for the Eastern Mediterranean
GV	Health Financing Policy, Process and Governance
HF	Health Financing
HFPM	Health Financing Progress Matrix
HSS	Health System Strengthening
LSHTM	London School of Hygiene and Tropical Medicine
MoH	Ministry of Health
OOPs	Out-of-pocket payments
PFM	Public Financial Management
PHC	Primary Health Care
PR	Pooling Revenues
PS	Purchasing and Provider Payment
RR	Revenue Raising
SDG	Sustainable Development Goals
SEARO	WHO Regional Office for South East Asia
SHA	System of Health Accounts
SSK	Shastho Surokhsma Karmasuchi, Health Protection Scheme
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
WHO	World Health Organization
WPRO	WHO Regional Office for the Western Pacific

1. INTRODUCTION, MOTIVATION AND OBJECTIVES

This paper outlines the background to and design of the Health Financing Progress Matrix (HFPM), WHO's standardized qualitative approach to assessing country health financing systems. Primarily qualitative in nature, the HFPM assesses a country's health financing institutions, processes, policies and their implementation, benchmarked against good practice in the context of universal health coverage (UHC). The paper also details processes which ensure that country assessments are credible. While health financing is only one of the core functions of a health system, it significantly influences both the extent to which the population accesses health services, and the extent to which they face financial hardship in the process. Through a forward-looking assessment process the HFPM contributes to building resilience within health systems, which also contributes directly to improved emergency preparedness and response.

Most countries have official policy statements on health financing which address issues such as the level and mix of revenues for the health sector, and how those funds are allocated for both individual and population-based health services. Policies may be in the form of a health financing strategy, or statements within a broader health sector strategy. Statements are often high level, setting broad goals, and as such require further detail in terms of the specific interventions or reforms to be developed and implemented; this is the point at which the results of a HFPM assessment engages with the domestic policy cycle.

There is currently no standardized approach to assessing a country's health financing system in terms of the quality of its institutions, processes, policies, and their implementation, which is explicitly based on evidence about what works in health financing to make progress towards UHC. A number of international agencies have developed health financing assessments, some extremely thorough and comprehensive, providing invaluable information, but requiring considerable time and money, and hence conducted less frequently. Others are developed primarily for internal purposes and are not always publicly available; the HFPM aims to complement and build on these assessments, but is being developed as a global public good.

Quantitative indicators, such as Sustainable Development Goals (SDG) indicators 3.8.1 and 3.8.2, as well as detailed National Health Accounts studies, have a number of limitations. First, data are available with a minimum of two years delay, given the time lag in data collection, analysis and verification; secondly, data are often only available as national averages limiting their usefulness for the development of policy, although progress is being made on this front; thirdly, while essential for monitoring purposes, quantitative indicators alone provide little direction for policy makers in terms of the next steps, and the priority actions required to make progress.

The HFPM, rooted in a causal framework which links system reforms to results, aims to address these issues, by providing an assessment which both complements quantitative analysis, and provides more

timely information for policy makers. The HFPM is designed to capture the dynamics of policy development and implementation processes, in particular any shifts in direction, whether implicit or explicit. HFPM assessment questions reflect a movement back down the results chain from outcomes to inputs and actions i.e. policy decisions, allowing an assessment to be made of how aligned current and emerging health financing policy is with both theory and empirical evidence of good practice in the context of UHC and health security; it also allows an assessment of whether this alignment gets stronger or weaker over time.

To provide timely, regular information for policy makers, the HFPM needs to be parsimonious. The first time an assessment is conducted, the time required will be longer than for subsequent iterations, which will focus on updating baseline assessments and highlighting areas of change. This approach allows country assessments to be produced within shorter timeframes, with relatively few resources, more frequently, and as a result to synchronize with real time policy development, review and revision cycles.

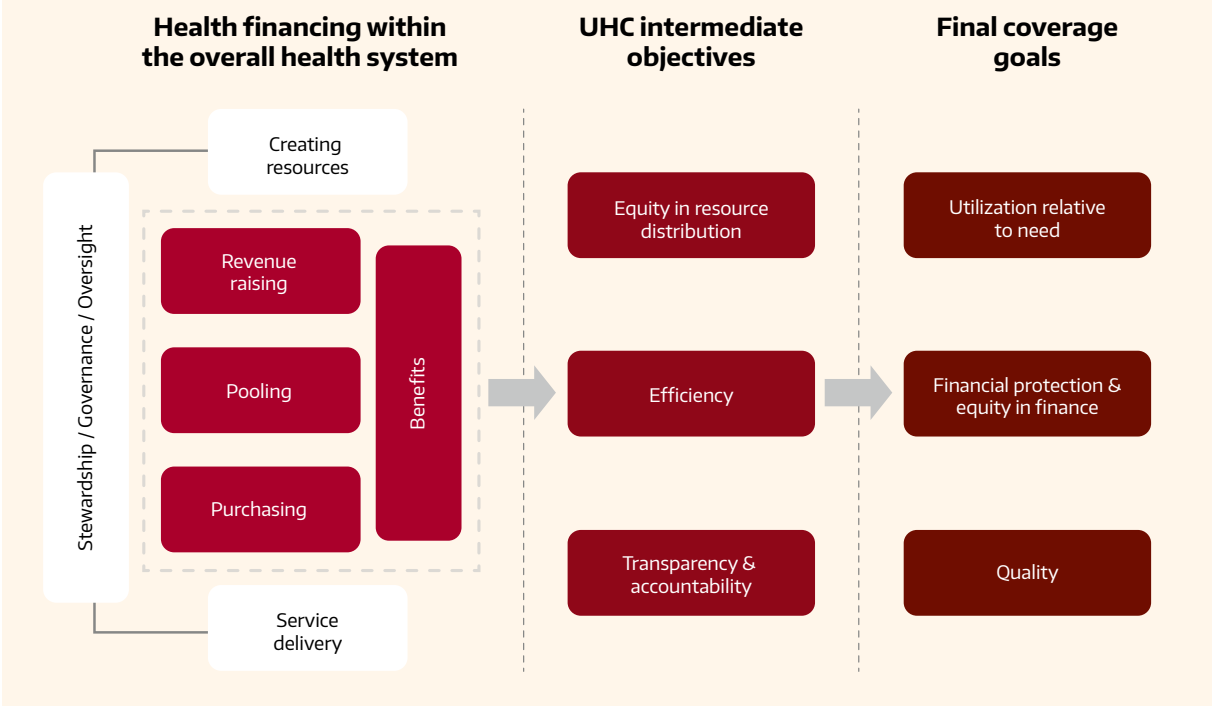
2. WHO'S GUIDANCE ON HEALTH FINANCING FOR UHC

2.1 A FRAMEWORK BASED ON FUNCTIONS

The HFPM crystallizes thinking on what matters in health financing for UHC, based on a body of evidence and normative work developed over the past twenty years or more. The HFPM builds on the health systems framework presented in the World Health Report 2000 [2] which defines four core functions performed by all health systems, one of which is health financing. The health financing function is further unpacked into three core sub-functions, revenue raising, pooling of funds, and purchasing of health services, together with benefit design as a fourth policy area of central concern [3].

These sub-functions provide a common basis to analyze health financing policies and institutions in all health systems, whether in high, middle or low-income countries, and irrespective of the label attached to them, e.g. tax-based or health insurance. All WHO's work on health financing, including the HFPM assessment, takes this functional approach as

Figure 1: WHO's framework for health financing and UHC[2]



Source: [4]

2 In light of the current pandemic, the above framework is being amended to include health security at the level of a final coverage goal.

illustrated in Figure 1 [4]. When organized this way, health financing is focused on revenue raising, pooling, purchasing and benefit design policies that drive progress towards UHC (final coverage goals) and, ultimately, improvements in population health. Conceptualized this way, the details of health financing policy are about the pathways through which revenue raising policy impacts on UHC directly or indirectly.

2.2 DESIRABLE ATTRIBUTES IN HEALTH FINANCING

WHO's strategic policy guidance on health financing has been detailed in numerous documents over the past twenty years, and is summarized in a few key publications [3, 5-12]. This guidance, which draws on both normative thinking and empirical evidence, was initially described in a set of guiding principles [11]. These principles have been further developed and reframed as *desirable attributes*, built around the sub-functions of health financing systems; attributes are also developed for public financial management, and the process of health financing policy governance. *Desirable attributes* are normative statements of "what matters" in health financing policy and its implementation in order to make progress towards UHC.

Desirable attributes are written in a way that describes an ideal situation in terms of policy design and implementation, or institutional arrangements. Attributes are effectively a set of benchmarks, based on the assumption that progress towards the attribute will impact positively on UHC. Nineteen desirable attributes form the foundation of the HFPM (see Table 1). Unique attributes have not been defined for the "Public health functions and programmes" assessment area; the questions in this section draw on five attributes defined in other sections (and repeated at the end of Table 1). The progress levels (see Section 3.2) for questions in the "Public health functions and programmes" assessment area hence relate to these attributes. Two unique attributes are defined for PFM, but given the cross-cutting nature of this issue, the questions in this section draw on a much wider set of attributes, for example RR2 and RR3. A summary of how questions are mapped to attributes is provided in detail in Annex 3, with summaries provided in Annexes 4 and 5.

2.3 THE EVIDENCE-BASE FOR DESIRABLE ATTRIBUTES

As noted above, the HFPM formalizes thinking on health financing for UHC, through the nineteen desirable attributes, based on a mixture of theory and empirical evidence generated over many years. In order to be explicit about this evidence base, relevant literature has been systematically organized and mapped to the different elements of the HFPM i.e. desirable attributes, assessment questions, and objectives and goals. The evidence base shows how and why certain policy changes or specific means of implementation have positively influenced progress towards UHC.

