Health Financing Roadmap:

Moving Towards Universal Health Coverage in the Republic of Tajikistan

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Abbreviation

BBP	Basic Benefit Programme/Package
GDP	Gross Domestic Product
HI	Health Insurance
MHI	Mandatory Health Insurance
MHIF	Mandatory Health Insurance Fund
MOH	Ministry of Health of the Republic of Tajikistan
MOF	Ministry of Finance
OHD	Oblast Health Department
PHC	Primary Health Care
VHI	Voluntary Health Insurance

1. Introduction

During April-June 2013 a feasibility study on introduction of Mandatory Health Insurance (MHI) as a mechanism enabling movement towards universal health coverage (UHC) was conducted in Tajikistan with the technical support of WHO. In addition, this study or framework included policy options and recommendations for the Government of Tajikistan to move forward with health financing reforms in line with the principles of moving towards UHC. The MHI Feasibility Study reviewed the Health Insurance (HI) Law of the Republic of Tajikistan (including mandatory and voluntary HI), assessed the feasibility of MHI implementation in Tajikistan, identified key implementation questions, performed limited financial analyses and documented stakeholder opinions. This study concluded that if the MHI implementation pre-conditions are met, then MHI is feasible in Tajikistan.

Based on the results of this study the Ministry of Health and Social Protection of Population of the Republic of Tajikistan carried out certain activities during 2013 including initiation of policy dialogue with ministries and agencies, Government and Parliament on the feasibility of introducing MHI in Tajikistan in 2014 as it had been envisaged in the amendment to the Law "On Health Insurance in the Republic of Tajikistan" (2008). A joint decision was made to postpone MHI introduction till 2017, however it was recommended that preparation start immediately. One of the preparation steps envisioned is development of a Health Financing Roadmap with the rationale that well-defined implementation steps in a Roadmap will increase the probability of success of both MHI introduction and broader health financing reforms.

Building on the MHI Feasibility study a Roadmap on comprehensive health financing reform that should lead to introduction of MHI in Tajikistan has been developed. It was widely discussed with all stakeholders involved in health financing in Tajikistan during Health Financing mission (March 24-28, 2014) and Flagship course on Health system strengthening with a focus on health financing issues (March 31-April 3, 2014). Furthermore, during the Senior Policy Seminar (SPS) that took place on April 4, 2014, it was agreed to translate the Roadmap into the detailed strategic plan of further health financing reforms in Tajikistan till 2018 while moving forward toward UHC. The Ministry of Health and Social Protection of Population of the Republic of Tajikistan (MOH&SPP) committed to approve this strategic plan by the Government of Tajikistan within a few months after SPS. This should intensify the interactions at the technical level between the three ministries (MOH&SPP, MOF and MOE) and Development partners while changing the health financing architecture in Tajikistan.

2. MHI Feasibility Study Pre-conditions

The MHI feasibility study identified five categories of MHI preconditions grouped by the three health financing functions of *revenue collection, pooling of funds and health purchasing and also institutional structure, roles and relationships and implementation strategies and sequencing*. The study is relevant to a broader Health Financing Roadmap as it suggested there is no reason why achieving the pre-conditions and implementing MHI shouldn't trigger or catalyze health financing and structural reform, create strong linkages to service delivery improvement, increase population and community involvement, and enable Tajikistan to get on

the road to universal coverage for its population. The MHI implementation preconditions are summarized in the following Table 1.

