Health Financing Progress Matrix assessment

Ethiopia 2022

Summary of findings and recommendations

ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH · ETHIOPIA

World Health Organization

Health Financing Progress Matrix assessment

Ethiopia 2022

Summary of findings and recommendations

ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH · ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!

World Health Organization

Health Financing Progress Matrix assessment, Ethiopia 2022: summary of findings and recommendations

ISBN 978-92-4-006755-4 (electronic version)
ISBN 978-92-4-006756-1 (print version)

Design and layout by Phoenix Design Aid

Contents

Figures

About the Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's health financing system. The assessment builds on an extensive body of conceptual and empirical work and summarizes "what matters in health financing for Universal Health Coverage (UHC)" into nineteen desirable attributes, which form the basis of this assessment.

The report identifies areas of strength and weakness in Ethiopia's current health financing system, in relation to the desirable attributes, and based on this recommends specific shifts in health financing policy directions, specific to the context of Ethiopia, which can help to accelerate progress to UHC.

The qualitative nature of the analysis, but with supporting quantitative metrics, allows close-to-real time performance information to be provided to policy-makers. In addition, the structured nature of the HFPM lends itself to the systematic monitoring of progress in the development and implementation of health financing policies. Country assessments are implemented in four phases as outlined in Fig. 1; given that no primary research is required, assessments can be implemented within a relatively short time-period.

Figure 1: Four phases of HFPM implementation

Phase 2 of the HFPM consists of two stages of analysis:

- Stage 1: a mapping of the health financing landscape consisting of a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.

- Stage 2: a detailed assessment based on thirty-three questions of health financing policy. Each question builds on one or more desirable attribute of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Countries are using to HFPM findings and recommendations to feed into policy processes including the development of new health financing strategies, the review of existing strategies, and for routine monitoring of policy development and implementation over time. HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Further details about the HFPM are available online: https://www.who.int/teams/health-systemsgovernance-and-financing/health-financing/diagnostics/health- financing-progress-matrix

About this report

This report provides a concise summary of the Health Financing Progress Matrix assessment in Ethiopia, identifying strengths and weaknesses in the health financing system, and priority areas of health financing which need to be addressed to drive progress towards UHC. Findings are presented in several different summary tables, based on the seven assessment areas, and the nineteen desirable attributes of health financing. By focusing both on the current situation, as well as priority directions for future reforms, this report provides an agenda for priority analytical work and related technical support. The latest information on Ethiopia's performance in terms of Universal Health Coverage (UHC) and key health expenditure indicators, are also presented. Detailed responses to individual questions are available on the WHO HFPM database of country assessments or upon request.

This assessment is a living document and is circulated for further feedback and comments; it can also form the basis of annual updates for monitoring purposes.

Acknowledgements

The assessment was conducted by the Ministry of Health (PCD/HEFA) and WHO; Ermias Dessie (WHO/Ministry of Health), Samual Abera (Ministry of Health), Tesfaye Messele (Ministry of Health), Jessika Yin (WHO), Dr. Indrajit Hazarika (WHO) and Dr. Feven Girma (Ministry of Health), Dr. Munir Kassa (Ministry of Health) and Matthew Jowett (WHO headquarters). Evidence was drawn from the detailed raw assessment report available on the WHO HFPM database of country assessments or upon request. Thanks to Juan Gregorio Solano who prepared all templates, charts, and diagrams.

WHO and the Ethiopian Ministry of Health would like to thank Adiam Nega (Addis Ababa University), Beruktawit Mamo (Ministry of Health), Dawit Berhanu (Ministry of Finance), Dr. Asmamaw Atnafu (University of Gonder), Dr. Grimay Dannsa (Harvard/Fenot project), Dr. Munir Kassa (Ministry of Health), Eyerusalem Animut (Abt Associate), Fiyameta Amde (EHIA), Frehiwot Endeshaw (Ministry of Finance), Gezahegn G/Mariam (Ministry of Health), Halima Abate (EHIA), Israel Fekede (Government of the United Kingdom), Salle Worku (AAU), Tesfaye Mesele (Ministry of Health), Tilahun Alemu (Ministry of Health), Tseganeh Amsalu (World Bank), and Wudalew Tesfaye (CHAI) for reviewing this report and providing valuable comments during the preliminary findings validation workshop.

Abbreviations

CBHI	Community-Based Health Insurance
CIFF	Children's Investment Fund Foundation
DHS2	Demographic Health Survey
DPT3	Diphtheria, Tetanus Toxoid and Pertussis Vaccine.
EHSP	Essential Health Services Package
EPSA	Ethiopian Pharmaceuticals Supply Agency
FBG	federal block grant
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GGHE P.C	General Government Health Expenditure Per Capita
GGHE-D	Domestic General Government Health Expenditure
HCF	health care financing
HEFA	Health Economics and Financing Analysis
HFPM	Health Financing Progress Matrix
HFS	Health Financing Strategy
HHM	Health Harmonization Manual
HIA	Health Insurance Agency
HIBP	Health Insurance Benefit Package
IBEX	Integrated Budget and Expenditure System
MDG	Millennium Development Goals
MEFF	Macro-Economic/Fiscal Framework
MTEF	Medium Term Expenditure Framework
OOPs	Out of Pocket Expenditures
PCD	Partnership Cooperation Directorate
SDG-PF	Sustainable Development Goals Pooled Fund
PHC	Primary Health Care
RMNCH	Reproductive, Maternal, Child, And Newborn Health
SDG	Sustainable Development Goals
SHI	Social Health Insurance
TWG	Technical Working Group
UHC	Universal Health Coverage
USD	United States Dollar
VAT	Value Added Tax
WHO	World Health Organization
WB	The World Bank

Methodology and timeline

WHO Headquarters and WHO Regional Office for Africa invited the WHO Ethiopia Country Office to conduct the assessment as part of field testing of version 1.0.

The WHO consultant/staff deployed at Ministry of Health/HEFA works and supports the Ministry of Health closely and agreed verbally to conduct the assessment mid-late 2019. The assessment was conducted over a 4-month period, end of 2019 through 2020. After a hiatus during the COVID outbreak, stakeholders including the Ministry of Health, Ministry of Finance and the Health Insurance Agency were convened for a two-day workshop at the Adulala Resort, Bishoftu, to review and validate the assessment, and update information where necessary; a separate report on this workshop is available together with a blog here. Further updates to the assessment were made throughout 2022.

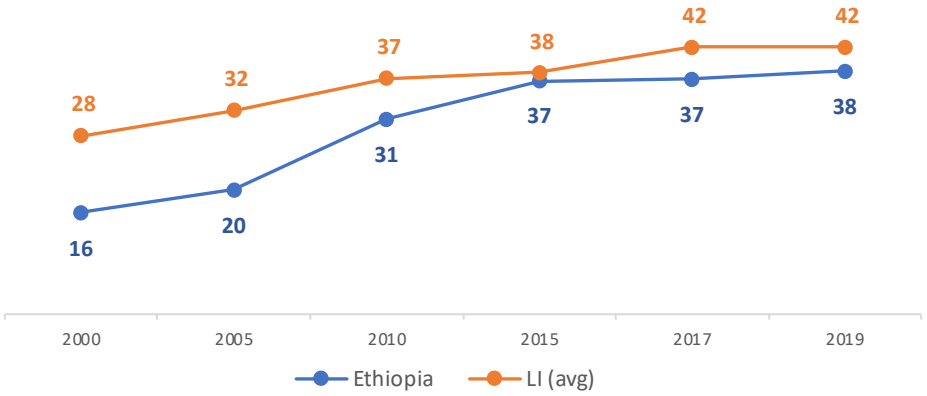
Ethiopia has designed a new HCF strategy and Health Sector Transformation plan for the next five years; the results of the Health Financing Progress Matrix provide an important baseline in relation to these documents and will continue to be part of the annual national health care financing (HCF) policy dialogue in the future.

It is proposed that the process continues via the Ministry of Health (Ministry of Health) given that the National HF TWG is coordinated and chaired by Partnership Cooperation Directorate (PCD) MOH. The HF TWG is composed of major players in government and development partners including the WHO Country Office that are actively working on health financing.

Ethiopia UHC performance

SDG indicator 3.8.1 relates to the coverage of essential services and is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access (World Health Organization, 2021). The service coverage index is a score between 0 and 100, which in Ethiopia has doubled since 2000.

Figure 2: Service coverage index trend in Ethiopia 2000-2019



Source: Global Health Observatory 2021 (https://www.who.int/data/gho/data/themes/topics/service-coverage)

For some service components of the index, it is possible to obtain disaggregated information, as shown in Figure 3, to get a picture of inequalities in access, which have decreased over time.