Two important perspectives underpin the development of the evidence-base. First, the structure follows the functional approach, (as discussed in Section 2.1) rather than categorizing entries using labels such as health insurance. Secondly, we review evidence of policies and interventions which contribute to UHC, which requires looking at the impact of health financing policies from the perspective

Table 1: Desirable attributes of health financing systems

Health financing policy, process & governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs
Public health functions & programmes[3]	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

3 No unique attributes are defined for this assessment area; rather the questions draw on attributes from other assessment areas.

of the overall health system, rather than one intervention or scheme in isolation without consideration of possible negative spill-over effects on the broader health system [13].

Evidence mapping is an approach to literature reviews which categorizes relevant literature for a specific topic or issue. The identification of literature was selective, purposeful and targeted, based on resource materials developed by WHO, other agencies, and supplemented by database searches, resulting in the inclusion of a total of seventy-six publications. Review of these publications was carried out by three individuals with selective double-coding to ensure a degree of reliability.

Each publication was organized into three broad categories, further detailed in Table 2:

- key publication characteristics
- key findings, study design and research methods employed
- description of the health policy action studied in terms of the relevant health financing function(s), health financing attributes, UHC intermediate objectives and final coverage goals, all based on existing health frameworks.

Mapping of evidence was completed once additional reviews resulted in repeatedly coding the same aspects. Theoretical papers include those relating to principal-agency issues which informs thinking on purchasing arrangements such as the separation of purchasers and providers; theory relating to the law of large numbers and adverse selection inform thinking on risk-sharing strategies. Empirical studies include results from quasi-experimental studies, descriptive studies of health financing arrangements such as the basis of participation in insurance schemes, and country experiences e.g. descriptions of public financial management bottlenecks.

The exercise highlights the extent to which each attribute is backed by evidence, the type of evidence which exists, and the research methods on which they are based. Reforms in complex systems, which are typically based on a mix of interventions which interact with each other, do not easily lend themselves to Cochrane-like RCTs. Furthermore, some areas have not have been extensively researched (e.g. the potential gains from unifying information platforms across programmes and schemes, or the constraints arising from fragmented service delivery platforms). Despite this,

Table 2: Criteria used to map the evidence base

Basic publication identifiers	Author(s), year of publication, title of publication, publication type/ source
Key findings	Brief summary of main results and related conclusions/policy implications
Study characteristics	Study design, methods, setting
Health financing functions and policies	Revenue raising, pooling, purchasing, benefit design, PFM
Health financing desirable attribute(s)	e.g. health expenditure is based predominantly on public /compulsory funding sources
UHC intermediate objectives	Equity in resource distribution, efficiency, transparency.
Final coverage goals	Utilization relative to service need, financial protection, quality

desirable attributes are still included if there is a strong element of informed intuition. In some cases, desirable attributes are based on plausible hypotheses that form the basis for a future research agenda. The evidence base for the HFPM will continue to be developed, reviewed and improved over time.

Box 1 summarizes a 2018 study by Patcharanarumol et al[4] which illustrates how evidence was mapped and how it demonstrates the connections between health financing functions, desirable attributes and health system objectives; in this case, desirable attributes for policy development, purchasing and governance contributed to improvements in efficiency and transparency and accountability. The findings from this study of the health system in Thailand were consistent with a large body of existing literature on provider payment methods, which reinforced existing lines of thought. The study also takes a system-wide perspective, looking not only within each scheme but also at inequalities across schemes.

Box 1: An example of mapping evidence to attributes, objectives and goals

Purchasing health services in Thailand

This paper analyzed the different purchasing practices in the Universal Coverage Scheme (UCS) and the Civil Servants Scheme in Thailand; in the latter purchasing is passive, relying on fee-for-service payment for outpatient care, without measures to control costs such as gatekeeping, allowing members direct access to specialists. In contrast, purchasing in the UC Scheme adopted closed-ended provider payments such as age-adjusted capitation payments based on the catchment population, and DRGs with a global budget for hospital services; gate-keeping is also used, and collective purchasing power exercised e.g. centrally purchasing of high-cost medicines to obtain lower prices, and engaging views of members in the decision making process.

Based on an analysis of expenditure data, key informant interviews and a range of documentation, the primary finding by the authors were that the different policies on purchasing and other areas, resulted in cost escalation and overspending in the Civil Servants Scheme, with expenditure per member four times higher than in the UC Scheme which adopted a more strategic approach to purchasing.

The study provides critical evidence which form part of the foundation for the matrix, including the importance of incorporating population health needs (PS1), budgetary controls (PS3), and effective institutional arrangements to hold health financing agents accountable (GV2), to ensure good performance in terms of efficiency, and transparency and accountability, and progress towards UHC. The study also highlighted the importance of a system-wide perspective.

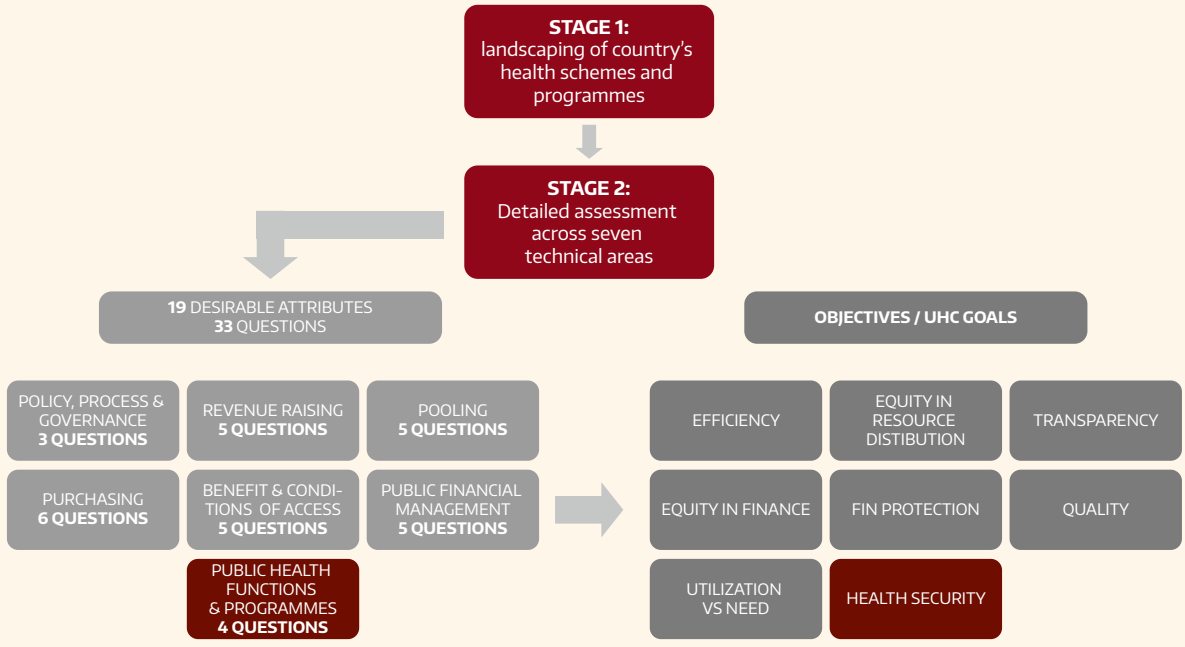
4 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0195179

3. STRUCTURE OF THE HEALTH FINANCING PROGRESS MATRIX

3.1 OVERVIEW

The HFPM assessment is organized into two stages (see Figure 2); in Stage 1, the main health coverage arrangements or programmes[5] in the country's health system are mapped and described. The aim is not to be exhaustive, but rather to capture the important or significant schemes either in terms of financial dominance, policy relevance, or both. For each scheme or programme included, the key features are described, such as the population covered (target and actual), revenue sources, benefit entitlements, conditions of access, pooling and purchasing arrangements and the structure and design of any patient copayment; Annex 1 provides further details.

Figure 2: Overview of the HFPM assessment



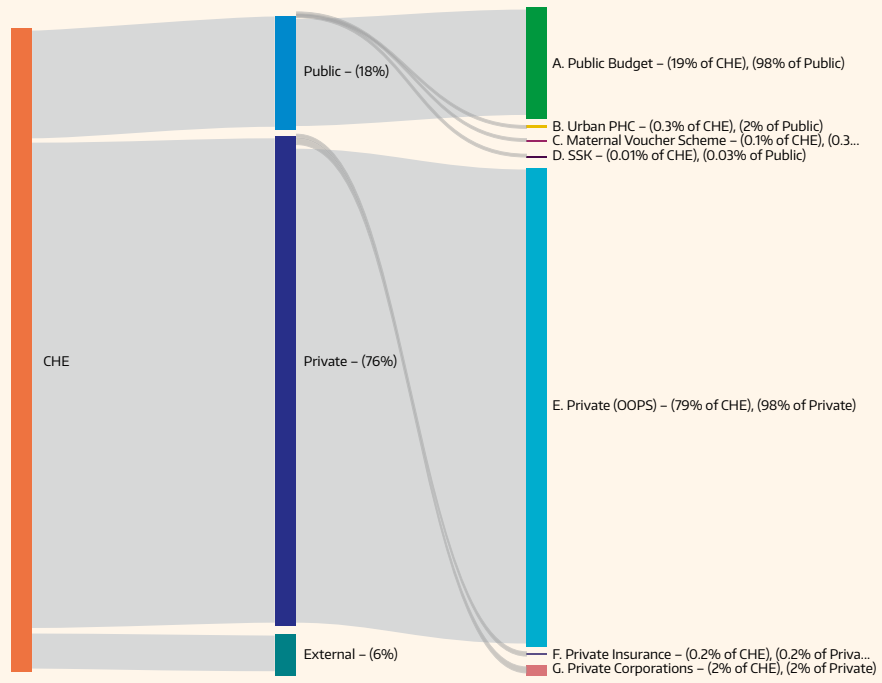
5 These are sometimes referred to as health financing "schemes", the criteria being that they have a distinct pool of funds associated with them. This is different from how the term "schemes" is used in the System of Health Accounts (SHA), which is a group of financing arrangements with similar characteristics. For example, out-of-pocket payments are categorized as a scheme in SHA, but not in the HFPM.