Table 1. Preconditions for introduction of MHI in Tajikistan

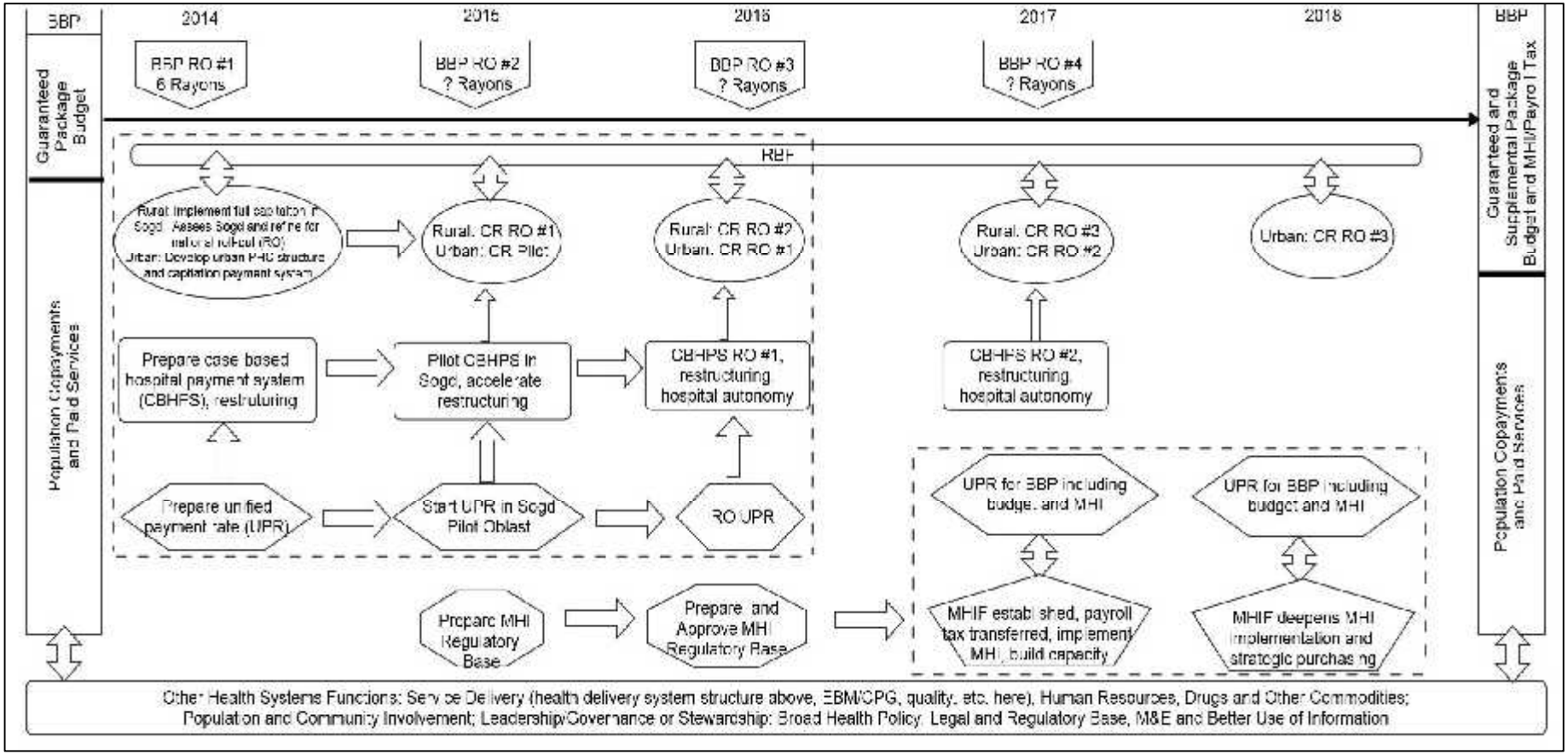
Category	Pre-condition	Description
Institutional Structure, Roles and Relationships	Health Purchaser Institutional Structure	Establishment of MHIF as unified payer with independent legal status.
	Health Purchaser Organizational Dev.	Initial MHIF organizational development sufficient to enable successful operation of MHI.
	Roles and Relationships	Establish clear roles and relationships between new MHIF and other Tajik ministries and entities. Clear separation of functions between MOH and MHIF.
Revenue Collection	Determination of who collects MHI payroll tax	Recommendation of Option 2: existing payroll or social tax collection entity.
	Health budget transfers	Clear policies and procedures for how the MOF would transfer health budget funding for non-working populations to the MHIF.
Pooling of Funds	Pooling of Funds	Pooling of general tax and payroll tax funds at least at the oblast level.
Health Purchasing	Determination of what to purchase: BBP	Specification or refinement of basic benefits package (BBP) including both guaranteed (free) package and population copayments
	Determination of how to purchase: provider payment systems	MHIF as unified payer purchases health services using output-based provider payment systems to match payment to BBP.
Implementation	Implementation strategies and sequencing	Dynamic action driving implementation and helping to ensure the many and varied tasks meld into a cohesive whole or functioning MHI system.

Source: *MHI Feasibility study, WHO, 2013*

3. Health Financing Roadmap

The Health Financing Roadmap presented below in Figure 1 was developed based on stakeholder dialogue. It encompasses MHI introduction, broader health financing reform and the relationship to health delivery system organization and structure. Health financing interventions being implemented in 2014 are the foundation of the Roadmap and demonstrate that reform is accelerating. They include Basic Benefit Package (BBP) roll-out to 6 more rayons, implementation of full capitated rate payment system in all of Sogd Oblast, and initiating MCH hospital restructuring in Khatlon Oblast and tied to a condition that the savings are retained and reinvested.

Figure 1. Health Financing Roadmap moving toward Universal Health Coverage in Tajikistan



The Health Financing Roadmap is described in the following eleven points.

1. Health Financing Roadmap Chart Structure

The basic structure of the Health Financing Roadmap chart is as follows:

- It's bounded on the left and right sides by the population entitlement or health system product of Basic Benefit Package (BBP), described in #3 below.
- The bottom of the chart shows the linkage to other health systems functions, described in #11 below.
- The action in the Roadmap moves from left to right through each year of the five year timeframe, described in #2 below.
- Each of the lines in the chart moving across the five year timeframe is a different shape reflecting relevant elements of the health financing functions of pooling and purchasing. BBP is a downward-facing pentagon described in #4 below. Primary Health Care (PHC) capitated rate payment system including Results based financing or Performance based financing (RBF/PBF) and related PHC organization is a circle described in #5 below. Case-based hospital payment system and related hospital restructuring is a rectangle described in #6 below. Pooling of funds at least at oblast level or unified oblast payment rate is a hexagon described in #7 below. MHI legal and regulatory base is an octagon described in #8 below. Establishing Mandatory Health Insurance Fund (MHIF) as health purchaser is an upward-facing pentagon described in #9 below.
- The dotted lines are the critical path or focal areas before and after MHI implementation described in #10 below.
- The arrows portray especially key relationships and are described in each of the relevant Roadmap areas.

Each year is designated at the top of the Health Financing Roadmap with activities for each type of intervention portrayed on a different line below each year. In summary, it's possible to view the Roadmap either by type of activity across each year from left to right or by all activities within each year from top to bottom.

2. Health Financing Roadmap Timeframe

The Health Financing Roadmap timeframe is five years from 2014 to 2018. It includes three years of preparation for MHI and two years of MHI implementation. As described throughout this report, the Health Financing Roadmap is broader than MHI as it encompasses all health financing reform. However, MHI does play an important role not only related to payroll tax revenue but in establishing the MHI Fund (MHIF) as a change agent to drive improving pooling and purchasing arrangements. Therefore, the Roadmap timeframe is aligned around the Government decision to implement MHI in 2017 (amendment to Health Insurance Law 2008, January 2014).