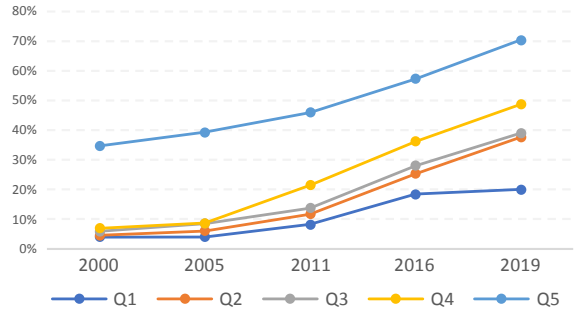
Figure 3: Antenatal care and DPT3 coverage by quintile in 2019

Antenatal care +4 visits

National average (2019): 43.2%

Value by quintile – 2019

Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
20.1%	37.7%	39.1%	48.7%	70.4%

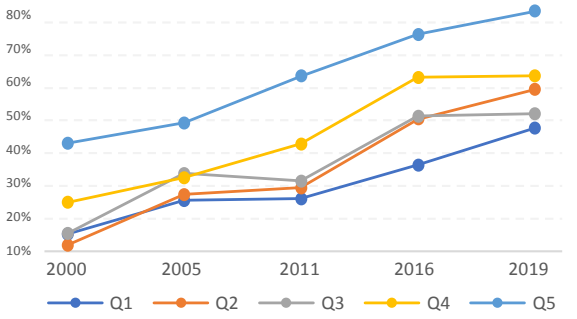


DTP3 coverage 1 year olds

National average (2019): 61.3%

Value by quintile – 2019

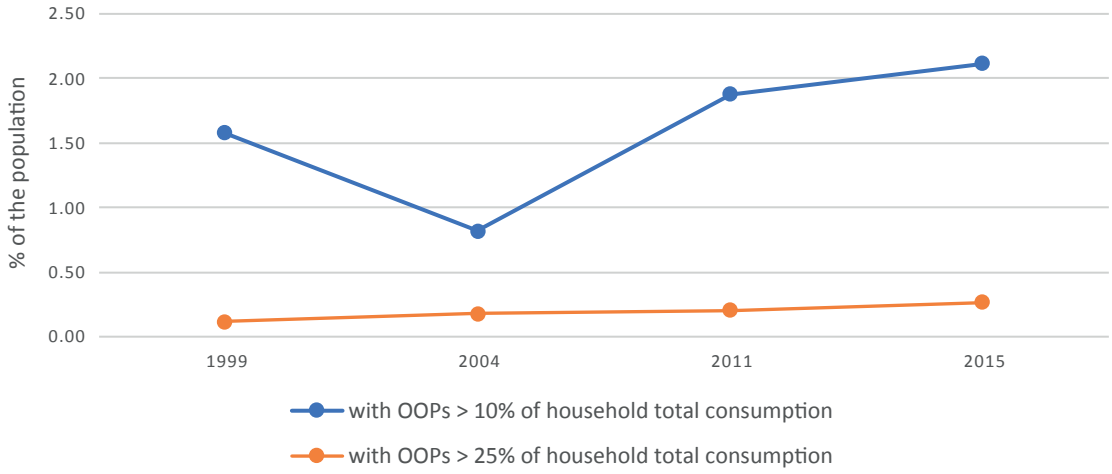
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
47.7%	59.5%	52.1%	63.7%	83.4%



Source: https://apps.who.int/gho/data/node.imr

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending, and defined as the "Proportion of the population with large household expenditure on health as a share of total household expenditure or income". Large is defined using two thresholds first greater than 10% of the household budget and secondly greater than 25% of the household budget.

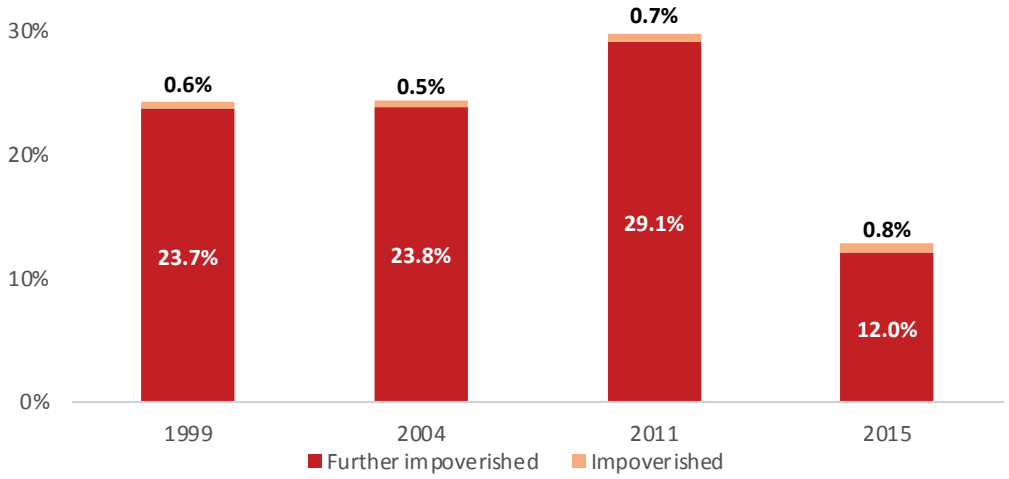
Figure 4: Trend in catastrophic health spending in Ethiopia 1999-2015



Source: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-(sdg-3-8-2)-(-)

Whilst not an official SDG indicator, an additional measure of financial protection looks at health spending which leads to impoverishment. Some people (the poor and the near poor in particular) are not able to spend more than 10% of their household budget on health. Indicators of impoverishing health spending are defined as the proportion of the population pushed and further pushed into extreme poverty (living with less than PPP$1.90 a day person) by out-of-pocket health spending.

Figure 5: Impoverishing out of pocket health spending in Ethiopia 1999-2015



Note: Those living in households already below the poverty line before incurring health out-of-pocket payments are considered further impoverished.

Source: https://apps.who.int/gho/data/node.main.UHCFINANCIALPROTECTION02?lang=en

Summary of findings and recommendations by desirable attributes of health financing

Policy process and governance

Desirable attribute 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
Key areas of strength and weakness in Ethiopia	Ethiopia has developed separate national health financing strategy documents to match with national policy frameworks in two rounds in 1998 and 2017. Since 1999, the Health Financing Strategy (HFS) has been linked to and evaluated through extensive diagnosis and assessment of the health financing system. Some structures and plans are directly accountable for the implementation of health financing strategy interventions. Although there is strong leadership and coordination in the sector as a whole, there are deficits at different levels in terms of leadership and coordination to achieve health financing goals, due to the different challenges to the facilities and institutions' governing body processes.
Recommended priority actions	Well-organized implementation plans should be developed at all levels of the health system to strengthen capacity to analyze health financing requirements, implement new strategies, and monitor and evaluate progress in health financing policy implementation.
Desirable attribute GV2	**There is transparent, financial and non-financial accountability, in relation to public spending on health**
Key areas of strength and weakness in Ethiopia	The Minister of Health chairs the National and Sub-National (Regional Health Bureau) Joint Steering Committee, which meets every two months. It aims to facilitate the efficient and effective implementation of health sector plan priorities, including health financing. Although the federal and the regional counterparts of the Ministry of Finance, namely the Bureau of Finance and Development Cooperation, collect the annual expenditure of their respective regions to conduct systematic expenditure tracking, there is a delay in publishing the public financial report. Furthermore, the public financial report does not reflect the linkage between performance and health sector priorities and the level of resources.
Recommended priority actions	No specific recommendations
Desirable attribute GV3	**International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments**
Key areas of strength and weakness in Ethiopia	The Federal Government of Ethiopia has been using the Macro-economic/fiscal framework (MEFF) since 1996/97 to set budget ceilings for regions and federal bureaux. The macroeconomic and fiscal framework are developed, with final decisions made by the Council of Ministers and although data from national health accounts, public expenditure reviews and others are regularly produced, shared online and disseminated, data for other health financing functions e.g., regarding pooling, benefits, and purchasing of health services is less regularly monitored, and not used to inform policy development.
Recommended priority actions	• Ethiopia's health system has experienced many positive developments but is also becoming more complex and diverse. This vision and strategy can incorporate estimates of possible resource mobilization scenarios over this period, reflecting the effects of economic growth and social development and possible changes in the external resource mobilization scenario in the future. • The monitoring and evaluation of the health care financing strategy implementation should be considered as an integral part of the national regular performance reviews and other monitoring and evaluation undertakings.

Revenue raising

Desirable attribute RR1	Health expenditure is based predominantly on public/compulsory funding sources
Key areas of strength and weakness in Ethiopia	**The general tax system has some elements of progressiveness:** taxes collected from individuals are highly progressive, such as taxes on employment and business income, which range from 0% to 35% of taxable income. However, most domestic tax revenues come from other sources, namely VAT (15% standard rate) and a flat rate corporate tax (30% standard rate), representing 54% and 33% of total domestic tax revenue respectively. **Financing for health is predominantly regressive:** the health system continues to rely on OOPs and external funding, representing circa one-third of total health expenditure respectively. While indigent households benefit from a CBHI premium waiver, for remaining households CBHI premiums are set at a flat rate which is the same for all in the district. SHI, once launched, will be financed by proportional matching contributions from employees and employers. The percentage of total government recurrent expenditure allocated to health is low at 4.8% and has remained fairly constant over the past decade. **The government's policy orientation as outlined in the revised HCFS is to gradually substitute donor funding with domestic funding.** Strategic initiatives to achieving this include increasing the government budget allocation for health and scaling up CBHI and SHI.
Recommended priority actions	Global evidence has shown that greater reliance on public funding (mandatory and pre-paid) sources is closely associated with better performance on UHC. Shifting away from reliance on OOP payments, donor funding and voluntary contributions, and towards **an increasing role of government health budgets** would help to make health financing more equitable and sustainable as Ethiopia graduates to middle-income status. While CBHI schemes have the potential to raise some additional resources for health, evidence show that resource generation is limited in most models of CBHI. Few countries have managed to make significant progress towards UHC without increasing general budget allocations. Setting the CBHI premiums based on ability to pay could help make the health financing system more equitable.