Stage 1 provides a picture of the health financing landscape across the health system, providing an initial picture of the extent of fragmentation and misalignment across the health system. Expenditure data from the **Global Health Expenditure Database** (or where available, from country Health Accounts studies) are then mapped onto the individual coverage programmes, providing a picture of the relative financial weight or importance of each coverage scheme. Figure 3 provides an illustration based on preliminary analysis from Bangladesh which also allows per capita spending to be estimated for each scheme. This is one concrete way in which quantitative and qualitative information are combined to add value to the assessment.

3.2 DESIRABLE ATTRIBUTES, QUESTIONS AND PROGRESS LEVELS

As noted earlier, the HFPM is built on nineteen desirable attributes of health financing policy, crystallizing both theory and empirical evidence about what matters in order to make progress towards UHC. To keep the assessment manageable in length the HFPM is focused on capturing the critical elements of a health financing system; more detailed assessments exist for deep-dive diagnostics into issues such as PFM bottlenecks or the provider payment landscape. Linking each assessment question to at least one attribute ensures a robust internal logic.

Figure 3: Mapping health expenditure data to a Stage 1 analysis – example from Bangladesh



Public Expenditure per capita
(US$ per entitled beneficiary)

A Public Budget	8
B. Urban PHC	2
C. Maternal Vouche Scheme	18
D. SSK	4

Private Expenditure per capita
(US$ per entitled beneficiary)

A Public Budget	8
E. Private (OOPs	9
F. Private Insurance	95
G. Private Corporations	23

Stage 2 comprises thirty-three questions, each building on at least one desirable attribute, and forming the basis of the entire assessment (see Annex 2)[6]. Annex 3 details the relationship between attributes and questions, with Annex 4 and Annex 5 repeating this in summary form. Most questions within an assessment area are mapped to attributes unique to the issue being addressed, but in some cases there is a cross-walk to attributes from other assessment areas. For example, several PFM questions are linked to attributes defined under the revenue raising and other sections (see Annex 5).

Each question captures either fully or partially the attribute on which it builds, with the assumption that some policies and modes of implementation are better than others in terms of making progress towards UHC. Four progress levels are defined for each question, defined as "Emerging" "Progressing" "Established" and "Advanced", based on criteria considered central to making progress on the specific issues being assessed. There are two broad approaches to structuring questions and progress levels: the first is to have relatively lengthy questions, with scales defined very simply with little detail. A second approach is to have shorter questions with greater detail provided for each progress level, together with an explanation of both why the question matters, and what progress looks like. Following an extensive proof-of-concept phase conducted in twenty countries the latter approach is followed, with detailed explanation for each progress level provided in the HFPM Country Assessment Guide [1]. While the HFPM is primarily qualitative in nature, relevant quantitative information is also used in the assessment; the latest country values for relevant indicators have been compiled on a bespoke dashboard[7] to support the country assessment process, and will be further developed and tailored to assessment questions over time.

3.3 CROSS-CODING AND MAPPING TO OBJECTIVES

Given the interaction between multiple components of health systems, and the often complex non-linear relationship between policy interventions, their implementation, and effects on health system performance, the separation of issues and questions into seven discrete assessment areas is a simplification, albeit a necessary one.

To overcome these limitations questions are cross-coded where relevant. Public financial management (PFM) is a useful illustration, with assessment area six comprising two dedicated attributes and five questions; however, an additional eight questions in other assessment areas are tagged or coded as relevant to PFM. Hence, the HFPM analysis of PFM in a country based on performance across thirteen questions. Each question is also mapped to one or more health system intermediate objective or final coverage goal, summarized in Table 3, with Annex 6 providing further details.

6 The number of questions has been reduced from forty-eight in Version 1 of the HFPM, implemented in twenty countries as part of proof-of-concept testing. Version 2 also includes four new questions addressing health financing for health security, common goods for health, core public health functions, and disease-specific or health programmes.

7 The dashboard can be accessed via the WHO Health Financing website using *this link.*

Table 3: Mapping of questions to intermediate objectives and final coverage goals		
		Number of questions mapped
FINAL COVERAGE GOALS	Financial protection	12
	Equity in finance	7
	Service use relative to need	13
	Health security[8]	5
	Quality	3
INTERMEDIATE OBJECTIVES	Efficiency	12
	Equity in resource distribution	9
	Transparency & accountability	12

Table 4: Mapping of questions to additional areas of policy concern	
	# questions mapped
Service delivery	13
Common Goods for Health	12
Decentralization	4
Pricing	3
Medicines	2

Cross-coding of questions, and the mapping of attributes and questions to objectives and goals is built into the database of HFPM country assessments, providing flexibility in how results can be viewed and extracted i.e. by assessment area, desirable attributes, or one of the intermediate objectives or final coverage goals. Additional coding has also been built into the HFPM database to reflect linkages between health financing and other areas of policy concern for which there are no dedicated assessment questions. For example, certain questions have direct linkages with service delivery, medicines and decentralization. Current mapping is summarized in Table 4 and will remain under development and review.

While health financing often focuses heavily on coverage of personal services i.e. those delivered directly to individuals, the HFPM also tags or maps questions to the financing of Common Goods for Health (CGH) [14]. CGH are population-based functions and interventions that require public financing, given they have either public good qualities or large externalities, and hence are undersupplied by private markets. CGH falls into five categories: 1) policy and coordination, 2) taxes and subsidies, 3) regulations and legislation, 4) information collection, analysis and communication, and 5) population-wide services. CGH serve as the foundation of any health system, and are fundamental to building national and global

8 As noted in the footnote to Figure 1, health security is now included as a final coverage goal.

health security and progress towards UHC, addressing pressing issues such as climate change, health security, gender and socio-economic inequality, disaster preparedness, environmental protection, and health promotion to tackle societal risk factors.

3.4 BUILDING A GLOBAL KNOWLEDGE DATABASE

In addition to the production of HFPM Country Assessment Reports, assessments are uploaded to a global knowledge database. With a wide range of dashboards and visualizations, the global knowledge database allows users to easily switch between overview graphics of areas of strength and weakness in the country's health financing system, or to drill down into performance on individual questions, with aggregate views around desirable attributes, assessments areas, intermediate objectives, and final coverage goals. As a country conducts follow-up assessments, those areas where progress has been made over time, or not, will be highlighted.

As the number of country assessments uploaded to the global knowledge database increases, its usefulness will grow in terms of knowledge sharing, and cross-learning. The database also allows country performance on individual questions to be seen side-by-side with other countries. No overall country score or ranking of countries is calculated; rather the focus is to facilitate cross-learning through a database using a functional approach to categorization and analysis, and taking a system-wide perspective, which is central to universal health coverage. In summary, the HFPM collects information on measures of performance which can both be benchmarked against good practice, and also allow comparison across countries.

4. STRENGTHENING THE OBJECTIVITY OF HFPM ASSESSMENTS

4.1 METHODOLOGICAL CONSIDERATIONS

One challenge facing any assessment which is primarily qualitative in nature, is to ensure that results are objective and credible, while recognizing the limits when measuring performance in complex systems. Central to implementation of the HFPM is the independence of those conducting the assessment, and a separation between the assessment process and the discussion of results. While the assessment process will necessarily require the investigator(s) to engage with those responsible for health financing policy and its implementation, the focus is on gathering information and evidence to be used as the basis for the assessment.

To further strengthen the validity of results, the investigator(s) should be a recognized expert in health financing with an in-depth knowledge of the country's health system; the compilation of documentation together with relevant quantitative indicators strengthens the evidence base on which the assessment is made. The identification of gaps in knowledge and evidence is a important output of the HFPM, helping to set an agenda for future analytical and technical work.

The systematic structure and internal logic of the HFPM facilitates the production of clear, concise assessments, which further adds to the credibility of assessments. While the underlying foundations (Section 2.2) of the HFPM can be challenged and improved, the evidence base is explicit and under continual revision and improvement; assessment questions build directly on one or more desirable attribute, with an explanation of the criteria driving progress detailed in the four levels for each question provided in the HFPM Country Assessment Guide [1]; finally, attributes and questions are mapped to intermediate objectives and goals. Full transparency on each of these dimensions strengthens the HFPM, and facilitates for review and improvement.

Interpretation of the assessment findings is also important; more often than not it is misleading to assume that a specific health financing reform which led to progress in one country, would have a similar effect in a different country. Rather, appropriate technical assistance is based on a considered review and discussion of the key factors which made progress possible, something which is intrinsic to the HFPM. Further measures to strengthen the objectivity of country assessments are incorporated into the country implementation process, outlined in the next section.

4.2 COUNTRY ASSESSMENT IMPLEMENTATION PROCESS

While the specific implementation process followed will vary in each country, there are common elements which ensure rigour and

quality. In most cases a Principal Investigator is contracted to complete the assessment, supported by one or more health financing expert who provides feedback and review during the process. Certain questions require a significant technical knowledge of health financing, and the functional approach to the assessment requires interpretation in the specific institutional context of each country. This team, established for each assessment, will review drafts, suggest information sources, and provide feedback to the Principal Investigator.

Once a comprehensive, clearly written, and fully referenced Stage 1 and Stage 2 assessment is finalized, it is reviewed by two experts who were not closely involved in the assessment itself, but who have adequate knowledge of the country and its health system. Each expert reviews the assessment separately, including the scoring of each question against the four progress levels, and then discuss any issues on which opinions differ; for these issues a consensus score is agreed, together with the key findings and messages of the assessment. Discussed is then held with the Principal Investigator(s) and other interested parties, to finalize the assessment.