3. Basic Benefit Programme/Package

The Basic Benefit Programme (BBP) is represented in the Health Financing Roadmap as the two vertical boxes at the far left and the far right of the chart. BBP is the entitlement or product that Tajikistan delivers to its population. If the Health Financing Roadmap is likened to or compared with a car, the BBP is the visible body or chassis of the car while the five year Roadmap in the middle is the engine of the car which is hidden from view but its pooling and purchasing parts power the car.

At the start of the Health Financing Roadmap and before MHI introduction, BBP on the left consists of guaranteed package (free services) funded only with budget funds and population copayments (paid services). At the end of five year Roadmap, BBP on the right will have evolved to guaranteed package and possibly supplemental package funded by both budget and MHI payroll tax funds and population copayments/paid services.

Key dynamics or action of the Health Financing Roadmap is embodied in the line in the middle of the BBP. Over the course of five years, it moves down showing that health budget and MHI payroll tax are funding more so that guaranteed package increases and population copayments decrease thus increasing financial risk protection, reducing out-of-pocket payments and moving forward on the road to universal health coverage. The movement of the line is driven by both health revenue increases and obtaining efficiency gains from pooling and purchasing improvements. While the Health Financing Roadmap is intended to show movement and relationships rather than absolute numbers, an exemplary scenario is that BBP with approximately 27% of total funding from health budget (from NHA, PER, etc.) moves to BBP with approximately 40% of total funding from health budget and MHI payroll tax by the end of the five year Roadmap.

The relationship between BBP or the body of the car and the pooling and purchasing arrangements or engine of the car should be explicitly recognized including government and population shared responsibility. The BBP is what is purchased and provider payment systems are how the BBP is purchased. As the health budget only funds a small portion of the BBP, it is critical that health purchasing better target health budget funding to priority services and populations. Output-based provider payment systems including PHC capitated rate payment system and case-based hospital payment system are the mechanisms by which this targeting of priority services and populations can occur. If output-based provider payment systems directly target health budget funding to the BBP guaranteed package, it is very clear to providers what services are free and what services are paid which increases transparency and should improve provider responsiveness to the population and management of health services.

4. BBP Roll-Out (RO in chart)

As discussed above, definition of the health sector product to be purchased is critical to both MHI introduction and broader health financing reform as reflected in the Roadmap. Therefore, national BBP roll-out is a key activity as depicted on the first line of the Roadmap. It is assumed that national BBP roll-out would be completed when MHI starts in 2017 so that MHI

introduction includes clear specification of BBP or what health product will be purchased with both general revenue health budget and MHI payroll tax funding.

It's possible to frame Tajikistan BBP implementation as consisting of two phases – the pilot phase and the national roll-out phase. The pilot phase consisted of BBP development, introduction and refinement in the first 8 BBP rayons. It occurred over a number of years, can be characterized as progressing well although unevenly or up and down at times, and implementation accelerated over the last year. Given a total of 65 rayons, the national roll-out phase will include 57 rayons to be completed in a 4-stage roll-out from 2014-2017. Roll-out in 2014 was 6 rayons for a total of 14 which leaves 51 more rayons for roll-out in the three remaining years or stages of the national BBP roll-out. Very detailed implementation plans are required for the national BBP 3-year roll-out and development of these plans was initiated in the Flagship Course and will be continued by the MOH. These implementation plans will address details like whether best to roll-out to an equal number of rayons each year or fewer in the early stages at the beginning and more in the later stages at the end as roll-out methodology and process matures, and whether to prioritize completing roll-out in one oblast first or roll-out equally across oblasts. In summary, the Health Financing Roadmap contains four stages in BBP national roll-out phase from 2014-2017.

In addition to implementation in the remaining rayons in Tajikistan, national BBP roll-out also includes additional BBP specification or refinement to both BBP elements – guaranteed package and formal population copayments. Refinements of the guaranteed package will be developed and incorporated into each stage of national roll-out. Formal population copayment in Tajikistan is very complex due to the historical relationship between BBP population copayments and paid services or fee-for-service under Decree #600. BBP copayments were simple with a small number of prospective more bundled categories or groups (10-12). Previously paid services were complex with a large number of retrospective unbundled fee-for-service categories or groups. Extensive dialogue and methodological improvements over the last few years has resulted in the convergence of population copayments and paid services (under Decree #600). Thus, these both policies apply the same price list for co-payment and paid services but the list of beneficiaries are slightly differ and the level of co-payments and paid services are differ – under BBP 50%, 70%, 100% and under paid services 80% and 100%[1]. - Although a final assessment and BBP population copayment refinement should be done to ensure that specification is consistent with international best practice and avoids the unintended consequences of fee-for-service payment including supplier induced demand and cost escalation. This final assessment should also analyze the level of copayment by type of beneficiary and any desired revision of expenditure guidelines for copayment. The MOH&SPP will unify these two policies (BBP and Decree #600) into one policy within the framework of this Roadmap leaving BBP as a main policy.

5. PHC capitated rate payment system roll-out and PHC reorganization

Like the BBP, PHC capitated rate payment system implementation on the second line of the Roadmap was initiated many years ago, occurred over a number of years, can be characterized

[1] See for more details Policy Brief # 4 "Overview of health financing reforms in Tajikistan", MOH/HPAU, 2013.

as progressing well although unevenly or up and down at times, and implementation accelerated over the last year. Implementation sequencing for PHC capitated rate payment system was first phase including direct patient care or variable costs, and second phase including salaries as they're complicated and require extensive planning and management.

Movement to Phase II PHC full capitated rate payment system started in Sogd Oblast in 2013. Sogd Oblast full capitated rate implementation was based on a MOH and MOF joint decree for two rayons starting April 1, 2013 (Karkum and Istarafshan). The MOF initiated another MOH and MOF joint decree to begin roll-out of full capitation to all of Sogd Oblast starting July 1, 2013, and implementation has continued into 2014.