Revenue raising

Desirable attribute RR2	The level of public (and external) funding is predictable over a period of years
Key areas of strength and weakness in Ethiopia	The Treasury is responsible for preparing **the three-year rolling Macro Economic and Fiscal Framework (MEFF),** which generates macro-economic and government revenue forecasts and is used to the set expenditure targets. A **fiscal space analysis for the health sector** was conducted as part of the development of the five-year Health Sector Transformation Plan (HSTP II). The analysis showed significant funding gaps even in the "business as usual" scenario, indicating uncertainty over future funding to fully implement the HTSP II. **External sources channeled through Ministry of Health** (Channel 2) was close to 550 million USD in 2017/18 (compared to 300 million USD channeled through implementing partners), of this over 150 million USD was channeled through the SDG Performance Fund.
Recommended priority actions	Increasing **unearmarked donor funding** channeled through the SDG Performance Fund or other domestic financing mechanisms can improve predictability in the short to medium term. Addressing some of the PFM issues highlighted by multiple reports can help make the case for this. Predictability can be further improved by **strengthening the links between the MEFF and multi-year health sector strategic plans and the annual budgets and activity plans at federal and sub-national level**, ensuring that these are aligned and building on realistic multi-year projections of public revenues. In the long term, an approach such as the MTEF can help to strengthen and formalize the overall multi-year perspective in fiscal planning, expenditure policy and budgeting, with potential benefits for the health sector and beyond.
Desirable attribute RR3	**The flow of public (and external) funds is stable and budget execution is high**
Key areas of strength and weakness in Ethiopia	**Overall health budget utilization is generally high**, ranging between 76% and 95% from 2005/06 to 2016/17. However, the rates **are generally lower for the SDG performance Fund, for capital and non-salary spending at the regional level.** In particular, the predictability of, and access to, resources at the sub-national level has been identified as a major recurring problem. These challenges in budget execution are due to a combination of factors, including a top-down approach to budgeting, capacity limitation in procurement and infrastructure project management, and inaccurate cash flow projections. While the regions in theory have full control over their planning and budgeting, in practice budgets and plans are linked to national plans and goals set by the federal government, which limits the region's ability to plan and allocate resources. **CBHI claims management** is mainly paper-based with a limited degree of automation, which often lead to delays in payments.
Recommended priority actions	While budget execution is in general high, there is room for improvement particularly for the SDG Performance Fund, for capital spending and at the sub-national level. There is a need to better understand PFM and procurement bottlenecks and capacity issues that drive low execution rates in these areas. Investments to improve the accuracy of cash flow projections and shifting towards digital insurance claims management can lead to further improvements, particularly for the sub-national level and for health facilities.
Desirable attribute RR4	**Fiscal measures are in place that create incentives for healthier behavior by individuals and firms**
Key areas of strength and weakness in Ethiopia	Ethiopia has received several international awards recognizing the government's **leadership and efforts in tobacco control**, including the use of fiscal measure in line international guidance. The House of Peoples Representatives approved a major **tobacco taxation policy change** as part of the new excise tax proclamation in February 2020, leading to the adoption of a mixed system for tobacco products (a specific rate of 8 Ethiopian Birr per pack of cigarettes alongside with a 30% ad valorem tax on the production cost). The proclamation also introduced an **increase in exercise tax** on alcoholic beverages (mixed system), soft drinks (ad valorum) and bottled water (ad valorum). In 2008, Ethiopia **removed all its fossil fuel subsidies**, which had previously amounted to more than $600 million a year.
Recommended priority actions	Critical progress has been made in the use of fiscal measures to reduce consumption of unhealthy products. Going forward, it is important to monitor the impact on consumption, revenues, and illicit trade, to inform any necessary adjustments in design and implementation, and to respond to the criticism that the industry has levied against the government.

Pooling revenues

Desirable attribute PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
Key areas of strength and weakness in Ethiopia	**There are multiple mechanisms for intra-governmental transfers of pooled donor funds and government budgets.** The distribution of these funds is **equity-oriented**, focusing on PHC expansion, fee-waivers for the poor and providing coverage to the informal sector via the CBHI. Donor and government funding are pooled and allocated via the federal block grant (FBG) based on a general resource allocation formula which takes into consideration population size and the resource needs of major pro-poor sectors, including health (Channel 1). Complementary to this, the SDG Performance Fund pools donor funding for health and is used to fill gaps in service provision once available resources from other funding sources are known. **CBHI schemes are pooled and managed at the district level.** There is limited risk-sharing between schemes and many schemes are financially unstable. The government plans to introduce several measures to improve the current pooling structure, including making the CBHI mandatory; moving pooling of the CBHI schemes to a higher level; launching a mandatory SHI scheme which will be gradually merged with the CBHI schemes.
Recommended priority actions	Implementing the planned changes to the CBHI design, such as mandatory membership and higher-level pooling, can lead to more effective risk-sharing, but also improves the efficiency and sustainability of the schemes by leveraging economies of scale. When the SHI scheme is launched, there will be a need to carefully design and implement mechanisms for risk-pooling and redistribution between CBHI and SHI schemes, avoiding the common pitfalls of introducing separate schemes for different sub-populations. Allocating more unearmarked donor funding to be managed by the treasury, by the Ministry of Health and sub-national governments (Channel 1 and Channel 2) would also help to de-fragmentize funding channels.

Pooling revenues

Desirable attribute PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Key areas of strength and weakness in Ethiopia	Government leadership has resulted in a well-integrated and coordinated health system as envisioned in the concept of "**One Plan, One Budget, one report**", even though there are areas of improvement. Coordination challenges exist between government entities responsible for policy development (Ministry of Health, HIA) and those responsible for implementation (sub-national health bureaux). The HIA has the overall responsibility to implement an integrated health insurance system. They are currently revising the CBHI benefit package, coordinating with the Ministry of Health to ensure alignment with the Essential Health Service Package (EHSP), which stipulates a minimum level of benefits, and other health programmes. Each CBHI scheme manages its own **health insurance information system**, creating silos between insurance data and routine health information collected via the **Health Information Management System** (HMIS). Some duplication exists in terms of overlapping target populations, e.g. indigents can benefit from fee-waiver and from subsidies to cover their CBHI premium. Provider payments mechanisms are generally coherent and coordinated: the government budget funds fixed costs, e.g. salaries; costs for drugs and diagnostics etc. are covered by user-fees or the CBHI reimbursements according to the same fee schedule.
Recommended priority actions	The revised Health Harmonization Manual (HHM) from 2020 outlines a framework for more effective coordination and alignment of programmes within the health sector. Full implementation of the HHM with support from donors, implementing partners and other important stakeholders will help to create a more integrated health system. Ongoing efforts to digitalize and render the different health information systems more interoperable could improve the health system's ability for data-driven decision-making and M&E.

Purchasing health services

Desirable attribute PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
Key areas of strength and weakness in Ethiopia	The basis for resource allocation to (public) providers is based on the following: **input-based budgeting** which uses facility norms and as a result the same level of health facility receives similar levels of resources; and **user-fees or fee-for-service**, which reflects service utilization but does not promote preventive services and does not address the health needs of those not seeking care due the resulting financial barriers. The government relies primarily on managerial mechanisms and performance monitoring and planning, such as the annual planning process, to improve service coverage and quality. Provider-level data is collected via DHS2 and the CBHI claims management system. However, the **use of this data to make purchasing decisions is limited.** While CBHI clinical audits include assessments based on Standards Operating Procedures (SOPs), there is limited follow-up action when problems are detected. A performance-based financing **mechanism based on quality of care and maternal and child health service delivery** has been piloted and is a mechanism that can help strengthen the link with provider performance.
Recommended priority actions	The current basis for allocating resources can be modified to further promote population health, efficiency, equity, and quality. Developing the current input-based budgeting approach to consider indicators of need (such as mortality rate, poverty rate, etc.) is recommended. Addressing barriers to care would also help ensure that resources are allocated according to the health needs of the population.
Desirable attribute PS2	**Purchasing arrangements are tailored in support of service delivery objectives**
Key areas of strength and weakness in Ethiopia	Under current purchasing arrangements, public providers are automatically included and funded based on primarily **line-item budgeting, user fees and fee-for-service**, with no explicit financial incentives promoting efficiency, service quality or better coordination. Ethiopia's UHC service coverage index score of 39 is below the regional average (SSA: 46) and indicates gaps in essential services provision. Hospitals and health posts **have financial autonomy over its internal revenues**, generated e.g. from user-fees, CBHI reimbursements and private hospital wings. Their **governing boards** that evaluate the utilization of funding. The use of **internal and external auditors** further contributes to financial accountability.
Recommended priority actions	Giving health facilities further autonomy over their budgets should be explored, balanced with the strengthening of health facility governance structures and monitoring systems to ensure accountability. This includes improving how health insurance data and other routine health information is collected and used to monitor provider behavior and outcomes, from a purchaser and system wide perspective. In addition, purchasing agencies need to be empowered to be able to detect poor service quality and other issues, and to establish necessary consequences and feedback to providers.

Purchasing health services

Desirable attribute PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Key areas of strength and weakness in Ethiopia	There is currently **limited incentive for providers to improve efficiency in service delivery** given the reliance on input-based line-item payments, fee-for-service, and user-fees. Capitation for the CBHI schemes is being piloted. However, it is unclear whether capitation will be rolled out only for CBHI members or for the whole population. Digitalization of claims management is also being piloted and has the potential to improve cost control and detection of fraudulent reporting. **Budgetary control for medicines** is reflected through centralized procurement via the Ethiopian Pharmaceuticals Supply Agency (EPSA), together with a focus on generic medicines. However, a large majority of drugs, (circa 70% in the public sector and 90% in private sector) are still defined as "unaffordable".
Recommended priority actions	It is critical to **take a system-wide view of all provider payment methods**, to build a picture of how the multiple incentives and resource allocation processes interact and impact on health facilities and the overall health system. Well-functioning health financing systems use a mix of different payment methods e.g. capitation and some form of form of variable component, together with other forms of purchasing arrangements to promote budget control, quality of care and the achievement of other health system goals. There is continuous monitoring of costs and other intended and adverse effects with re-adjustments when needed. Regarding spending on medicines, **improved capacity to regulate and set affordable prices and monitoring of prescription practices** would help to further contain costs and improve financial protection.