A second-stage review is then conducted by a team of technical experts tasked with ensuring consistency in scores across countries. This is particularly important once assessments are uploaded to the global knowledge database where country performance can be compared. Finally, the assessment is presented to and discussed with the MoH and or relevant health financing working group, to discuss and correct any factual errors, and to address any issues of contention, prior to finalization.

4.3 IMPROVING THE HFPM OVER TIME

The HFPM has been developed as a global public good with the aim of further aligning country health financing systems with UHC; as such, it is anticipated that a range of stakeholders globally will be engaged in its continued development. It is important that the HFPM evolves and improves over time, learning from implementation experience, to ensure the production of high quality, credible, country assessment reports. A number of governing processes based on good practice [15] will be put in place to ensure this continuous improvement, including:

- ensuring a clear strategic direction for the HFPM i.e. maintaining a focus on its purpose and value proposition.
- overseeing the implementation and performance of the HFPM, through the establishment of processes to update the assessment tool as evidence and normative thinking evolves, and to review and improve the country implementation process
- financial sustainability i.e. ensuring the necessary financial and non-financial support to sustain the production of high-quality country assessments, and improve support products including the health financing evidence base, and the global knowledge database
- management of stakeholder relations; this involves understanding the needs and expectations of policy-makers and other users of HFPM assessments, engaging with and aligning stakeholders around the development and use of assessments; both aspects can support the development of global consensus around key policy directions for health financing policy.

ANNEX 1: STAGE 1 ASSESSMENT OF HEALTH COVERAGE ARRANGEMENTS

Stage 1 involves describing the key design elements of each scheme or programme using the template provided, with guidance provided in the table below. Stage 1 is largely descriptive and supports the critical assessment of the health financing system in Stage 2, by identifying the extent of structural fragmentation within a health system.

	ASSESSMENT AREA	GUIDANCE NOTES
A	**FOCUS OF THE SCHEME**	Once the scope of schemes has been agreed, describe each in terms of its focus; this may be all citizens in the case of general budget funding for health facilities, an insurance scheme for public sector employees, community-based insurance, free-care programmes, vertical disease programmes etc. In addition to adding a short description please code using the drop-down list.
B	**TARGET POPULATION**	Please add here the best estimate of the number of people entitled to receive services or other benefits under this scheme. This provides a denominator for various equity related calculations.
C	**POPULATION COVERED**	Please add data or estimates about the numbers covered relative to the target population. This figure provides numerator information and, in some cases, will be the same as the denominator e.g. where the basis for coverage (next question) is automatic. In other schemes such as those targeting informal sector, or non-salaried workers, the figure of actual enrolees may be significantly lower.
D	**BASIS FOR ENTITLEMENT / COVERAGE**	What is the legal basis for coverage or entitlement? Is it a) mandatory, i.e. where entitlement to service benefits depends on a contribution made by or on behalf of individuals that is required by law (e.g. payroll-deductions under a social health insurance scheme); b) automatic, i.e. where the basis for entitlement is "non-contributory" (e.g. citizenship, residence, income, poverty status); or c) is participation and hence the basis for entitlement voluntary, i.e. not required by government even if it may be required by an employer?
E	**BENEFIT ENTITLEMENTS**	Under the scheme, is a specific set of services, medicines etc. listed explicitly as being covered (positive list)? Are all services covered with, for example, some exclusions (a negative list)? Please add a description and code using the drop-down list.
F	**CO-PAYMENTS (USER FEES)**	Do users have to make a co-payment (user fee)? If so, please give further details of what services these are applied to, and whether to certain subgroups. Are there exemptions, based either on individual (e.g. income, poverty status, age, sex, disease) geographic (e.g. rural vs urban), or facility type (e.g. health centre vs hospital)? Finally, please describe how the co-payment is structured e.g. a single fixed amount, a series of fixed amounts, a percentage of the bill; if the latter, is there a ceiling on total payments over a period of time?
G	**OTHER CONDITIONS OF ACCESS**	In addition to any co-payments which users may have to pay, there may be other conditions which must be met in order to access services. For example, patients may have to follow a referral system, or be limited to public health facilities or a preferred provider network. Other conditions may be that only generic medicines are provided, or there are limits on the treatment intervention provided; for example, in the early years of the Universal Coverage Scheme in Thailand, haemodialysis was only publicly funded as treatment for renal failure if peritoneal dialysis (the first line of treatment), was not effective.

	ASSESSMENT AREA	GUIDANCE NOTES
H	**REVENUE SOURCES**	Where does funding for the scheme or programme come from? Funds may come from the health budget, for example as direct funding to health facilities, allocations to a targeted scheme e.g. under 5s, or transfers to a health insurance scheme on behalf of the poor. Other examples are pre-paid contributions linked specifically with coverage as in insurance schemes. Finally, indicate any funding from external sources.
I	**POOLING**	Are revenues for the scheme held at the national level, or allocated to subnational government authorities? Does the scheme poo its revenue in a single fund, or in multiple funds, for specific population groups or geographical areas?
J	**GOVERNANCE OF HEALTH FINANCING**	Briefly describe the management and governance arrangements of the different schemes or programmes where possible. There is some similarity with pooling arrangements so please add here information about the line Ministry which the scheme falls under (e.g. MoH, Min. Social Welfare), as well as information about governing boards etc. Please add references for more detailed information.
K	**PROVIDER PAYMENT**	Describe the way in which health service providers are paid under this scheme; there may be multiple approaches. Please code using the drop-down list.
L	**SERVICE DELIVERY & CONTRACTING**	Which type of facilities provide services under the scheme? Public, private-for-profit, private-non-profit? Is there an accreditation scheme, or a preferred provider network? Are contracts or service performance agreements used?

ANNEX 2: STAGE 2 QUESTIONS BY ASSESSMENT AREA

ASSESSMENT AREA	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
1) HEALTH FINANCING POLICY, PROCESS & GOVERNANCE	Q1.1	hfstrat	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	govacntbl	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	data4gov	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) REVENUE RAISING	Q2.1	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	predict	How predictable is public funding for health in your country over a number of years?
	Q2.3	stable	How stable is the flow of public funds to health providers?
	Q2.4	prgrsv	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	hlthtax	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) POOLING REVENUES	Q3.1	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
4) PURCHASING & PROVIDER PAYMENT	Q4.1	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	ppmqlcrd	Do purchasing arrangements promote quality of care?
	Q4.4	ppmeff	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?

ASSESSMENT AREA	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
5) BENEFITS & CONDITIONS OF ACCESS	Q5.1	benexplct	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	benprcss	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	benundrstd	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	benrevalgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) PUBLIC FINANCIAL MANAGEMENT	Q6.1	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	bdgtprcss	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	expinfmon	Is health expenditure reporting comprehensive, timely, and publicly available?
7) PUBLIC HEALTH FUNCTIONS & PROGRAMMES	Q7.1	prgalgnplcy	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?

ANNEX 3: STAGE 2 QUESTIONS BY DESIRABLE ATTRIBUTE

ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
1) HEALTH FINANCING POLICY, PROCESS & GOVERNANCE	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services.	GV1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?	hfstrat	Q1.1
			Are health financing agencies held accountable through appropriate governance arrangements and processes?	govacntbl	Q1.2
			Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?	bdgtprcss	Q6.3
			Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?	prgalgnplcy	Q7.1
			Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?	prgpoolalgn	Q7.2
			Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?	scrtyprep	Q7.3
			Are public financial management systems in place to enable a timely response to public health emergencies?	scrtyresp	Q7.4
	There is transparent, financial and non-financial accountability, in relation to public spending on health	GV2	Are health financing agencies held accountable through appropriate governance arrangements and processes?	govacntbl	Q1.2
			Is health expenditure reporting comprehensive, timely, and publicly available?	expinfmon	Q6.5
	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments	GV3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?	data4gov	Q1.3
			Is there an up-to-date assessment of key public financial management bottlenecks in health?	pfmdiag	Q6.1

ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
2) REVENUE RAISING	Health expenditure is based predominantly on public/ compulsory funding sources	RR1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?	revpol	Q2.1
			To what extent are the different revenue sources raised in a progressive way?	prgrsv	Q2.4
			Are there measures to address problems arising from both under- and over-budget spending in health?	bdgtcntrl	Q6.4
	The level of public (and external) funding is predictable over a period of years	RR2	How predictable is public funding for health in your country over a number of years?	predict	Q2.2
			Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?	bdgtprcss	Q6.3
	The flow of public (and external) funds is stable and budget execution is high	RR3	How stable is the flow of public funds to health providers?	stable	Q2.3
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?	bdgtprcss	Q6.3
			Are there measures to address problems arising from both under- and over-budget spending in health?	bdgtcntrl	Q6.4
	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms	RR4	To what extent does government use taxes and subsidies as instruments to affect health behaviours?	hlthtax	Q2.5

ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
3) POOLING REVENUES	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds	PR1	To what extent are the different revenue sources raised in a progressive way?	prgrsv	Q2.4
			Does your country's strategy for pooling revenues reflect international experience and evidence?	poolpol	Q3.1
			To what extent is the capacity of the health system to re-distribute prepaid funds limited?	redistlim	Q3.2
			Are multiple revenue sources and funding streams organised in a complementary manner, in support of a common set of benefits?	revpool	Q3.4
			What is the role and scale of voluntary health insurance in financing health care?	vhispill	Q3.5
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are public financial management systems in place to enable a timely response to public health emergencies?	scrtyresp	Q7.4
	Health system and financing functions are integrated or coordinated across schemes and programmes	PR2	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?	data4gov	Q1.3
			Does your country's strategy for pooling revenues reflect international experience and evidence?	poolpol	Q3.1
			What measures are in place to address problems arising from multiple fragmented pools?	fragsolve	Q3.3
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?	prgalgnplcy	Q7.1
			Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?	prgpoolalgn	Q7.2
			Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?	scrtyprep	Q7.3