In stakeholder consultations, the Ministry of Finance (MOF) stated they do not believe the Sogd Oblast full capitated rate payment system is capitation. There could be some definition or terminology differences, for example, if the MOF is referring to a per capita normative for ***budget formation*** rather than a per capita or capitated rate ***provider payment system***. If the MOF is referring to only changing the budget formation process while retaining the old line-item budget payment system rather than moving to output-based provider payment systems, this will not drive health financing reform, allow matching payment to BBP priority services and populations, or enable reinvesting savings from hospital restructuring. In Appendix 1 the summary of the meeting with MOF that took place during WHO health financing mission (March 24-28, 2014) could be found.

The Roadmap's first PHC full capitated rate payment system step in 2014 is continuing implementation in Sogd Oblast, followed by monitor and assess Sogd implementation, and refine PHC full capitated rate payment system design and operating procedures in preparation for national roll-out. World Bank technical assistance could contribute to the process of assessing Sogd Oblast implementation and refining PHC full capitated rate payment system to prepare for national roll-out. Factors to take into account in refining PHC full capitation payment system are specifics of the formula including age/sex, population density and other adjustors, and adding vertical programs into PHC capitated rate (e.g. TB, HIV). Health Financing Roadmap steps in 2015-2018 consist of roll-out in stages with three stages or years planned for roll-out of both rural and urban PHC full capitated rate payment system.

Two other important elements of PHC payment system are the relationship to PHC organization and the relationship to results-based financing (RBF). PHC organization is separated into rural and urban because of the substantial differences and level of reorganization required in urban areas where polyclinics need to be reoriented to PHC and/or Family medicine practices formed within polyclinics (in some settings this is the case already). Reorganization of rural PHC has been in process for many years as it was done in parallel with implementation of PHC capitated rate payment system for variable costs. Minimal structural reorganization is required in rural areas outside the rayon center as PHC facilities (e.g. health centers) already exist. Much of rural PHC reorganization activities involved establishing a PHC network manager, and in general the PHC network manager is the head of rayon polyclinic. Two issues for continued monitoring are prioritizing allocation of funds to family medicine practices over outpatient specialty services, and ensuring prioritization of PHC given that network manager reports to CRH after abolishing rayon health departments in 2012. Designing and developing a large urban area PHC model in Tajikistan is still in process (although a good basis for the model exists in the combined service delivery and medical education/training

polyclinics) and should be closely connected to development of PHC full capitated rate payment system to reflect the strong relationship between health financing and service delivery.

The arrows to and from PHC full capitated rate payment system reflect important relationships with other elements of the Health Financing Roadmap. The arrow to PHC capitated rate portrays that a portion of savings from hospital restructuring will be shifted to PHC (not all savings will be shifted as investment is also needed in hospitals to increase funding for direct patient care). The arrow from PHC capitated rate to RBF illustrates that PHC capitated rate payment system and RBF are not completely separate payment systems but rather are strongly related. RBF can be added on top of PHC capitated rate to enhance financial incentives and leverage all payment to PHC to improve the quality of care at PHC level. It should also be noted that it's very difficult or impossible to add RBF on top of the old line-item budget payment system as the mechanisms, systems, processes and procedures for output-based payment do not exist. In general, it's critical to ensure harmonization of health financing/purchasing/provider payment systems and public finance management (PFM). Finally, exact details of PHC capitated rate payment system roll-out were discussed in the Flagship Course and the MOH&SPP will follow-up on this initial detailed implementation planning.

6. Case-based hospital payment system, hospital restructuring and hospital autonomy

General principles of case-based hospital payment systems including diagnostic related groups (DRGs) are as follows:

- Health purchaser pays all hospitals included in the payment system a prospectively fixed lump sum payment rate for each treated case that falls into one of a set of defined case groups or DRGs. There must be a group of hospitals paid under DRGs.
- The fixed lump sum payment rate is intended to pay hospitals the average expected cost in an average-performing hospital to treat a case in a given case group. The actual costs of treating individual cases will exceed the payment rate in some cases and be below the payment rate in other cases, which is the feature of the payment system that creates incentives to improve hospital management and increase hospital efficiency. If a hospital within a system is paid its actual cost for each case, there is no reward, and therefore no incentive, to improve the efficiency of treating hospital cases. And the unintended consequence of increasing hospital admissions is worsened as hospitals are paid their own costs not the average cost of treating a case in a given group. In other words, case-based hospital payment systems should not include hospital-specific base rates as higher costs in rayon vs. oblast vs. republican hospitals should not be due to the type of hospital but rather the type and severity of cases they treat.

Current health budget purchasing mechanisms or provider payment systems generally allocate funds to staff costs (almost 86-90%)[2] and infrastructure including building and utility costs and these funds may or may not be disproportionately targeted at either priority services or the poor. The line-item budget provider payment system currently being used in Tajikistan usually works best in a mature health system not undergoing significant reform, with the

[2] *Effectiveness of Hospitals in Health Care Delivery: Current Situation in Tajikistan,* 2011, Quality Healthcare Project (USAID) and HPAU/MOH (WHO/EU)

number, structure, and role of health facilities determined and funding sufficient to pay for all health services defined in the benefit package. In Tajikistan, public expenditure reviews (PER), national health accounts (NHA), and other expenditure tracking, analyses or studies have generally shown that public funding through health budget is only about 27%[3] of total health funding with the remaining 72% from private and donor funding. Private out-of-pocket payments are very high and financial risk protection for the population especially poor and vulnerable populations is very low.