Benefits and entitlements

Desirable attribute BR1	Entitlements and obligations are clearly understood by the population
Key areas of strength and weakness in Ethiopia	While there is an explicit **Essential Health Services Package** and a **fee-waiver-system for indigents**, it is unclear if the population is fully aware of their entitlements, including which services should be available free-of-charge. In addition, many CBHI members, especially new ones, do not fully understand their CBHI-linked entitlements. The CBHI benefit package is currently being revised to create a positive rather than negative list of entitlements, which is expected to improve transparency. It is also not clear to the population exactly when CBHI premia should be subsidized and when the fee-waiver applies.
Recommended priority actions	It is important that the population understands their entitlements and obligations, so that providers can be held accountable. Information campaigns and household visits through the Health Extension Programme and Health Development Army should play a role in helping to improve understanding of the revised benefit packages as well as the entitlements and obligations of CBHI and SHI members.
Desirable attribute BR2	**A set of priority health service benefits within a unified framework is implemented for the entire population**
Key areas of strength and weakness in Ethiopia	The first EHPS was developed in 2005 and revised in 2019 using a participatory approach, with involvement from experts and stakeholders. Seven explicit criteria were used: burden of disease, cost-effectiveness, budget impact, equity, financial risk protection, and public and political acceptability. CBHI, as it scales up, and SHI, once launched, will introduce differences in entitlements in the health system between members and non-members.
Recommended priority actions	The EHSP is seen as a key priority-setting instrument which coordinates the activities of health system stakeholders and guarantees the right of citizens to a basic level of care. However, *de-facto* delivery of the EHSP requires more **effective implementation and operationalization** through active participation and adequate resource allocation from key stakeholders at national and sub-national level and **supply-side readiness** at all levels of the health system.
Desirable attribute BR3	**Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments**
Key areas of strength and weakness in Ethiopia	Budget impact and cost-effectiveness are two of the criteria used when revising the EHSP and the HIBP. As part of the revision, a fiscal space analysis was conducted for the EHSP and costing of the overall package and individual interventions for the HIBP (still ongoing) and the EHSP.
Recommended priority actions	The revisions of benefit packages relied on in-country capacity to conduct locally appropriate cost-effectiveness, budget impact and other analysis. However, benefit package design is not a one-off activity, but a continuous process whereby rigorous analyses are conducted before changes to the packages are made. Going forward, investing in the capacity to conduct these analyses will continue to be important, in particular considering the turnover of staff with hands-on experience from benefit package design.
Desirable attribute BR4	**Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers**
Key areas of strength and weakness in Ethiopia	The funding gap of total resources required to deliver the EHSP is estimated to be 33% in 2030 in a business-as-usual scenario. There is currently no explicit link between funds allocated to providers and the delivery of EHSP services.
Recommended priority actions	There is a need to increase the budget allocated to EHSP delivery considering the expected decline in donor funding as Ethiopia moves closer to middle-income country status. In the short term, it might be necessary to revisit the EHSP to avoid implicit rationing given the estimated funding gap. Improvements in incentive and accountability mechanisms for providers can help effectively operationalize the EHSP.

Benefits and entitlements

Desirable attribute BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Key areas of strength and weakness in Ethiopia	More than half of services covered under the EHSP are exempted from user-fees, while the remainder are guaranteed to be available with **cost-sharing and cost-recovery** mechanisms. In addition, there is a **fee-waiver system** for indigent households. Challenges remain, however, to fully implement these protection mechanisms: Often exemptions are only accepted by certain health facilities, while other, mostly higher-level facilities, refuse free treatment. The process of applying for waivers are perceived as bureaucratic. At the health facility, the provider will inform the patient of the user-fees once diagnostics and medicines have been prescribed.
Recommended priority actions	The exempted services and fee-waivers are in line with global evidence that show that these mechanisms can help to ensure coverage and protection of vulnerable groups. However, to be fully effective, the challenges in implementation need to be better understood and addressed.

Public financial management

Desirable attribute PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
Key areas of strength and weakness in Ethiopia	Ethiopia has a long-standing exercising compressive plan at all levels and enhancing health facility autonomy through the establishment of governing bodies at all levels. Budgeting implementation and the degree of flexibility depends on the financing source given that the federal government uses programme-based budgeting, but regional and woreda systems use line-item budgeting (i.e. 80-85 % of expenditures).
Recommended priority actions	Expanding the coverage, and improving the accuracy and detail, of the health information system is an immediate and important priority, given that it provides an essential evidence base for subsequent priority setting and policy decisions.
Desirable attribute PF2	**Providers can directly receive revenues, flexibly manage them, and report on spending and outputs**
Key areas of strength and weakness in Ethiopia	The IBEX and IFMIS public financial management systems are in place, although resources for health remain insufficient to deliver basic health services (USD 36 per capita). Despite this, there remains low budget utilization in some regions and woredas.
Recommended priority actions	Ethiopia needs to increase the level of public health expenditure particularly as external financing is likely to decline further in coming years as the country approaches lower-middle income status. Increasing public expenditure is, however, a necessary but insufficient response to the strategic needs and challenges that Ethiopia faces. Ethiopia needs to first improve its health information system to better track and assess the flow (and effectiveness) of various public expenditure streams.

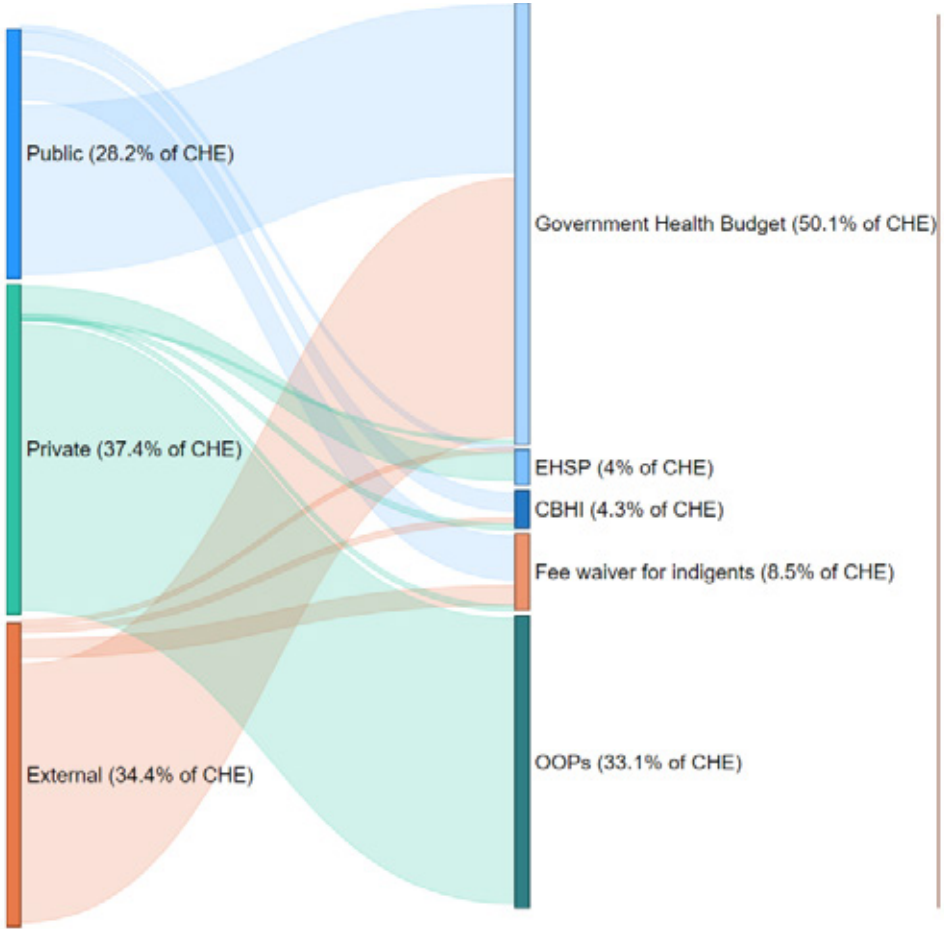
Stage 1 assessment

Key design feature	Government health budget	Essential health service Package) (EHSP	Community-Based Health Insurance (CBHI)	Fee waiver for indigents
A) Focus of the scheme	Main channel through which the government manages and disburses funding to the health sector. Covered all population who are the Ethiopian Citizen	Definition of health services which should be available either free of charge, or with cost-sharing or cost-recovery mechanisms. Covered all population who are the Ethiopian Citizen.	It targets those Ethiopians living in rural areas and urban areas with people working in the informal sector (largely informal sector without payroll).	To provide services for those that cannot afford user charges.
B) Target population	All Ethiopian Citizens.	All Ethiopian Citizens.	Informal sector; Employed in small enterprises with < 10 employees.	Indigent households.
C) Population covered	All Ethiopian Citizens.	All Ethiopian Citizens.	Enrolment rate: 58% of eligible population, in total 8.7 million household or 44 million people.	Estimated: less than 10% (circa 3 million) of the in total circa 27 million people that lives below the poverty line.
D) Basis for entitlement / coverage	Automatic	Automatic	Voluntary basis. Enrollment at the household level.	The process for identifying eligible persons differs across districts.
E) Benefit entitlements	It is guided by the essential Health Services Package for Ethiopia, aiming to provide a minimum standard of care that fosters integrated service delivery. However, there is limitation expenditure not linked to specific benefits entitlements	The EHSP defines a list of prioritized services. Some services included in the Essential Health Services Package for Ethiopia are legally exempt, which means 100% subsidization of key reproductive, maternal, child, and newborn health (RMNCH) and other high-priority health services (e.g., malaria and tuberculosis treatment).	Currently a negative list. Explicit list is being developed.	Fee-waiver covers services with user-fees in the EHSP.
F) Co-payments (user fees)	Free, share and recover systems that provide services which are not legally exempt from user fees and charge a minimal user fee but GHE not linked to specific user fees.	Either (56%) free of charge or with cost-sharing (38%) and cost-recovery (6%) mechanisms. User fee level can vary across regions.	No co-payments for CBHI members.	No co-payments for household identified as indigents under this scheme
G) Other conditions of access	Referral system is in place for condition to access.	First point of contact, nearest health center Referral system must be followed.	First point of contact, nearest health center Referral system must be followed.	First point of contact, nearest health center Referral system must be followed.
H) Revenue sources	Government Taxes and Loans, DPs including SDG pool fund. Some funds are earmarked for specific health programmers, e.g., GAVI, Global fund or CIFF funding.	Service inputs: Government Taxes and Loan; DPs. Service outputs (drugs, tests, supplies): User fees, voluntary contribution from employer: for services that are not exempted.	General subsidy via federal government (10% of premiums). Regions (70%) and district (30%) cover indigents; Premiums from members.	Government Taxes and Loans, Donor funding either via Channel 1 or Channel 2.