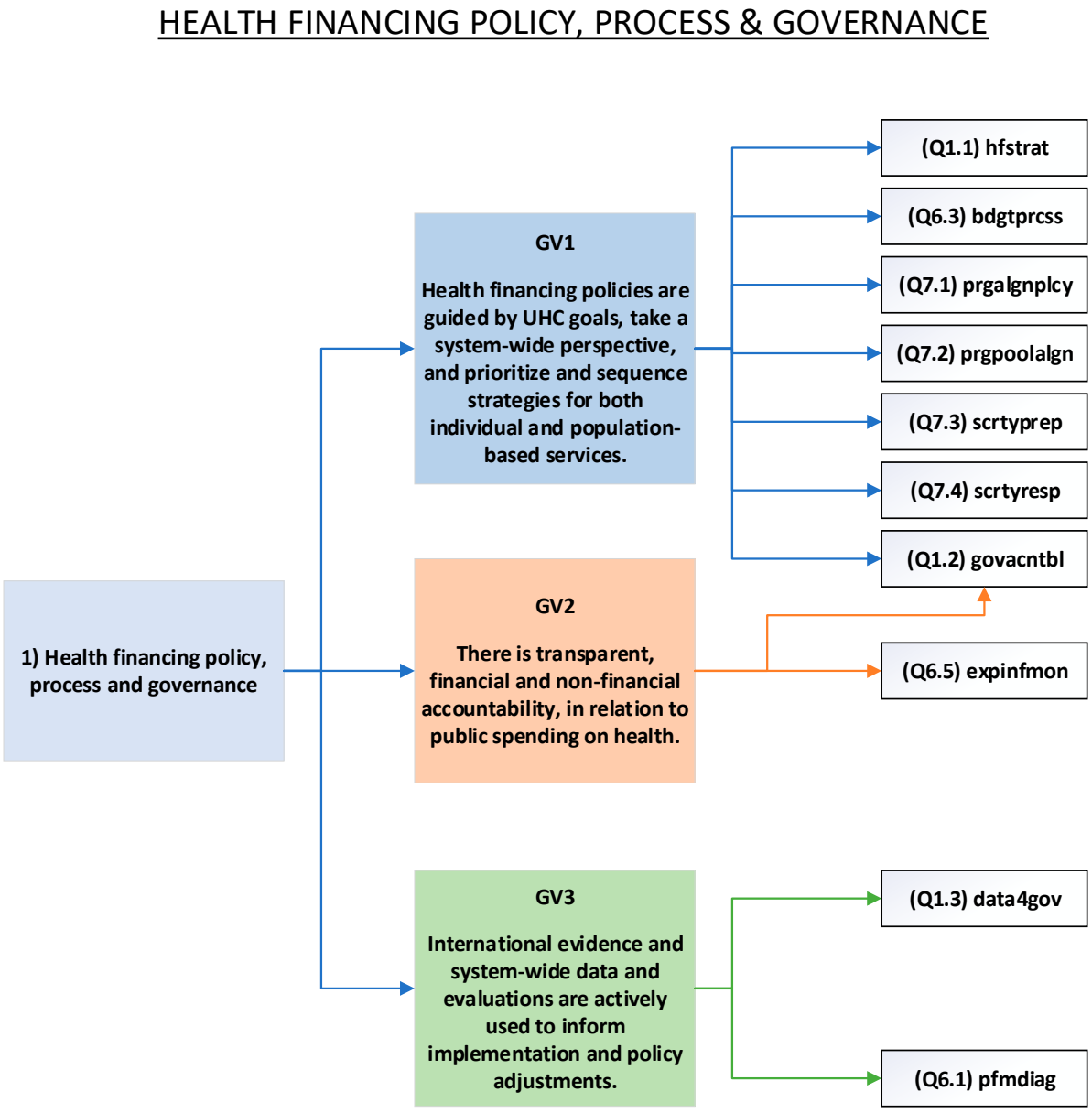
ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
4) PURCHASING & PROVIDER PAYMENT	Resource allocation to providers reflects population health needs, provider performance, or a combination	PS1	To what extent is the payment of providers driven by information on the health needs of the population they serve?	allocneeds	Q4.1
			Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?	ppmcohrnt	Q4.2
			Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?	info4prch	Q4.5
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
	Purchasing arrangements are tailored in support of service delivery objectives	PS2	Do purchasing arrangements promote quality of care?	ppmqlcrd	Q4.3
			Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?	ppmeff	Q4.4
			Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?	info4prch	Q4.5
			To what extent do providers have financial autonomy and are held accountable?	prvdauton	Q4.6
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are there measures to address problems arising from both under- and over-budget spending in health?	bdgtcntrl	Q6.4
			Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?	scrtyprep	Q7.3
	Purchasing arrangements incorporate mechanisms to ensure budgetary control	PS3	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?	ppmeff	Q4.4
			Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?	info4prch	Q4.5
			Are there measures to address problems arising from both under- and over-budget spending in health?	bdgtcntrl	Q6.4

ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
5) BENEFITS & CONDITIONS OF ACCESS	Entitlements and obligations are clearly understood by the population	BR1	Is there a set of explicitly defined benefits for the entire population?	benexplct	Q5.1
			To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?	benundrstd	Q5.3
			Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?	copaydsgn	Q5.4
	A set of priority health service benefits within a unified framework is implemented for the entire population	BR2	Is there a set of explicitly defined benefits for the entire population?	benexplct	Q5.1
	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments	BR3	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?	benprcss	Q5.2
	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers	BR4	To what extent is the payment of providers driven by information on the health needs of the population they serve?	allocneeds	Q4.1
			Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?	benrevalgn	Q5.5
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
	Benefit design includes explicit limits on user charges and protects access for vulnerable groups	BR5	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?	copaydsgn	Q5.4

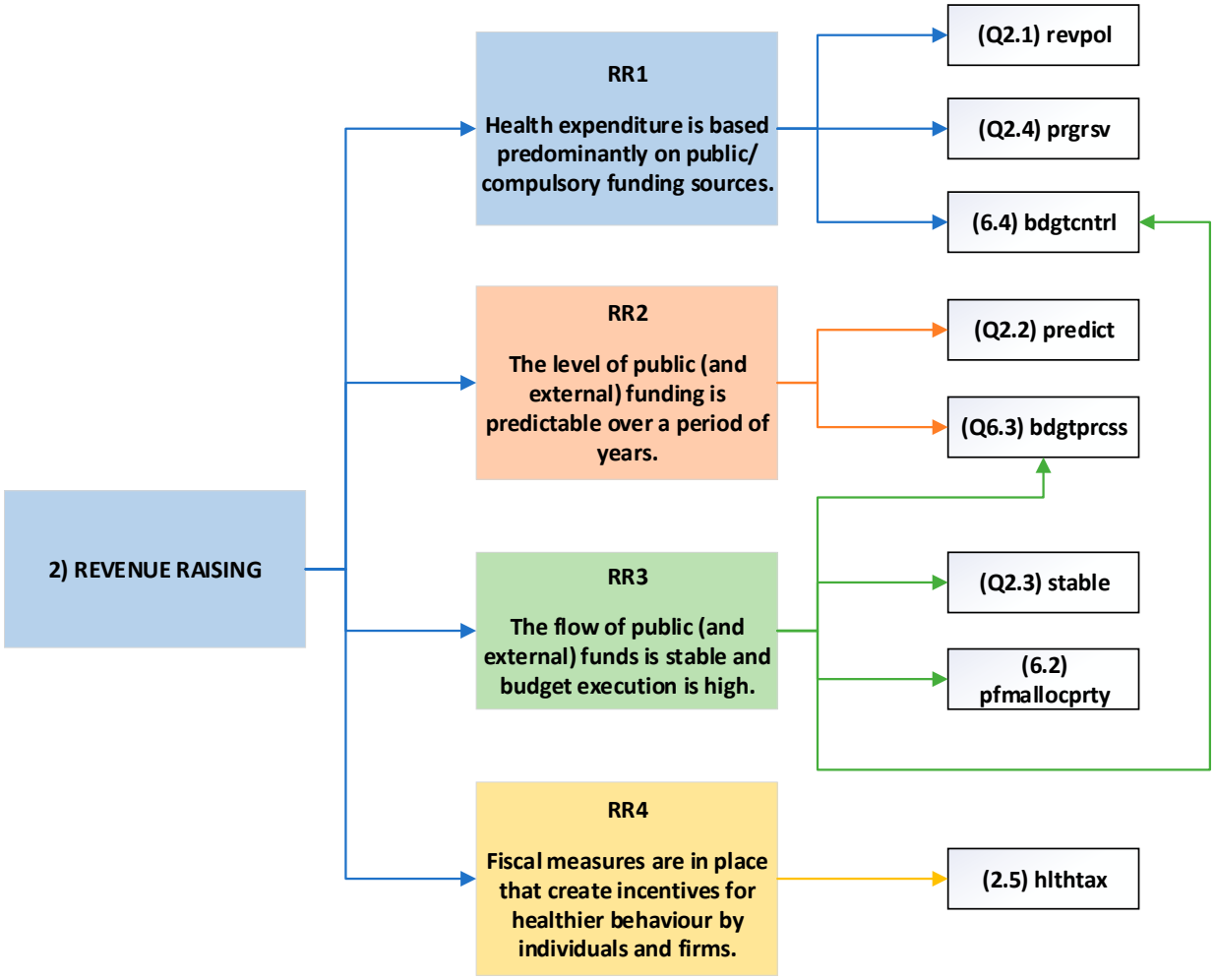
ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
6) PUBLIC FINANCIAL MANAGEMENT	Health budget formulation and structure support flexible spending and are aligned with sector priorities	PF1	To what extent do providers have financial autonomy and are held accountable?	prvdauton	Q4.6
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are public financial management systems in place to enable a timely response to public health emergencies?	scrtyresp	Q7.4
	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs	PF2	To what extent do providers have financial autonomy and are held accountable?	prvdauton	Q4.6
			Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?	pfmallocprty	Q6.2
			Are there measures to address problems arising from both under- and over-budget spending in health?	bdgtcntrl	Q6.4
			Is health expenditure reporting comprehensive, timely, and publicly available?	expinfmon	Q6.5