To address these problems, it is important that health purchasing targets or matches payment to services used by patients rather than to health facilities or buildings. In other words, if the health budget level is not sufficient to pay for all services for all individuals, to make sure priority services are delivered and the needs of the poor are covered payment should be made for specific populations and prioritized services rather than entire health facilities or buildings. The main factor is the ***definition of the product or unit of service*** – it's not a health facility or building and all services provided within it, it's an individual person (a patient) and the health services they require. Shifting to output-based provider payment systems allows government health budget to be explicitly and directly targeted at priority services and the poor. In essence, people matter more as providers are paid to deliver services to them. Additionally, this is aligned with WHO/Europe health policy through Health 2020 that Tajikistan endorsed in 2012. It clearly highlights the importance of strengthening people-centered health systems within the framework for actions towards coordinated/integrated health service delivery. In addition to linking with pooling arrangements to improve equity and financial risk protection, output-based provider payment systems have another major advantage – they support improvements in efficiency and transparency. They are directly related to improvements in governance, stewardship and management as they provide financial incentives for providers to manage better and allocate resources more efficiently. Transparency is improved as the rates paid for services are public information such that health providers know the amount they should be paid for the services they deliver.

While it has been discussed and planned for many years, Health Financing Roadmap development would benefit from a clear statement of why implement a case-based hospital payment system in Tajikistan. MOH&SPP will further specify expected contributions to health sector goals and objectives during Roadmap implementation planning but the general rationale for a case-based hospital payment system in Tajikistan is as follows:

- Contribute to realization of BBP by better matching health budget funding to guaranteed package services and populations;
- Enable improvements in hospital management and increases in hospital autonomy by output-based payment through which hospitals combine the best mix of resources to produce the desired result;
- Operating and billing system strengthens health information systems, accumulates data for analysis, improves monitoring and evaluation, and creates demand for policy analysis and operations research for continuous system refinement;

[3] System of Health Accounts applying 2012 data, HPAU/MOH&SPP, 2013

- Allow hospital restructuring to reduce excess capacity, obtain efficiency gains, and create and reinvest savings in direct patient care.

There has been a long-standing debate between the MOH&SPP and MOF on the relationship and sequencing between changes in hospital provider payment system and hospital restructuring. The MOF has advocated that hospital restructuring should be done first and then they would change the hospital payment system. The MOH&SPP has advocated that the hospital payment system should be changed first as it facilitates or is pre-condition for hospital restructuring. Experience in other Former Soviet Union/CIS countries supports that hospital payment system (e.g. case-based hospital payment system) needs to be changed first and then hospital restructuring as the new hospital payment system creates the mechanism for creating savings, reinvesting savings, increasing hospital autonomy and improving hospital management.

A case-based hospital payment system (e.g. DRGs) has already been developed in Tajikistan including case classification or clinical groups and relative weights. The system was tested by a paper simulation and it is ready for implementation. The Health Financing Roadmap contains four phases of case-based hospital payment system, hospital restructuring and hospital autonomy: (1) in 2014 prepare for case-based hospital payment system implementation and hospital restructuring and autonomy; (2) in 2015 case-based hospital payment system and hospital restructuring and autonomy pilot implementation in Sogd Oblast; (3) in 2016 first roll-out (RO in chart) of case-based hospital payment system and hospital restructuring and autonomy; and (4) in 2016 second roll-out of case-based hospital payment system and hospital restructuring and autonomy.

As MCH hospital infrastructure upgrading and restructuring is being supported by KfW in Khatlon Oblast and this investment further reveals the need for improvements in hospital financing and payment systems, the time is right to use this great opportunity to move forward with case-based hospital payment system implementation and hospital restructuring, autonomy, management improvements, and this sequencing is reflected in the Health Financing Roadmap. The arrow to PHC capitated rate portrays that a portion of savings from hospital restructuring will be shifted to PHC. The arrow being thinner than other Roadmap arrows reflects that not all savings will be shifted as investment is also needed in hospitals to increase funding for direct patient care.

7. Pooling of Funds at Least at Oblast Level or Oblast Unified Payment Rate

To date MOH&SPP and MOF have not reached consensus on pooling of funds. MOH&SPP has consistently held the view that pooling of funds at least at the oblast level is a health financing reform pre-condition and critical to increasing equity and financial risk protection for all Tajik citizens, increasing efficiency including hospital restructuring, full realization of BBP and moving towards universal health coverage. WHO supports this position and agrees it's critical for equity, access, efficiency, and moving towards universal health coverage.

The relationship between pooling of funds and equity and financial risk protection is generally well understood. However, the relationship between pooling of funds and increasing efficiency (particularly hospital restructuring, autonomy and management) is less understood but critical to the Health Financing Roadmap and improving delivery of health services for the

population of Tajikistan. If funds are pooled at the rayon level, it is likely that the Central Rayon Hospital (CRH) functions as a monopoly with all rayon funding for hospital care allocated to the CRH. Two problems with this pooling and purchasing arrangement are that the CRH probably has less than optimal incentives to increase efficiency or be responsive to patients, and the rayon is not paying for higher level hospital care at oblast or republican level through the rayon pool of funds. Pooling at the oblast level basically designates a seamless oblast health delivery system where patients can choose or flow across hospitals to increase efficiency and responsiveness and payment for oblast hospital services is made from the same pool of funds.

In the dialogue over the last ten years, at times there could have been some differences in terminology or definitions. For example, MOF agrees with the terminology "oblast unified payment rate" which in effect requires pooling of funds in order to pay the same rates to providers throughout the oblast. This terminology is included in the Roadmap.