Key design feature	Government health budget	Essential health service Package) (EHSP	Community-Based Health Insurance (CBHI)	Fee waiver for indigents
I) Pooling	**Three types of pooling systems in Ethiopia** 1. Channel 1 is a pooled fund for on-budget resources (gov't and DP). 2. MDG/SDG performance fund (part of channel 2) pools external aid and focuses on reaching MDG/SDG targets. 3. Health facilities pool funds (retained revenue, gov't allocation, and community contribution).	Funding via Channel 1 and 2 (donor and government) pooled to implement program at different levels of the health system. Channel 2: Used by DP to finance commodities for exempted services	District level pooling. Zonal/sub-city level pooling has been piloted in certain regions.	Regional and districts receive funding via Channel 1 and 2 and use own revenues to implement the programme.
J) Governance of health financing	The governance function for the main public services is carried out throughout the federal, regional and woreda(district) health bureaus. Channel 1 and 2: Funds are managed and disbursed by Ministry of Finance or Ministry of Health following GOE procedures.	Governed by different administration levels such as federal, regional and district or Woreda levels	Governed by the district administration (a general assembly and a board of directors) which is overseen by the kebele cabinet.	Governed by the district administration (a general assembly and a board of directors) which is overseen by the kebele cabinet.
K) Provider payment	Line items and program-based budget; User fees.	Line items and program-based budget; User fees	For the CBHI, all providers are currently paid using a fee-for-service approach. Although the EHIA is aware that this approach can lead to moral hazard and encourage oversupply, it is expected that as the CBHI scales up. The health insurance provider payments are based on user fee rates rather than the full costs, but assuming an underlying public subsidy to capital investment, staff costs, management and supervision, etc.	Providers compensated for forgone user-fees.
L) Service delivery & contracting	Public health facilities at all levels.	public health facilities at all levels. Some exempted services exist in the private sector.	Public health facilities at all levels. Private drug retailers: when there are shortages. If there are no health center available close by, the CBHI scheme can contract facilities in other districts	Public health facilities at all levels.

Health expenditure by Stage 1 coverage schemes

Figure 6: Expenditure flows by scheme (Sankey diagram)



WHERE DO SCHEMES/PROGRAMMES REVENUES COME FROM?

STAGE 1 SCHEMES	PUBLIC	PRIVATE	EXTERNAL	TOTAL
Government Health Budget	39%	1%	60%	100%
EHSP	1%	95%	4%	100%
CBHI	66%	1%	33%	100%
Fee waiver for indigents	66%	1%	33%	100%
OOPS	-	100%	-	100%

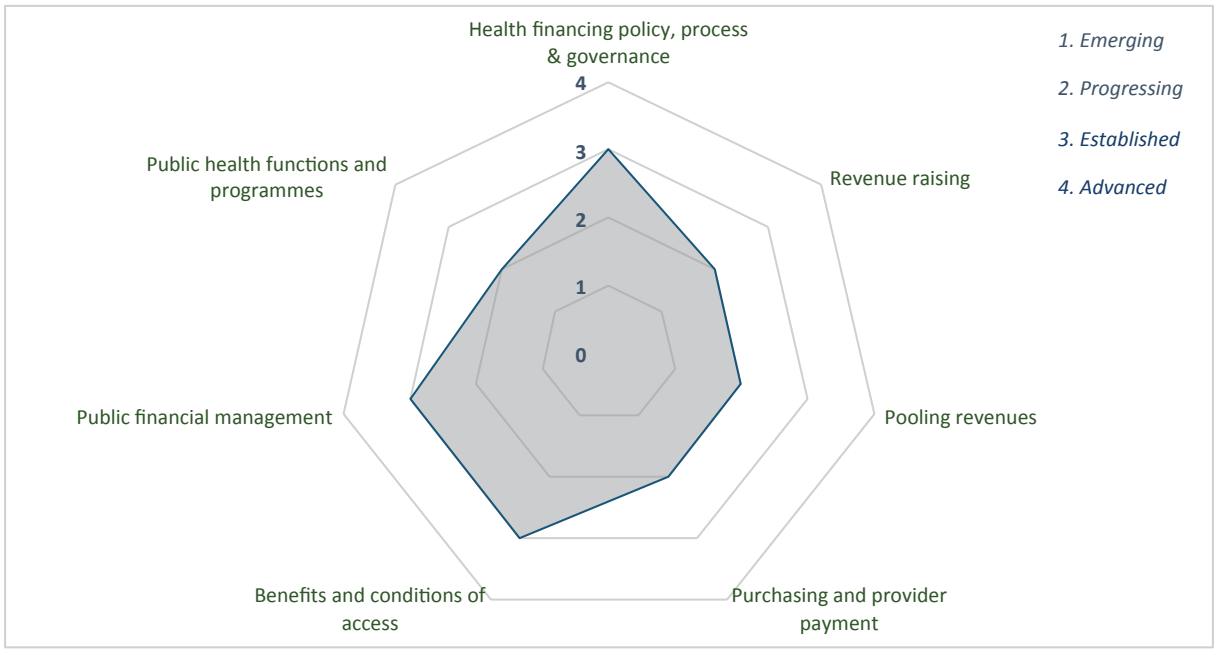
HOW ARE REVENUE SOURCES DISTRIBUTED ACROSS SCHEMES/PROGRAMMES?

STAGE 1 SCHEMES	PUBLIC	PRIVATE	EXTERNAL
Government Health Budget	69.9%	0.9%	87.2%
EHSP	0.2%	10.2%	0.4%
CBHI	10.0%	0.1%	4.1%
Fee waiver for indigents	19.9%	0.2%	8.2%
OOPS	-	88.6%	-
TOTAL	100%	100%	100%

Stage 2 assessment

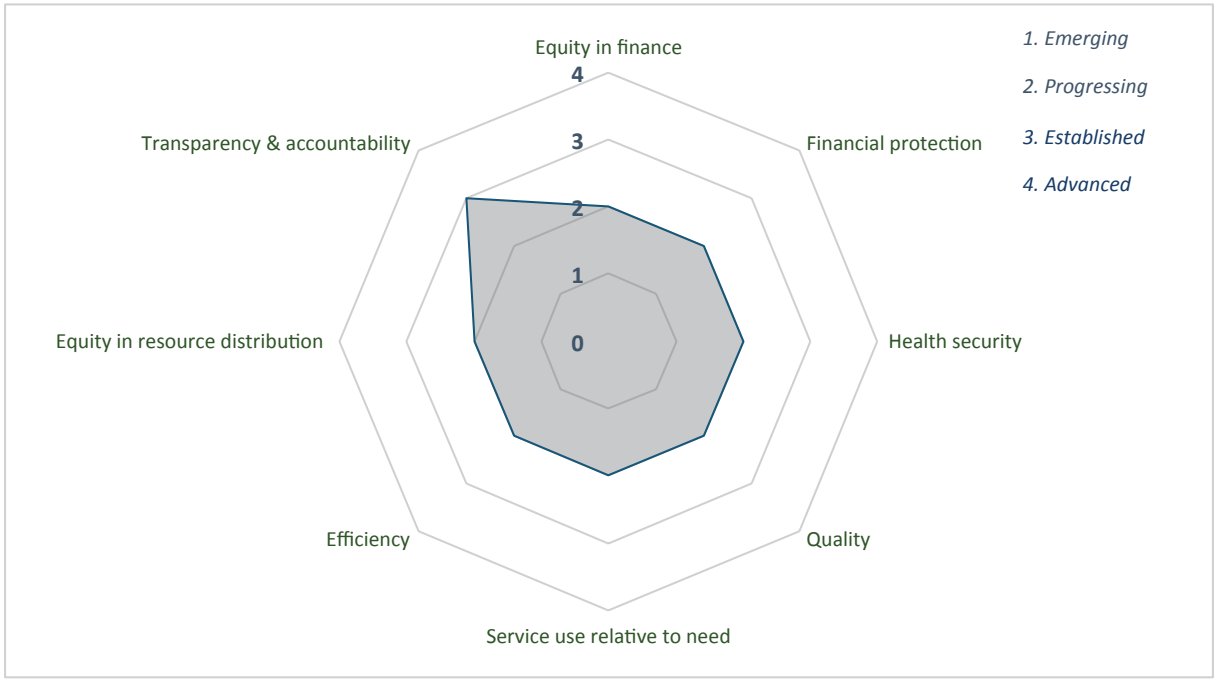
Summary of ratings by assessment area

Figure 7: Average rating by assessment area (spider diagram)



Source: Based on HFPM data collection template v2.0, Ethiopia 2022

Figure 8: Average rating by goals and objectives (spider diagram)

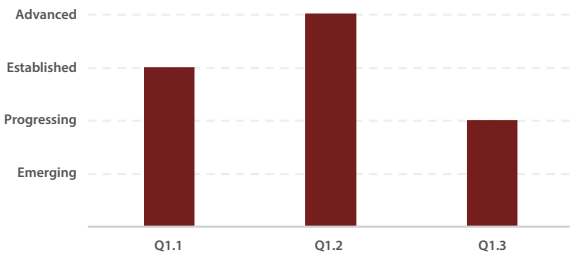


Source: Based on HFPM data collection template v2.0, Ethiopia 2022

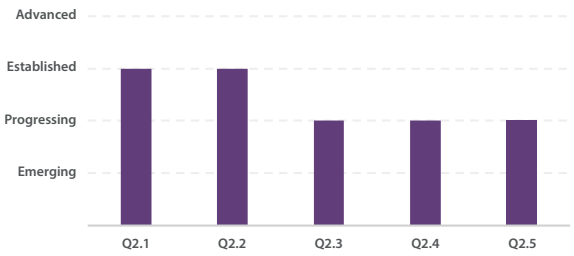
Assessment rating by individual question

Figure 9: Assessment rating by individual question

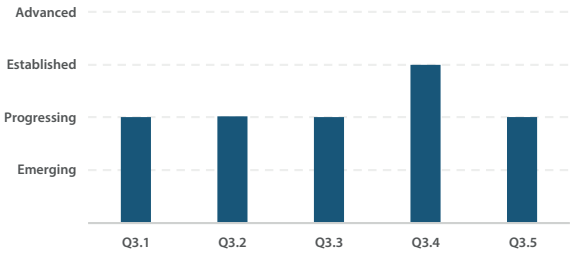
1. Health financing policy, process & governance