ASSESSMENT AREA	DESIRABLE ATTRIBUTE	ATTRIBUTE CODE	QUESTION TEXT	LINKED QUESTION CODE	LINKED QUESTION NUMBER
7) PUBLIC HEALTH FUNCTIONS & PROGRAMMES	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies	GV1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?	prgalgnplcy	Q7.1
	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds	PR1	Are public financial management systems in place to enable a timely response to public health emergencies?	scrtyresp	Q7.4
	Health system and financing functions are integrated or coordinated across schemes and programmes	PR2	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?	prgalgnplcy	Q7.1
			Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?	prgpoolalgn	Q7.2
			Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?	scrtyprep	Q7.3
	Purchasing arrangements are tailored in support of service delivery objectives	PS2	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?	scrtyprep	Q7.3
	Health budget formulation and structure supports flexible spending and is aligned with sector priorities	PF1	Are public financial management systems in place to enable a timely response to public health emergencies?	scrtyresp	Q7.4

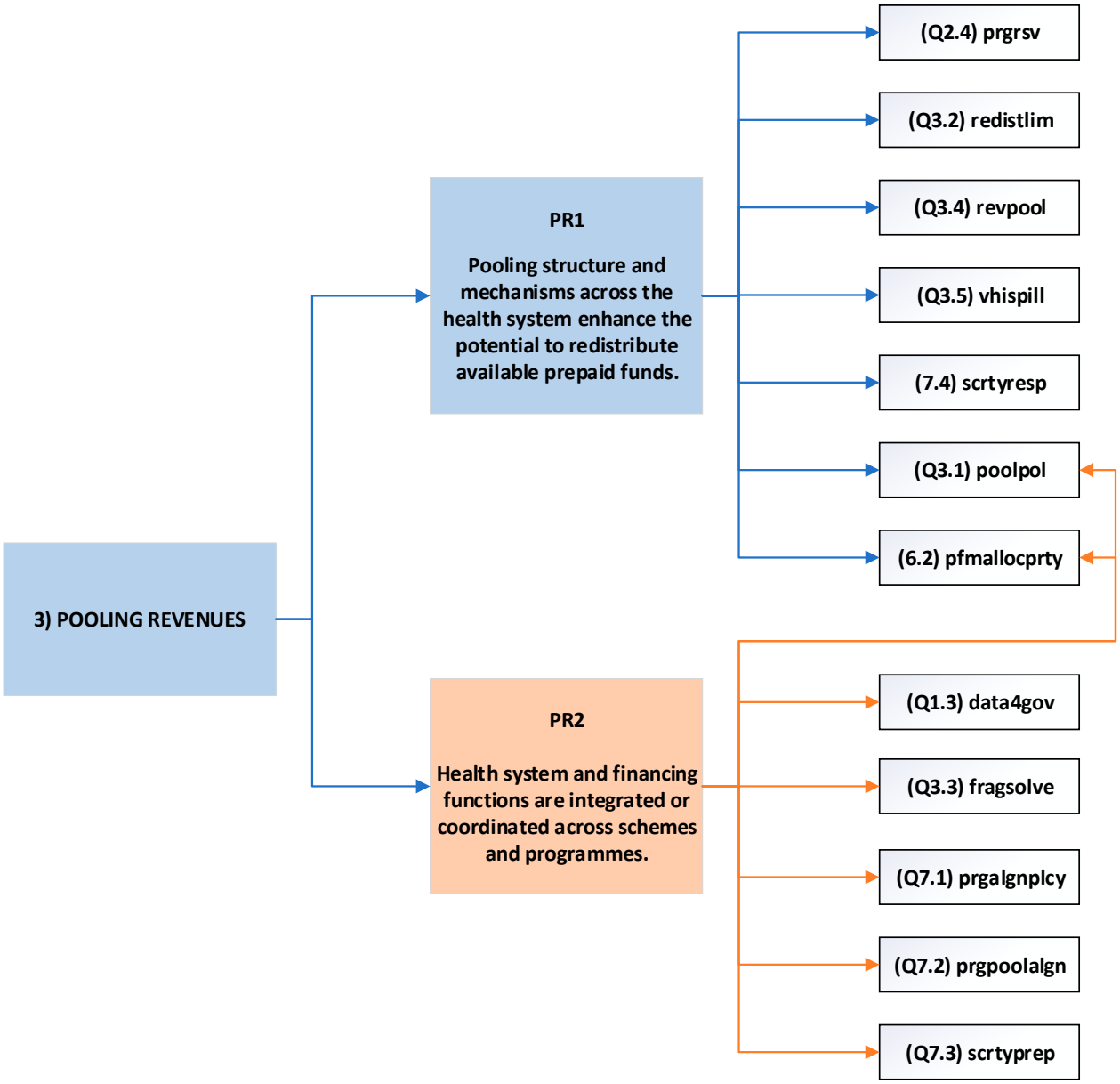
ANNEX 4: STAGE 2 QUESTIONS BY DESIRABLE ATTRIBUTE (VISUAL SUMMARY)