Pooling of funds is not a question of moving all cash to the oblast level as the exact nature of funds flow for payment of "oblast unified payment rates" can be managed through the Treasury System in a number of ways. But is a question of ensuring that budget formation and output-based provider payment systems include a combination of rayon, oblast and republican money pooled and distributed through an equal or unified oblast payment rate that ensures equal access, equity and financial risk protection for all Tajik citizens.

The Health Financing Roadmap contains four phases of pooling of funds: (1) in 2014 prepare for pooling of funds or oblast unified payment rate; (2) in 2015 pilot pooling of funds in Sogd Oblast in concert with directly related health purchasing interventions including case-based hospital payment system and hospital restructuring, autonomy and management improvements; (3) in 2016 roll-out pooling of funds or oblast unified payment rate nationally as part of final preparation for MHI introduction; and (4) in 2017 and 2018 incorporate pooling funds as an inherent element of MHI introduction and MHIF establishment in order to ensure realization of one BBP for all Tajik citizens. Pooling of funds is a priority for the extensive technical dialogue between MOH&SPP and MOF required to solidify Health Financing Roadmap and proceed with its implementation.

8. Health Financing Roadmap and MHI Legal and Regulatory base

While the Health Financing Roadmap is broader than MHI, there is a substantial intersection between the legal and regulatory base for Roadmap and for introduction of MHI. In 2014, legal and regulatory work will largely relate to continued roll-out of BBP and PHC capitated rate payment system as well as developing legal and regulatory foundation for case-based hospital payment system and pooling of funds as described above. Preliminary MHI legal and regulatory base development will begin in 2014, intensify in 2015 and be approved in 2016 to start MHI implementation in 2017. A first step is developing a comprehensive list of legal and regulatory documents needed for both Health Financing Roadmap and MHI implementation.

9. Establishing MHIF as Health Purchaser

The health financing function of health purchasing requires a health purchaser and there is also a strong relationship with the pooling of funds function as the health purchaser tends to administer the pool of funds. Initial Tajikistan health reform efforts focused on strengthening

the health finance department or establishing a new department under Oblast Health Departments (OHD) to serve as the health purchaser. However, these efforts did not bear fruit as pooling of funds at oblast level did not happen and public finance management (PFM) and Treasury System rigidities did not allow purchasing of health services through output-based provider payment systems. It is expected that one of the benefits of MHI introduction will be MHIF establishment in 2017 as a unified or single payer for the BBP using both MHI payroll tax and general revenue health budget as it has been outlined in the MHI Law in Tajikistan dated 2008 (see MHI pre-conditions above). MHIF as health purchaser could serve as a change agent driving improvements in pooling and purchasing arrangements and full realization of the guaranteed portion of the BBP for the population of Tajikistan. In addition to establishing the health purchaser, another MHI pre-condition is initial MHIF organizational development which is also encompassed in the Roadmap.

10. Implementation Strategy or Critical Path Before and After MHI Implementation

The two dotted line boxes are intended to reflect the implementation strategy or critical path before MHI introduction in 2014-2016 and in the first two years after MHI introduction in 2017-2018. Key activities in preparation for MHI introduction focus on how to purchase health services or provider payment systems, in concert with BBP roll-out. National roll-out in phases of PHC capitated rate payment system including PHC reorganization together with introduction of case-based hospital payment system including hospital restructuring and its pooling of funds pre-condition will match health budget funding to BBP priority services and populations, drive efficiency gains and set the stage for successful MHI implementation. After MHI introduction, the action will shift to the role of the MHIF as health purchaser in solidifying pooling and purchasing arrangements to contract with providers for provision of BBP services.

11. Relationship to Other Health Systems Functions

International experience shows that there's no magic bullet or perfect health financing or provider payment system. Tajikistan should strive to select the option best matching its country challenges and opportunities, culture and environment at any particular time in the health systems strengthening process. In addition, health financing is necessary but not sufficient to reach health system goals. Health provider behavior change is nearly impossible to accomplish if the desired service delivery improvements are inconsistent with the financial incentives faced by providers or if health professionals lose money by using best clinical practices. In summary, it is critical that provider payment systems including new output-based payment systems contain financial incentives stimulating service delivery improvements.

The Health Financing Roadmap is explicit in recognizing that the health financing function must relate to the other health systems functions: (1) service delivery including PHC strengthening, introducing evidence-based clinical practice guidelines, quality improvement techniques, priority programs (IMCI, SM, CVD, TB, HIV), public health (SES) and community/population involvement; (2) human resources including medical education and distribution; (3) drugs and other commodities; and (4) governance/stewardship including legal and policy base, institutional structure, roles and relationships, M&E and better use of information. Improving

the relationship between health financing and other health systems functions is envisioned to occur throughout all five years of Roadmap implementation.

4. Conclusion

The three linked mission elements of stakeholder consultation, Flagship Course and Senior Policy Seminar (SPS) were successful in developing a Health Financing Roadmap encompassing both MHI introduction and broader health financing reform. Stakeholder consultation resulted in a Roadmap chart to serve as an umbrella for the reform process, the Flagship Course initiated development of detailed Roadmap Implementation Plan for MOH&SPP follow-up, and SPS included high level policy dialogue validating the Health Financing Roadmap and its step-by-step approach to health financing reform.

The primary recommendation or next step emerging from this report documenting the three mission elements is that the MOH&SPP and MOF engage is more extensive technical level dialogue to establish common definitions and terminology, and further develop health financing policy and detailed Health Financing Roadmap Implementation Plan. Including Sogd Oblast Health Department and Oblast Finance Department representatives in this technical level dialogue will add practical experiences and lessons learned and contribute input on concrete refinements needed to continue to expand and roll-out elements of the Health Financing Roadmap.

Appendix 1. Summary of meeting with MOF, WHO Health financing mission (March 27, 2014)

The Ministry of Finance (MOF) sees the health financing reform as a change of health budget formation procedures through the change of major financing norms.