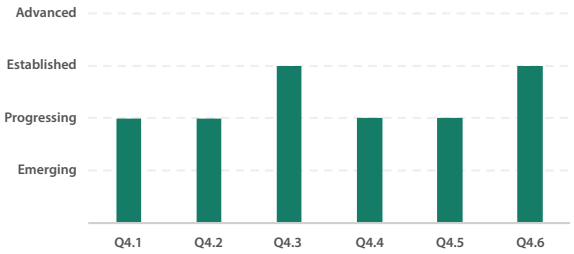
2. Revenue raising



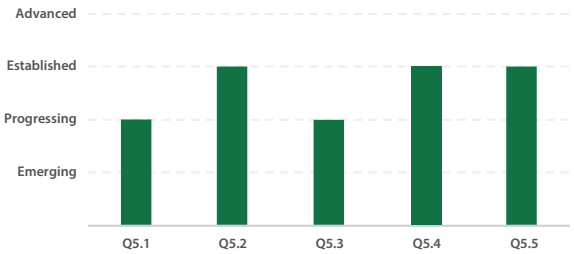
3. Pooling revenues



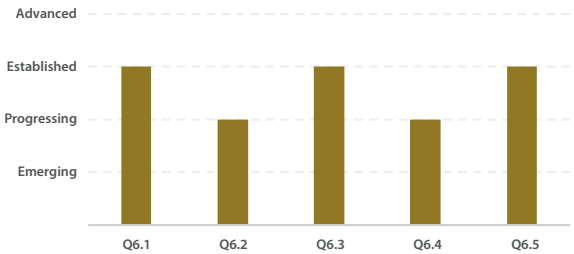
4. Purchasing and provider payment



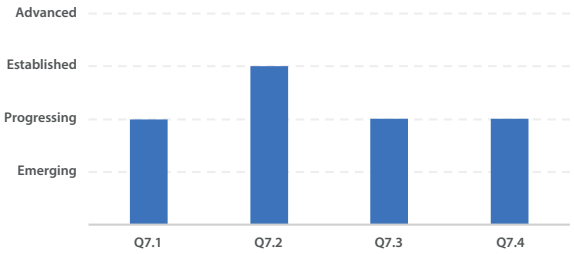
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes

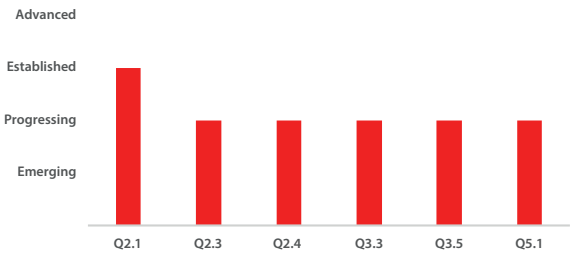


See Annex 3 for question details

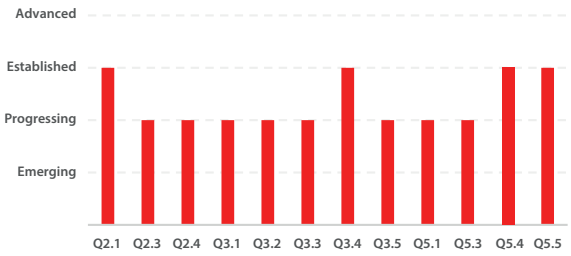
Assessment rating by UHC goals

Figure 10: Assessment rating by intermediate objective and final coverage goals

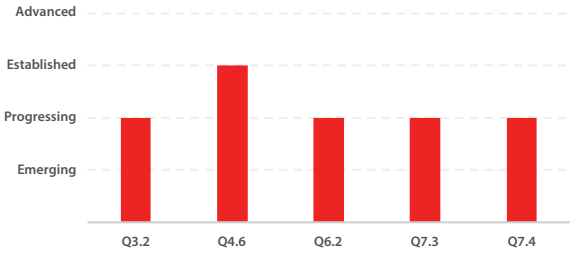
Equity in finance



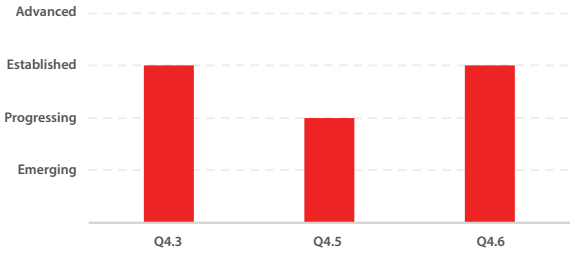
Financial protection



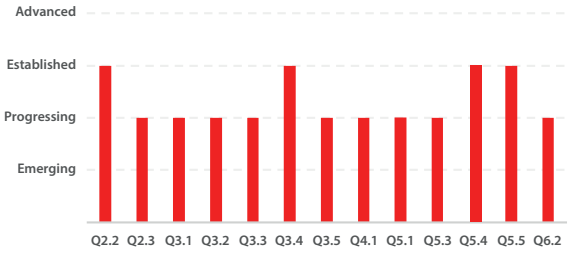
Health security



Quality



Service use relative to need

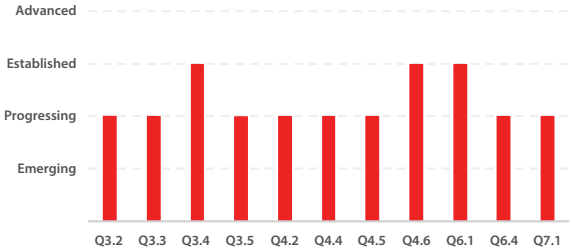


See Annex 3 for question details

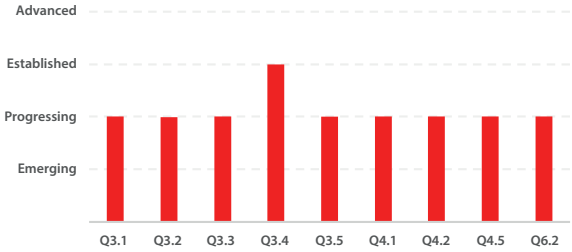
Assessment rating by intermediate objective

Figure 10 (continued): Assessment rating by intermediate objective and final coverage goals

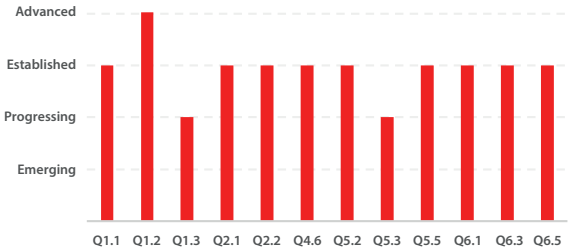
Efficiency



Equity in resource distribution



Transparency & accountability



See Annex 3 for question details

Resources

1. Ethiopian Federal Ministry of Health. Health Sector Transformation Plan I (2015/16 - 2019/20).; 2015.
2. Ministry of Health of Ethiopia. Health Sector Transformation Plan II (2020/21-2024/25).;2021
3. Ministry of Health of Ethiopia. Health Policy of The Transitional Government Of Ethiopia.;1993
4. Ministry of Health of Ethiopia. Health care financing strategy 1998.;1998
5. Ministry of Health of Ethiopia. Health Care Financing Strategy 2022 –2031,2022
6. Ministry of finance of Ethiopia. Federal Government Budget Proclamation,2021
7. Ministry of Health of Ethiopia. The HSDP Harmonization Manual (HHM) First Edition.; 2007
8. Ministry of Health of Ethiopia. The HSTP Harmonization Manual (HHM) second Edition.; 2020
9. Ministry of Health. Essential Health Services Package for Ethiopia.; 2019.
10. Ministry of Health. Essential Health Services Package for Ethiopia.; 2005.
11. Ethiopian Health Insurance Agency. Health Insurance Strategic Plan (HISP) II (2020/21 – 2024/25). 2020.
12. Ethiopian Health Insurance Agency. Community Based Health Insurance Proclamation.2021
13. Ethiopian Health Insurance Agency. CBHI Members' Registration and Contribution (2011-2020): Trend Bulletin. 2020.
14. Ethiopian Health Insurance Agency. May 2015. Evaluation of Community-Based Health Insurance Pilot Schemes in Ethiopia: Final Report. Addis Ababa, Ethiopia.
15. Alula M. Teklu 1, Yibeltal K. Alemayehu 1,2,3, Girmay Medhin 1,4, et al (2021). The Impact of Community-Based Health Insurance on Health Service Utilization, Out-of-Pocket Health Expenditure, Women's Empowerment, and Health Equity in Ethiopia: Final Report. Addis Ababa, Ethiopia: MERQ Consultancy PLC.
16. Ministry of Health of Ethiopia. Health and Health-Related Indicators 2012EFY (2019/2020). 2020
17. Federal Ministry of Health. (2021). Health and Health Related Indicators 2013 E.C. (2020/21). Ministry of Health: Addis Ababa, Ethiopia
18. Ministry of Health. Annual Performance Report. Vol 2012.; 2021.
19. Ministry of Health. Annual Performance Report. Vol 2012.; 2020.
20. Ministry of Health. Health Sector Transformation Plan: Woreda Based Health Sector Annual Core Plan.; 2020.
21. Ministry of Health of Ethiopia. Ethiopia National Heath Accounts Report, 2019/20.; 2022
22. Ministry of Health of Ethiopia. Ethiopia Health Accounts 2016/17.; 2019
23. Ministry of Health of Ethiopia. Sub-National Public Expenditure Review (PER) in Health.;2021
24. Alebachew, A; Yusuf, Y; Mann, C; Berman, P.; Federal Ministry of Health. 2015. Ethiopia's Progress in Health Financing and the Contribution of the 1998 Health Care and Financing Strategy in Ethiopia. Resource Tracking and Management Project
25. Ethiopia Economic Association. (2016). Measuring Efficiency of Public Tertiary Hospitals in Ethiopia.
26. Mann C, Dessie E, Adugna M, Berman P, Chan HTH. Measuring Efficiency of Public Health Centers in Ethiopia.;2016.
27. Federal Ministry of Health and EPHI. (2018). Service availability and readiness assessment (SARA). Addis Ababa, Ethiopia.
28. Ethiopian Public Health Institute (EPHI), Federal Ministry of Health and ICF International (2014). Ethiopian Service provision assessment plus survey 2014.
29. Kelly R, Hemming R, Glenday G, Bharali I, Alebachew A. Public Financial Management Perspectives on Health Sector Financing and Resource Allocation in Ethiopia.; 2020. doi:10.2139/ssrn.3534342
30. Waddington C, Alebachew A, Chabot J. Roadmap for Enhancing the Implementation of One Plan, One Budget and One Report in Ethiopia.; 2012.