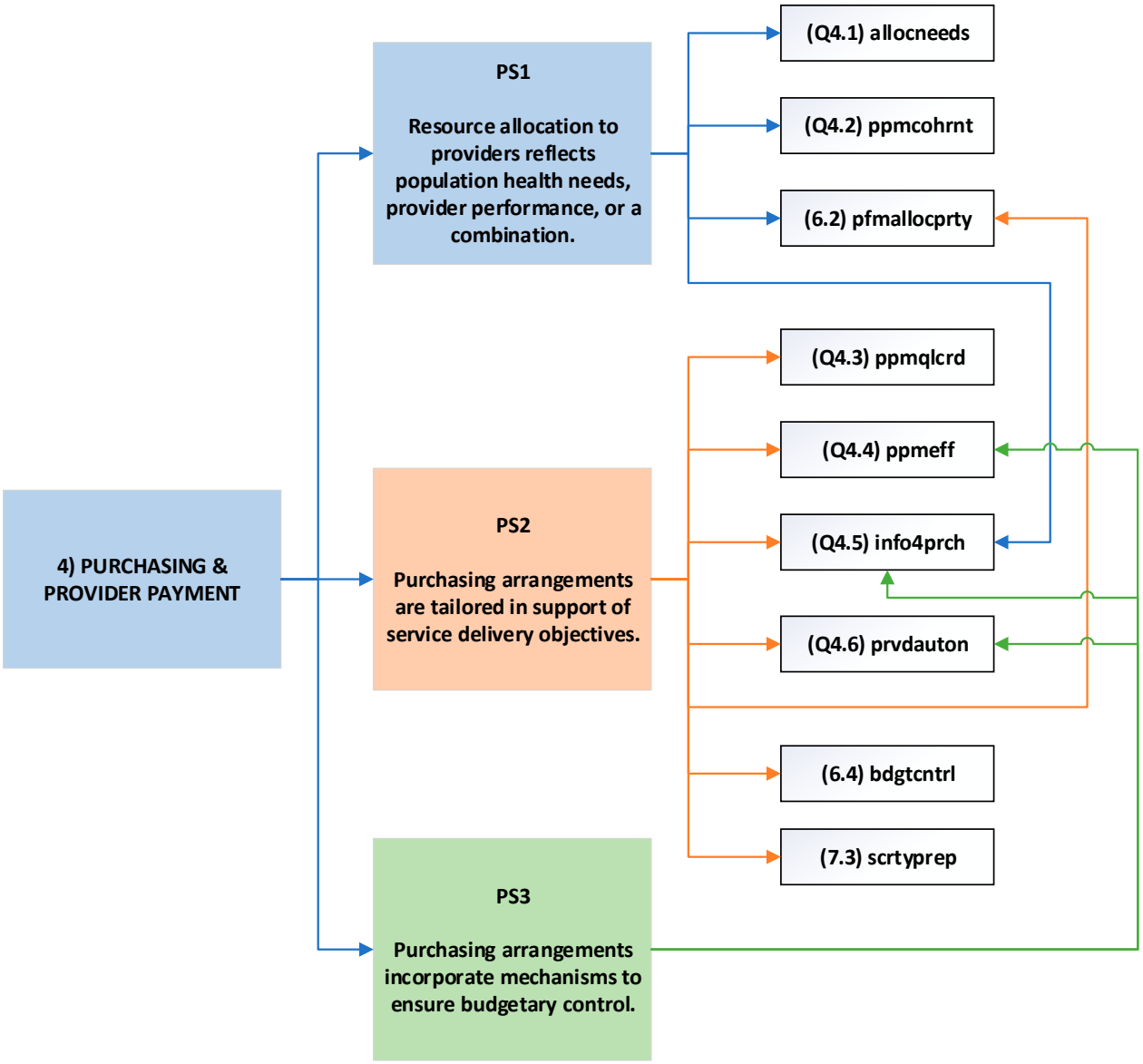
REVENUE RAISING



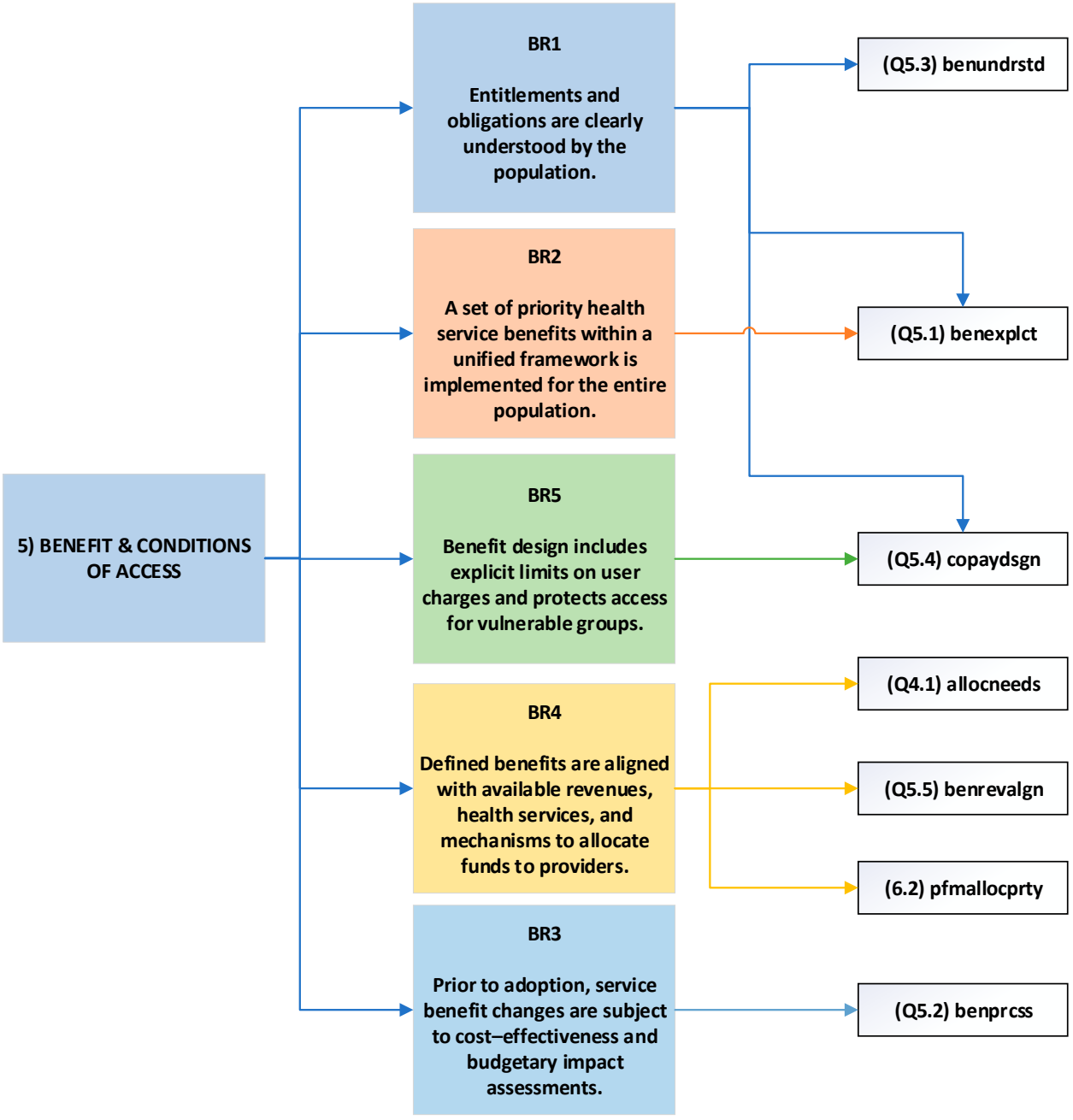
POOLING REVENUES



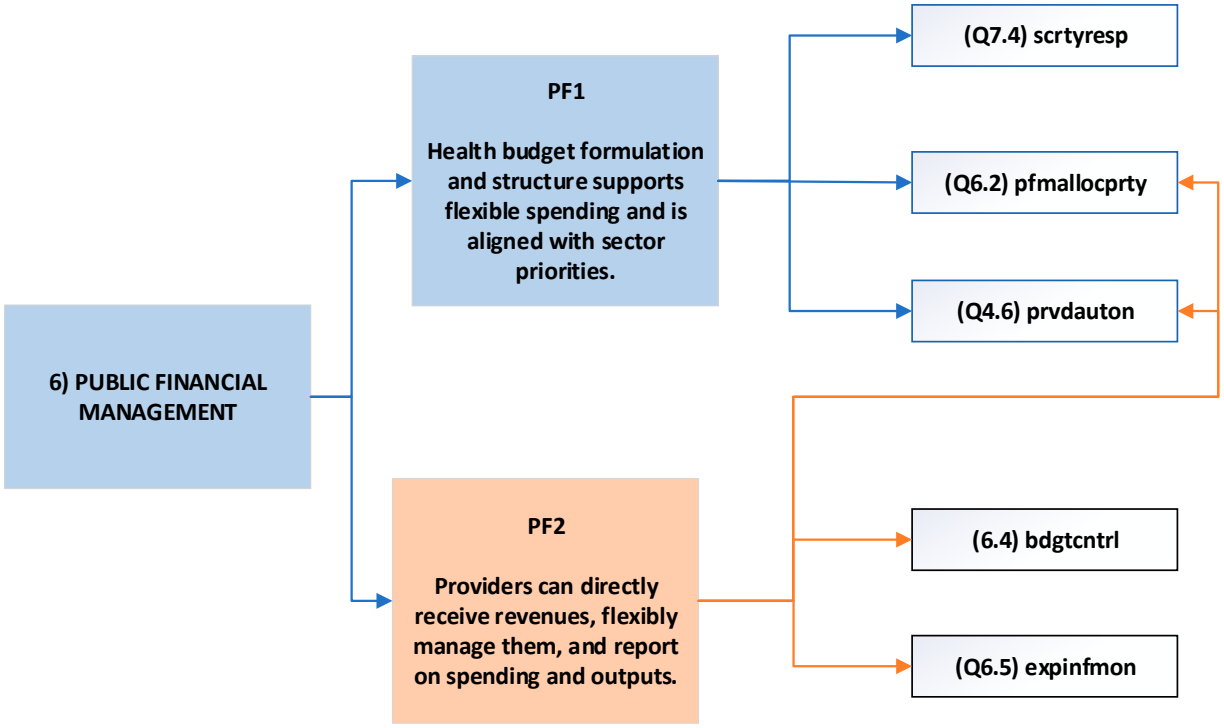
PURCHASING AND PROVIDER PAYMENT



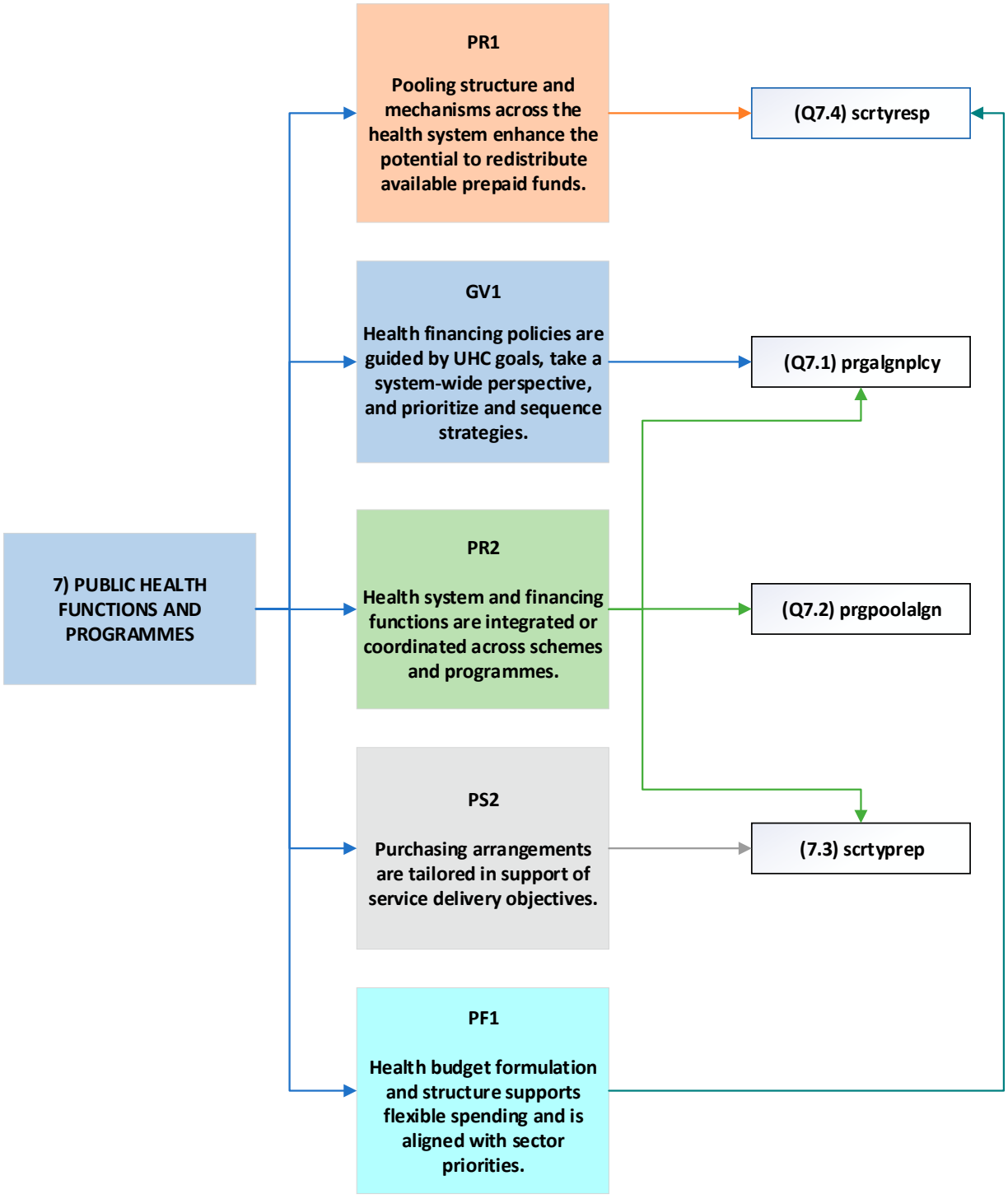
BENEFITS AND CONDITIONS OF ACCESS



PUBLIC FINANCIAL MANAGEMENT



PUBLIC HEALTH FUNCTIONS AND PROGRAMMES



ANNEX 5: STAGE 2 QUESTIONS BY DESIRABLE ATTRIBUTE (SUMMARY TABLE)