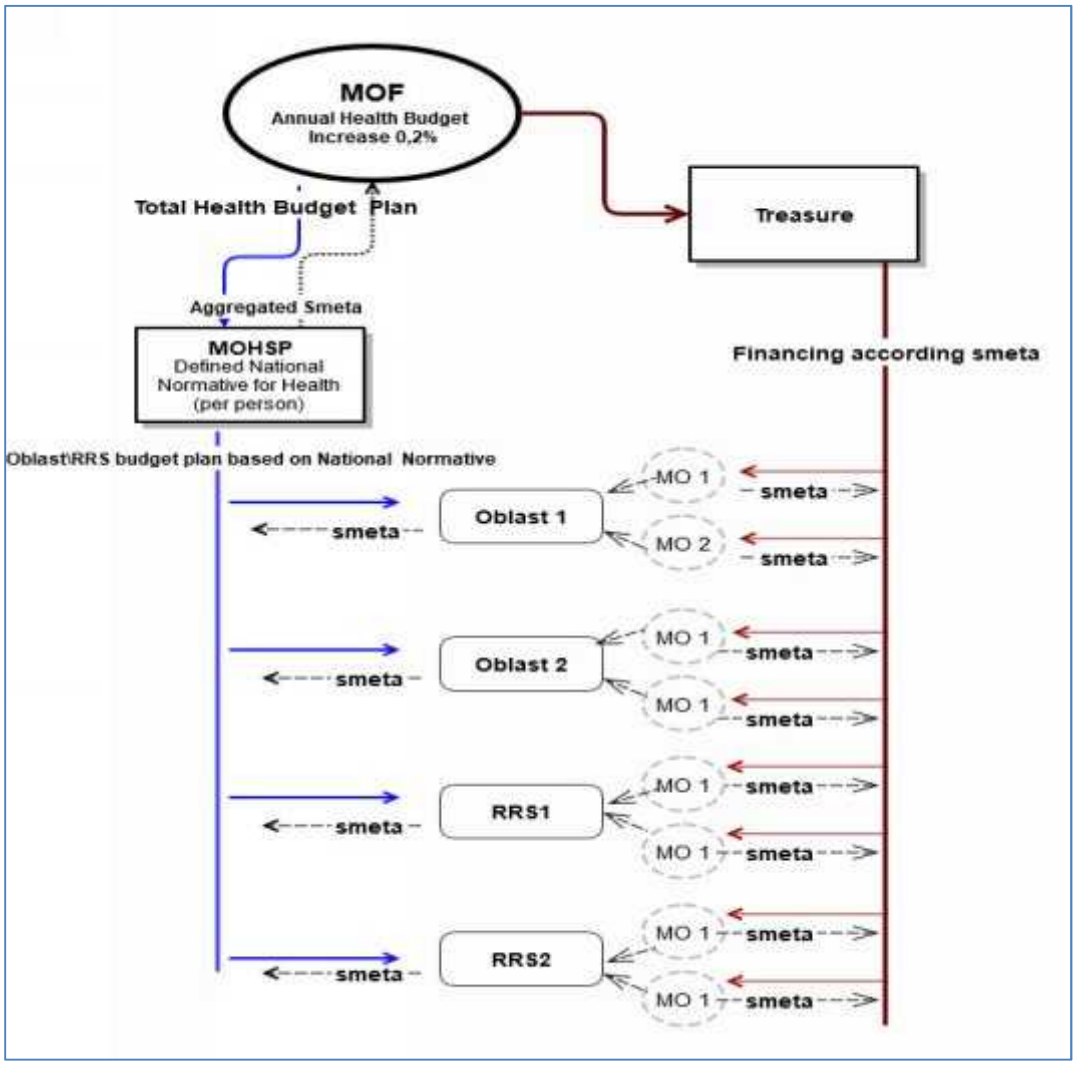
The determination of the overall health budget at the national level is based on historical budgets with an annual increase of 0.2% in order to achieve the planned level of 4% of GDP by 2020. The next step is the allocation of the health budget to administrative levels (oblasts, rayons of republican subordination, GBAO, and Dushanbe city) and further down to health facilities, which is currently allocated based on the historical budgets as well as the network and staffing capacities.

In general, the Ministry of Finance supports a departure from the methods of planning and budget allocation based on network and staffing indicators across administrative areas (subjects). It sees budget allocation based on a single national capitation rate as one of the possible options. This model involves the definition of a single (national) capitation for all health care within overall planned expenditures for health and the further formation of benchmarks of local budgets based on the established standard, the size of resident population in the administrative area and adjustment coefficients. Thus, the system envisages budget allocation from the central level to the field based on a per capita geographical distribution budget formula. Based on the target figures, local budget authorities form and approve budgets estimates of health facilities and allocate funding to health facilities within the budget estimates through the Treasury, as it happens now. Below is a diagram of the model under consideration (Figure 2).

MOF understands that the transition to a capitation formula of health budgeting would allow a more equitable distribution of resources nationally, but also involves reallocation of funds across administrative units; with the introduction of the new funding formula some administrative entities may "lose" while others "win". There may be quite a big difference between the historical budgets and budgets formed based on per capita formula. Since the health budget in Tajikistan is small, it will be politically sensitive to reallocate funds, especially in respect of those administrative entities that would "lose" their budget under the new system. To address this issue, mechanisms for gradual alignment of budgets across territories may be introduced; however, such mechanisms suggest additional resources in the health system, which is unlikely to happen.