31. Federal Ministry of Health. (2020). Health and Health Related Indicators 2012 E.C. (2019/20). Ministry of Health: Addis Ababa, Ethiopia

32. Federal Ministry of Health. (2010e). Financial and Administrative Management System Manual for Community Based Health Insurance Schemes, Prototype. Federal Ministry of Health: Addis Ababa, Ethiopia

33. Berman P, Mann C, Ricculli M-L. Can ethiopia finance the continued development of its primary health care system if external resources decline? Health Systems & Reform. 2018;4(3):227-38.

34. Ekbladh, Leah, Yenehun Tawye, and Leulseged Ageze. October 2013. Health Sector Financing Reform in Ethiopia: Lessons Learned and Ways Forward. Bethesda, MD: Health Finance and Governance Project, Abt Associates Inc. Draft internal document

35. HFG/HSFR. (2010). Assessment of user fee revision experience in Ethiopia. Abt Associates, Inc: Addis Ababa, Ethiopia.

36. Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG. Assessing country health financing systems: the Health Financing Progress Matrix. Geneva: World Health Organization; 2020 (Health financing guidance, no. 8 https://apps.who.int/iris/handle/10665/337938). Licence: CC BY-NC-SA 3.0 IGO.

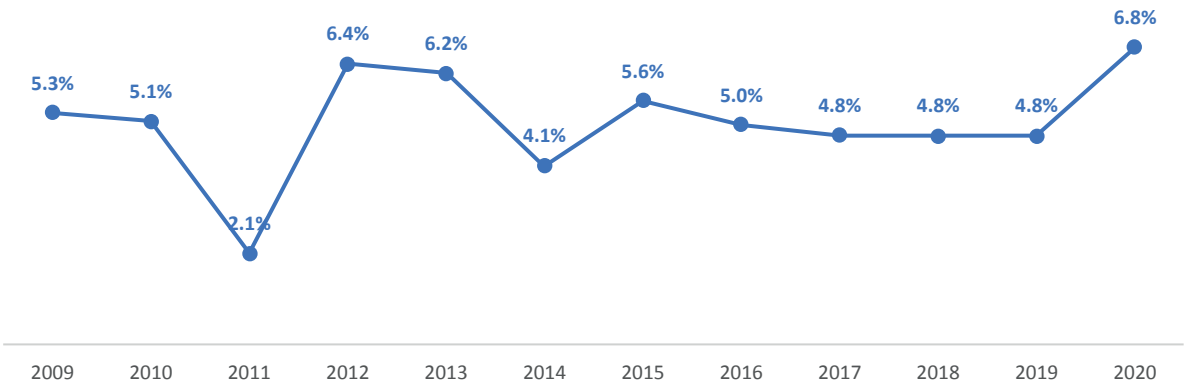
37. The Health Financing Progress Matrix: country assessment guide. Geneva: World Health Organization; 2020 (Health financing guidance, no. 9 https://apps.who.int/iris/handle/10665/337969). Licence: CC BY-NC-SA 3.0 IGO.

Annexes

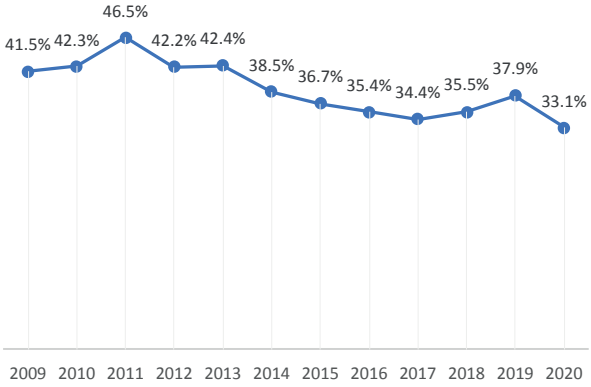
Annex 1: Selected contextual indicators

Figure 11: Health expenditure indicators for Ethiopia

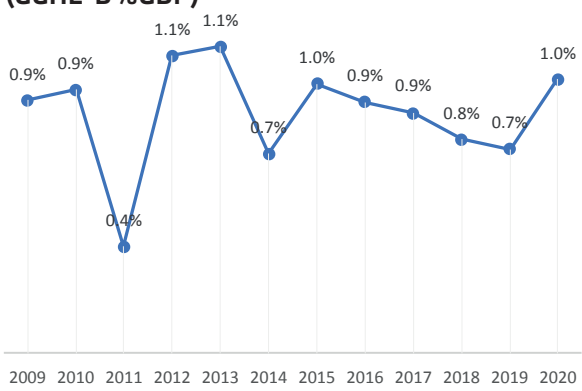
General government expenditure (GGHE% GGE)



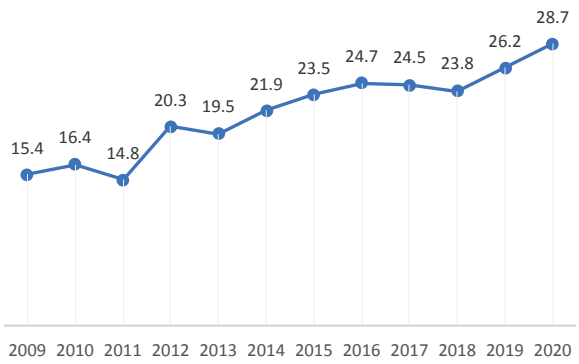
Out of pocket spending (OOPS%CHE)



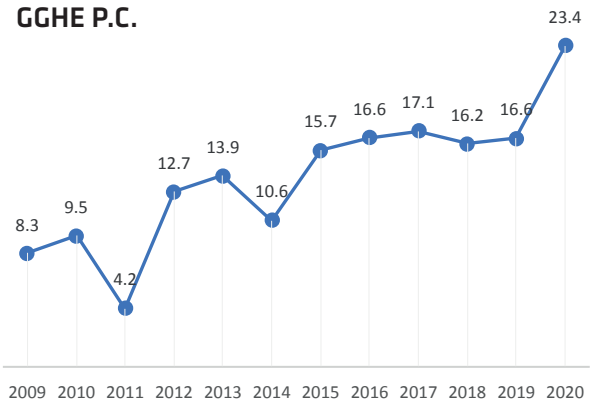
Public spending on health as % GDP (GGHE-D%GDP)



Total health spending (CHE per capita USD)

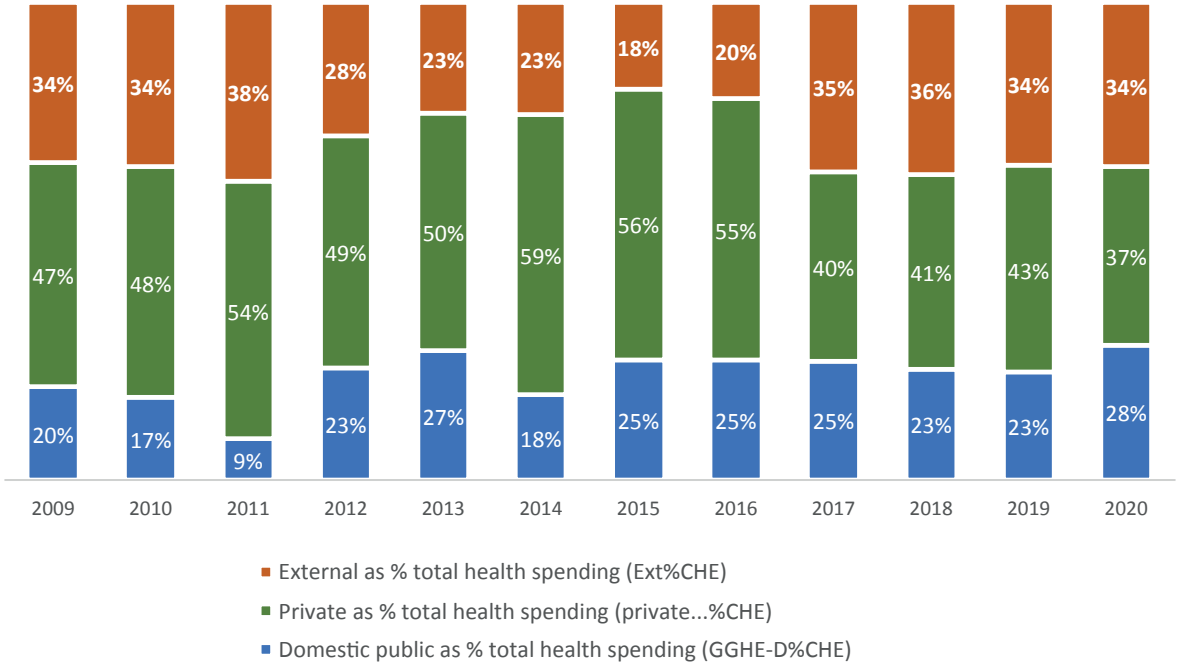


GGHE P.C.