		(GV1)	(GV2)	(GV3)	(RR1)	(RR2)	(RR3)	(RR4)	(PR1)	(PR2)	(PS1)	(PS2)	(PS3)	(BR1)	(BR2)	(BR3)	(BR4)	(BR5)	(PF1)	(PF2)		Attributes associated
		4	2	2	3	2	4	1	7	7	4	7	3	3	1	1	3	1	4	4	63	
Health Financing Policy, Process & Governance	1.1	X																			1	4
	1.2	X	X																		2	
	1.3			X						X											2	
Revenue Raising	2.1				X																1	5
	2.2					X															1	
	2.3						X														1	
	2.4				X				X												2	
	2.5							X													1	
Pooling revenues	3.1								X	X											2	2
	3.2								X												1	
	3.3									X											1	
	3.4								X												1	
	3.5								X												1	
Purchasing & Provider Payment	4.1										X						X				2	6
	4.2										X										1	
	4.3											X									1	
	4.4											X	X								2	
	4.5										X	X	X								3	
	4.6											X							X	X	3	
Benefits & Conditions of Access	5.1													X	X						2	5
	5.2															X					1	
	5.3													X							1	
	5.4													X				X			2	
	5.5																X				1	
Public Financial Manage-ment	6.1			X																	1	14
	6.2						X		X	X	X	X					X		X	X	8	
	6.3	X				X	X														3	
	6.4				X		X					X	X						X	X	6	
	6.5		X																X	X	3	
Public Health Functions & Pro-grammes	7.1	X								X											2	5
	7.2									X											1	
	7.3									X		X									2	
	7.4								X												1	

ANNEX 6: STAGE 2 QUESTIONS MAPPED TO OBJECTIVES AND GOALS

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
EQUITY IN RESOURCE DISTRIBUTION	Q3.1	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
EFFICIENCY	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
	Q4.2	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	ppmeff	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q7.1	prgalgnplcy	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
TRANSPARENCY & ACCOUNTABILITY	Q1.1	hfstrat	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	govacntbl	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	data4gov	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	predict	How predictable is public funding for health in your country over a number of years?
	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
	Q5.2	benprcss	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	benundrstd	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	benrevalgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.3	bdgtprcss	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	expinfmon	Is health expenditure reporting comprehensive, timely, and publicly available?
SERVICE USE RELATIVE TO NEED	Q2.2	predict	How predictable is public funding for health in your country over a number of years?
	Q2.3	stable	How stable is the flow of public funds to health providers?
	Q3.1	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	benexplct	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	benundrstd	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	benrevalgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

OBJECTIVE / GOAL	QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
FINANCIAL PROTECTION	Q2.1	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	stable	How stable is the flow of public funds to health providers?
	Q2.4	prgrsv	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	poolpol	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	revpool	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	benexplct	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	benundrstd	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	benrevalgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
EQUITY IN FINANCE	Q2.1	revpol	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	stable	How stable is the flow of public funds to health providers?
	Q2.4	prgrsv	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	benexplct	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
QUALITY	Q4.3	ppmqlcrd	Do purchasing arrangements promote quality of care?
	Q4.5	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
HEALTH SECURITY	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?

ANNEX 7: STAGE 2 QUESTIONS MAPPED TO ADDITIONAL TOPICS

ISSUE / TOPIC		QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
SERVICE DELIVERY	RELEVANT QUESTIONS	Q2.3	stable	How stable is the flow of public funds to health providers?
		Q4.2	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
		Q4.3	ppmqlcrd	Do purchasing arrangements promote quality of care?
		Q4.4	ppmeff	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
		Q4.5	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
		Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
		Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
		Q5.5	benrevalgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
		Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
		Q7.1	prgalgnplcy	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
		Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
		Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
		Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?
MEDICINES	RELEVANT QUESTIONS	Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
		Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
PRIMARY HEALTH CARE	RELEVANT QUESTIONS	Q2.3	stable	How stable is the flow of public funds to health providers?

ISSUE / TOPIC		QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
HEALTH PROGRAMMES	RELEVANT QUESTIONS	Q3.2	redistlim	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
		Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
		Q3.4	revpool	Are multiple revenue sources and funding streams organised in a complementary manner, in support of a common set of benefits?
		Q4.2	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
		Q4.3	ppmqlcrd	Do purchasing arrangements promote quality of care?
		Q5.2	benprcss	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
		Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
		Q7.1	prgalgnplcy	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
		Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
		Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
PUBLIC FINANCIAL MANAGEMENT	PRIMARY QUESTIONS	Q6.1	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
		Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
		Q6.3	bdgtprcss	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
		Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
		Q6.5	expinfmon	Is health expenditure reporting comprehensive, timely, and publicly available?
	QUESTIONS MAPPED FROM OTHER ASSESSMENT AREAS	Q2.2	predict	How predictable is public funding for health in your country over a number of years?
		Q2.3	stable	How stable is the flow of public funds to health providers?
		Q3.3	fragsolve	What measures are in place to address problems arising from multiple fragmented pools?
		Q3.4	revpool	Are multiple revenue sources and funding streams organised in a complementary manner, in support of a common set of benefits?
		Q4.1	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
		Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
		Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
		Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?

ISSUE / TOPIC		QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
PURCHASING & PROVIDER PAYMENT	PRIMARY QUETIONS	Q4.1	allocneeds	To what extent is the payment of providers driven by information on the health needs of the population they serve?
		Q4.2	ppmcohrnt	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
		Q4.3	ppmqlcrd	Do purchasing arrangements promote quality of care?
		Q4.4	ppmeff	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
		Q4.5	info4prch	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
		Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
	QUESTIONS MAPPED FROM OTHER ASSESSMENT AREAS	Q2.3	stable	How stable is the flow of public funds to health providers?
		Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
		Q5.5	benrevalgn	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
		Q6.1	pfmdiag	Is there an up-to-date assessment of key public financial management bottlenecks in health?
		Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
		Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
PRICING	RELEVANT QUESTIONS	Q3.5	vhispill	What is the role and scale of voluntary health insurance in financing health care?
		Q5.4	copaydsgn	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
		Q6.4	bdgtcntrl	Are there measures to address problems arising from both under- and over-budget spending in health?
DECENTRALIZA-TION	RELEVANT QUESTIONS	Q4.6	prvdauton	To what extent do providers have financial autonomy and are held accountable?
		Q6.3	bdgtprcss	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
		Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
		Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?

ISSUE / TOPIC		QUESTION NUMBER CODE	QUESTION TEXT CODE	QUESTION TEXT
COMMON GOODS FOR HEALTH **(PUBLIC HEALTH FUNCTIONS)**	RELEVANT QUESTIONS	Q6.2	pfmallocprty	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
		Q6.5	expinfmon	Is health expenditure reporting comprehensive, timely, and publicly available?
		Q7.2	prgpoolalgn	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
		Q7.3	scrtyprep	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
		Q7.4	scrtyresp	Are public financial management systems in place to enable a timely response to public health emergencies?

REFERENCES

1. Jowett, M., et al., *The Health Financing Progress Matrix: Country Assessment Guide, in Health Financing Guidance #9*. 2020, World Health Organization: Geneva, Switzerland.

2. World Health Organization, *The world health report 2000. Health systems: improving performance*. 2000, World Health Organization: Geneva.

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

4. Kutzin, J., *Health financing for universal coverage and health system performance: concepts and implications for policy*. Bull World Health Organ, 2013. 91(8): p. 602-11.

5. Cashin, C. Bloom, D., Sparkes, S. Barroy, H. Kutzin, J; O'Dougherty, S. *Aligning public financial management and health financing: sustaining progress toward universal health coverage*. Health Financing Working Paper No. 4, 2017: p. 56.

6. Gottret, P. and Scheiber, G. *Health Financing Revisited: A Practitioners Guide*. 2006, Washington: World Bank.

7. Baeza, C. and Packard, T. *Beyond Survival : Protecting Households from Health Shocks in Latin America*. 2006: Palo Alto, CA: Stanford University Press; Washington, DC: World Bank. © World Bank.

8. Mathauer I, et al., *Purchasing of health services for universal health coverage: How to make it more strategic?,* in *Health Financing Policy Brief No. 6*. 2019, World Health Organization: Geneva.

9. Jowett, M. and Kutzin, J, *Raising revenues for health in support of UHC: strategic issues for policy makers, in Health Financing Policy Brief #1.* 2015, World Health Organization: Geneva, Switzerland.

10. McIntyre D., Kutzin, J., *Health financing country diagnostic: a foundation for national strategy development, in Health financing guidance No. 1.* 2016, World Health Organization: Geneva, Switzerland.

11. Kutzin J., Witter, S., Jowett M., Bayarsaikhan D., *Developing a national health financing strategy: a reference guide.* 2017, World Health Organization.

12. World Health Organization, *Public financing for UHC: towards implementation, in Health Financing Working Paper 18.1.* 2018, World Health Organization: Genva.

13. Kutzin, J., *Anything goes on the path to universal health coverage?* No. Bull World Health Organ, 2012. 90(11): p. 867-8.

14. Yazbeck, A.S. and A. Soucat, *When Both Markets and Governments Fail Health.* Health Systems & Reform, 2019. 5(4): p. 268-279.

15. Office for Public Management; Chartered Institute of Public Finance and Accountancy, *The Good Governance Standard for Public Services.* 2004, UK Independent Commission on Good Governance in Public Services: London, UK. ISBN: 1 898531 86 2.

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