Obviously, at this stage, MOF sees the per capita financing system only for geographical allocation of the budget across administrative units per capita, and not as a PHC provider payment method. MOF has a successful experience in the formation and geographical allocation of a budget of basic (school) education by a formula based on pre-set expenditure rates per student by certain categories and number of students. Therefore, the MOF intends to apply a similar principle for health care. The suggested system substitutes some norms by others (the number of beds / staffing by per capita expenditures rate), but does not change the nature and procedures of budget formation and execution.

Figure 2: The process of per-capita health budget allocation



MOF understands that the health system is much more specific compared to the education system and therefore considers it necessary to conduct a detailed analysis of the possibility of switching to the health budget by a per capita formula, as well as the introduction of a capitation payment system for PHC providers. This detailed analysis should include a comparative analysis of the budgets of administrative entities, risk analyses, etc.

MOF also believes that the Ministry of Health and Social Protection of Population (MOH&SPP) at this stage should work more actively in restructuring the health care delivery network and increasing the efficiency of available health care resources. MOH&SPP holds the same position and is ready to undertake more active reforms consistent with a plan outlined in the Roadmap.

Active promotion of reforms will be impossible without major decisions at the level of the MOF and MOH&SPP on the implementation of mechanisms for reinvesting and accumulating the budget.

Introducing a mechanism for reinvestment is a basic condition of comprehensive reforms in the health system. In the process of reorganization of health care and implementation of the new payments systems (capitation payment for primary care and case-based in hospital, intended to improve the efficiency of the health system) the MOH&SPP and health facilities must be sure that the health budget will not be reduced; that all savings will remain in the health system and with health facilities and be not withdrawn at the end of the calendar year. To date, budgets of health facilities depend on capacity indicators, and if, after the introduction of new provider payment system, reorganization, reduction of beds, staff, implementation of resource saving technologies, etc. there is a smaller budget next year, all sense of transformation will be lost and the initiated reforms will be discredited.

MOF, in principle, supports the reinvestment approach, and, believes that such a mechanism is already in place as the overall health budget is formed by a political decision (0.2% increase) and the MOH&SPP as a line ministry, may determine a subsequent distribution. In practice, however, it makes sense to more clearly define reinvestment procedures in financial regulatory acts. Introduction of clear reinvestment procedure is necessary as pre-condition to start a joint MOH&SPP and KfW program restructuring perinal care in Tajikistan.

The level at which health care funds should be pooled is the next issue that needs to be addressed for the implementation of more efficient health provider payment methods and increasing access to health services by the population. Taking into account the structure of the health care delivery system in Tajikistan, where a package of basic services for the population is provided within oblasts and only special conditions require specialized assistance at the republican level, oblast level pooling of the health budget would be the most optimal option.

Pooling of funds at the oblast level would provide an opportunity to establish a more adequate system of patient flow and introduce new health care provider payment systems outlined in the national health strategy – a per case hospital payment and a PHC per capita payment system with certain pay for performance elements.

The MOF has some concerns regarding oblast level pooling of the health budget, considering that this may lead to undesirable consequences in the matters of decentralization of management and reduction of the role of local authorities in health issues. Currently, the MOF has no clear proposal from MOH&SPP for the distribution of functions between the oblast health department, Department of Finance and Treasury, under oblast level pooling of funds and new provider payment systems. The MOF however, is ready to consider in detail the pooling of funds issue and participate in the development of new PHC and hospital payment systems.

Currently Tajikistan is piloting a PHC per capita payment system in the Soghd region and plans to introduce a results-based financing (pay for performance) system within the World Bank project. Within these pilots, all issues related to allocation of functions and powers of the Department of Health and the Treasury at the oblast level, formulas and procedures of budgeting health facilities and fund flows, as well as strengthening the autonomy of health facilities should be addressed. The MOF is interested in conducting a detailed analysis of the pilots and participating in the development of recommendations for further improvement of the model and the possibility of expanding it to other areas. WB plans to provide expert assistance in the introduction of PHC per capita payment pilot projects in 2014.

Future activities and proposed next steps:

- Since there is some confusion on the conceptual and technical issues of per capita funding as a method for geographical distribution of health budget across oblasts (MOF) and as a method of payment for PHC providers (MOH&SPP), it is necessary to hold a separate meeting for the MOH&SPP and MOF bringing international experts to discuss the conceptual framework and the specificity of each of these methods. Possibly with the involvement of the World Bank and WHO experts.
- To continue the dialogue and to define more clearly the intention of the MOF in the development and implementation of a capitation formula for geographical distribution of health budget across administrative units. The detailed analysis and development of the formula is a very complicated process and, if a positive decision on the introduction of a geographical distribution formula is made, assistance of international experts will be needed most likely.
- In 2014, the MOH&SPP with support from the World Bank plans to conduct an analysis of a PHC per capita payment pilot in the Soghd oblast and develop recommendations to improve the model. Within this work it would be useful to analyze the possibility of setting (using) a single capitation rate for primary health care in all rural areas of the oblast, with a comparative analysis of all the rayons and submit the results to the MOF.
- The pilot Implementation of results based financing (pay for performance payment) system will present a good opportunity for the MOH&SPP to improve further the base per capita payment system and the quality of health care. Besides, it is important to use this pilot to realign funding flows and respective Treasury procedures. A payment system with results based financing (pay for performance) elements suggests a more flexible system of provider payment - the amount of funding depends on certain performance results, which cannot be planned or considered in cost estimates. Therefore, the Treasury procedures, which are now strictly tied to cost items, will also require revision. The experience of this pilot in improving treasury procedures will be critically important for the introduction of the new per case hospital payment system.
- It makes sense to model the per case hospital payment system on an example of one oblast. For this analysis, it is necessary to use a treated patient database; such a database was created in Khatlon oblast. The MOH&SPP may need expert support.