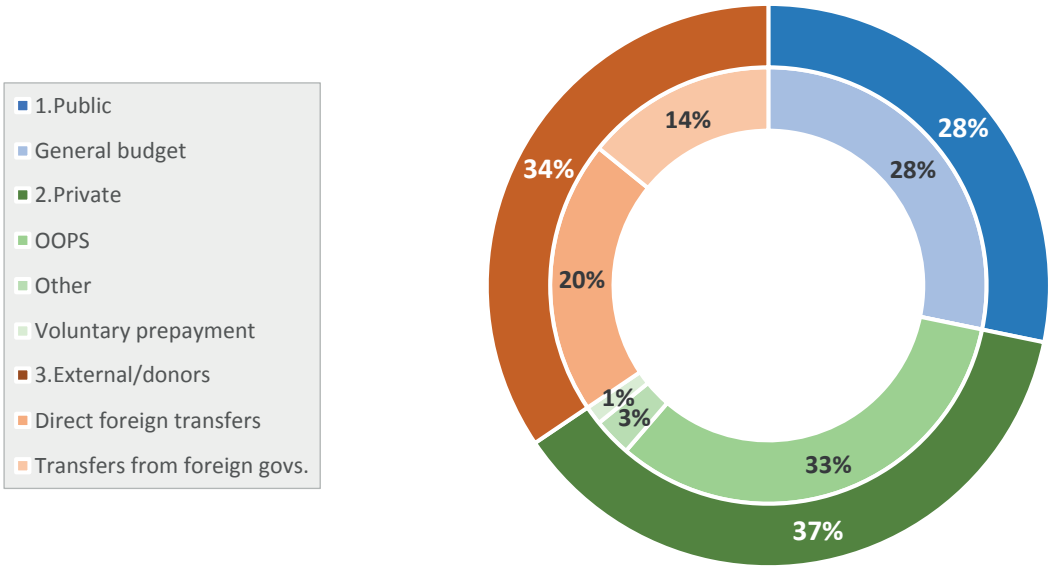
Source: The Global Health Observatory, 2022 (https://apps.who.int/nha/database/Home/Index/en)

Figure 12: Revenue sources for health in Ethiopia



Source: The Global Health Observatory, 2022 (https://apps.who.int/nha/database/Home/Index/en)

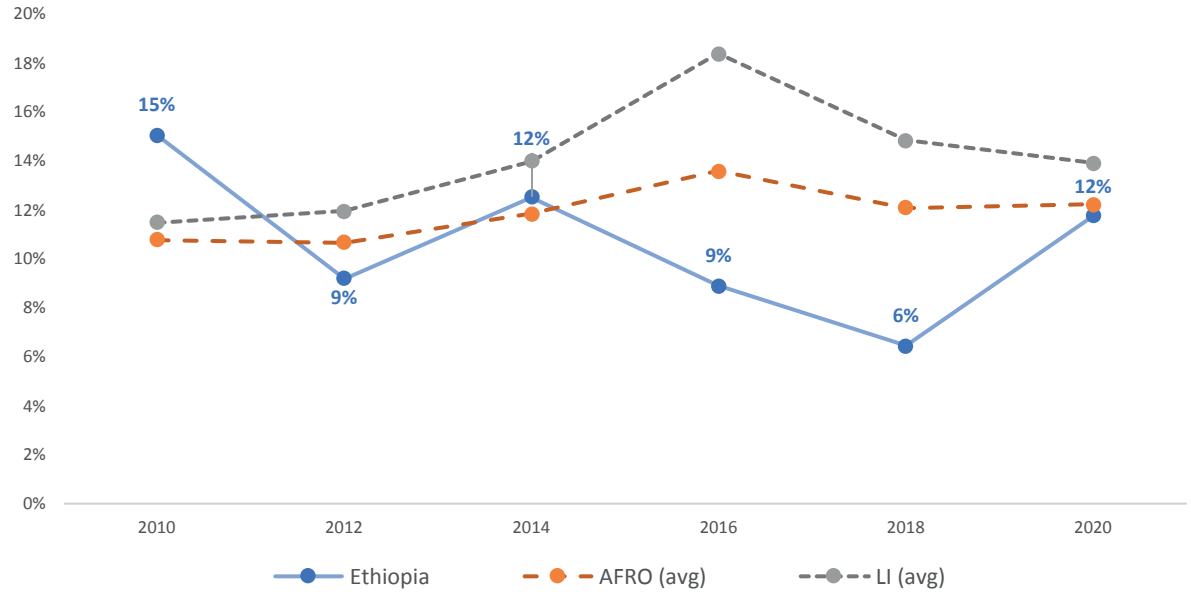
Figure 13: Recurrent expenditures by revenue source 2020



Source: The Global Health Observatory, 2022 (https://apps.who.int/nha/database/Home/Index/en)

Figure 14: Cigarette affordability in Ethiopia

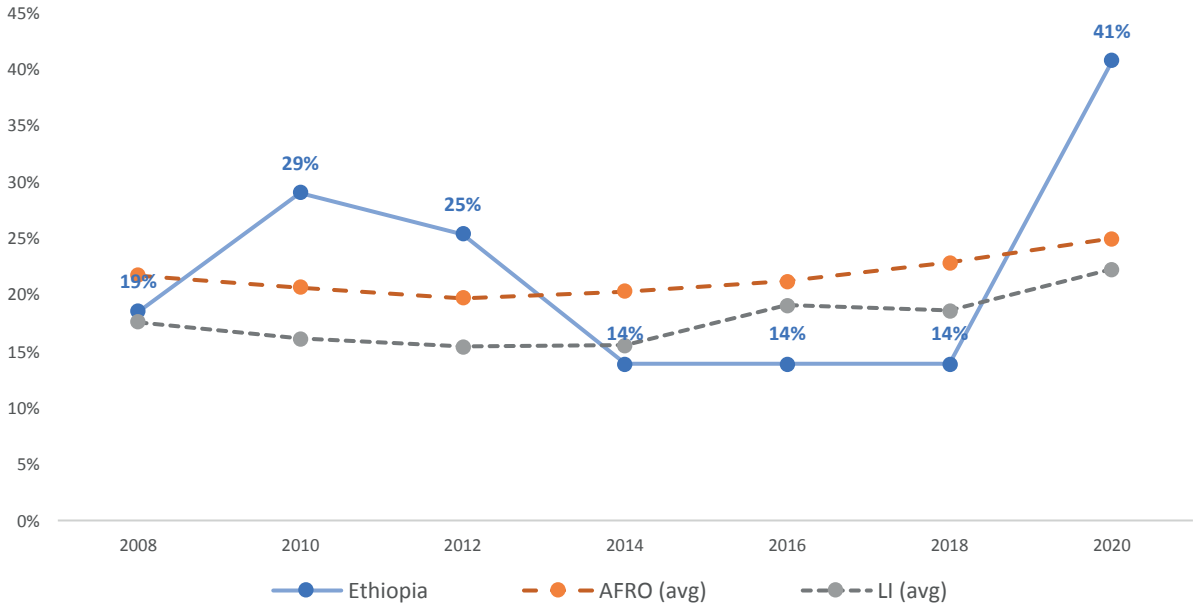
Reducing affordability is an important measure of the success of tobacco tax policy. In the longer term, a positive, higher measure means cigarettes are becoming less affordable. Short term changes in affordability are also presented.



Source: WHO report on the global tobacco epidemic 2019 (https://www.who.int/teams/health-promotion/tobacco-control/who-report-on-the-global-tobacco-epidemic-2019)

Figure 15: Excise tax share in Ethiopia (cigarettes)

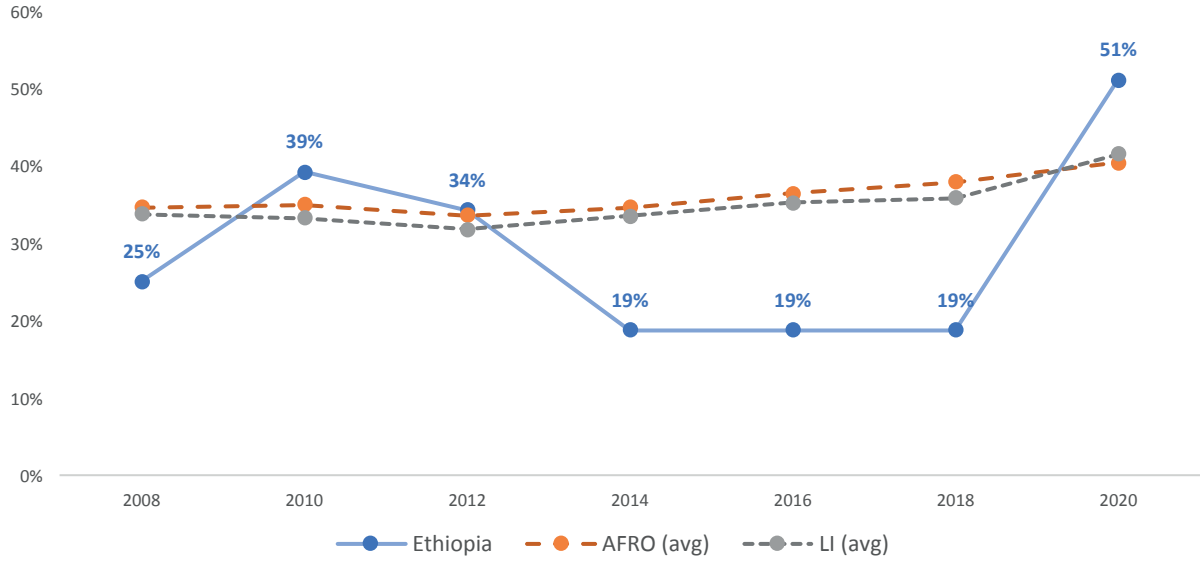
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



Source: WHO report on the global tobacco epidemic 2019 (https://www.who.int/teams/health-promotion/tobacco-control/who-report-on-the-global-tobacco-epidemic-2019)

Figure 16: Total tax share in Ethiopia (cigarettes)

This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, VAT/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.



Source: WHO report on the global tobacco epidemic 2019 (https://www.who.int/teams/health-promotion/tobacco-control/who-report-on-the-global-tobacco-epidemic-2019)

Annex 2: Desirable attribute of health financing

Policies which help to drive progress to UHC are summarized n terms of nineteen desirable attributes of health financing policy. For further information see: https://www.who.int /publications/i/item/9789240017405

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 behavior 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

Table 1: Desirable attributes of health financing systems

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

Annex 3: HFPM assessment questions

Assessment area	Question number code	Question text
1) Health financing policy, process & governance	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) Revenue raising	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviors?
3) Pooling revenues	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
4) Purchasing & Provider payment	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

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

Annex 4: Questions mapped to objectives and goals

Each question represents an area of health financing policy, selected given its influence on UHC intermediate objectives and goals, as explicitly defined below.

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

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

Objective / goal	Question number code	Question text
Financial protection	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
Equity in finance	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
Quality	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
Health security	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

The Health Financing Progress Matrix (HFPM) is WHO's standard approach to assessing country health financing systems. HFPM reports provide policy-makers with an up-to-date assessment of strengths and weaknesses in their health financing system relative to a set of desirable attributes. Recommendations are also made on the shifts in policy which can accelerate progress towards UHC.

For additional information, please contact:

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

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

9789240067554