Health Financing Progress Matrix

Master version 2.3

Prepared: December 2019

World Health Organization

BACKGROUND: the Health Financing Progress Matrix provides an objective assessment of a country's health financing system; it is a systematic qualitative assessment which complements quantitative information. Each question in the matrix is built on a guiding principle and reflects an attribute which, based on theory, evidence, and global thinking, influences health system performance in terms of UHC.

Stage 1 of the assessment is a landscaping of the major health coverage arrangements in a country, outlining the key attributes of each scheme; this initial mapping starts to identify the extent of structural fragmentation within a health system, and provides essential background for Stage 2 of the assessment, which uses 48 questions organized around the different functions of health financing.

In terms of process, a Principal Investigator completes the assessment, usually within a few weeks; the PI needs to be a health financing expert who is familiar with the health system in the country concerned. Information will come mostly from secondary sources which should be carefully referenced with supporting documents, or where relevant, with reference to conversations held with key officials and other experts.

This assessment also allows for a score to be applied to each question according to the four defined progress levels; while the Principal Investigator may apply scores, when requested formal scoring will be applied by an expert panel in order to ensure consistency across countries and the and the credibility of the process; direct comparison across countries is not the primary objective of the assessment, rather comparability of results over time within countries.

The assessment can be used to feed into sector reviews, or the development of strategic reforms. It provides a structured basis for discussion amongst policy makers and key stakeholders. Ideally a broad consensus is reached on the key areas of strengths and weaknesses in the current system, together with an identification of priority issues for action. Repeating the assessment either fully or partially over time allows progress towards UHC through to be gauged.

Note that WHO will not publish any information without the consent of the country concerned.

Box 1: Guiding principles (GPs) for health financing reforms in support of UHC (in summary form)[1]

1) Revenue raising (RR)	
Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation)	(RR1)
Increase predictability in the level of public (and external) funding over a period of years	(RR2)
Improve stability (i.e. regular budget execution) in the flow of public (and external) funds	(RR3)
2) Pooling revenues (PR)	
Enhance the redistributive capacity of available prepaid funds	(PR1)
Enable explicit complementarity of different funding sources	(PR2)
Reduce fragmentation, duplication and overlap	(PR3)
Limit distortionary effects of voluntary health insurance on equity and efficiency	(PR4)
Simplify financial flows	(PR5)
3) Purchasing services (PS)	
Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance, or a combination	(PS1)
Move away from the extremes of either rigid, input-based line item budgets or completely unmanaged fee-for-service reimbursement	(PS2)
Manage expenditure growth, for example by avoiding open-ended commitments in provider payment arrangements	(PS3)
Move towards a unified data platform on patient activity, even if there are multiple health financing / health coverage schemes	(PS4)
4) Benefit design and rationing (BR)	
Clarify the population's legal entitlements and obligations (who is entitled to what services, and what, if anything, they are they meant to pay at the point of use)	(BR1)
Improve the population's awareness of both their legal entitlements and their obligations as beneficiaries	(BR2)
Align promised benefits, or entitlements, with provider payment mechanisms	(BR3)

[1] *Kutzin J, Witter S, Jowett M, Bayarsaikhan D. Developing a National Health Financing Strategy: A Reference Guide. Geneva: World Health Organization; 2016*

STAGE 1: KEY DESIGN FEATURES OF THE MAJOR HEALTH COVERAGE SCHEMES

Using this template, list the major publicly funded "health coverage" schemes in your country. Start with the government budget for health in the first column; if government funds targeted free care programmes, list these separately. Other examples include mandatory health insurance schemes for salaried workers, and voluntary schemes which receive public funding through direct subsidies or tax breaks.

KEY DESIGN FEATURE	**HEALTH COVERAGE SCHEME** (start with the government budget)	**HEALTH COVERAGE SCHEME** (add specific name in your country)	**HEALTH COVERAGE SCHEME** (add specific name in your country)	**Add further schemes as required**
TARGET POPULATION Are all citizens covered, or a specific subgroup e.g. under 5s, salaried workers.				
POPULATION COVERED/ENROLLED Actual numbers relative to target pop.				
BASIS FOR COVERAGE/ENROLMENT e.g. mandatory, automatic, voluntary				
BENEFITS / ENTITLEMENTS Is a list of services, or level of care defined? Do users have to make co-payments?				
REVENUE SOURCES Where does the money come from? Budget allocations / transfers; pre-paid contributions.				
POOLING ARRANGEMENTS Is the health budget allocated to regional authorities, is there a single or multiple "insurance" fund(s)?				

KEY DESIGN FEATURE	HEALTH COVERAGE SCHEME (start with the government budget)	HEALTH COVERAGE SCHEME (add specific name in your country)	HEALTH COVERAGE SCHEME (add specific name in your country)	Add further schemes as required
PURCHASING ARRANGEMENTS Describe the management and governance arrangements of the different schemes where relevant e.g. line Ministry, composition of governing board.				
PROVIDER PAYMENT E.g. inputs through budget line items; fee-for service, case payment, capitation, performance-based.				
SERVICE DELIVERY & CONTRACTING Which providers are services purchased from? Public, private? Are contracts / services agreements used?				

STAGE 2: Policy Development Process

	1. Policy Development Process	----------→ PROGRESS ----------→				Objectives/Goals
Q1.1	**Has an in-depth diagnosis or assessment of your health financing system been conducted recently which examines the impact on health system performance along with the causes of performance problems?**	No diagnosis/ assessment has been conducted recently e.g. past 3-4 years	A quick diagnosis/ assessment has been conducted recently e.g. within the past 3-4 years	A diagnosis/ assessment has been conducted recently e.g. within 3-4 years, which examines the impact of health financing policy on health system goals	A detailed up-to-date and diagnosis/ assessment has been conducted, in collaboration with finance and health sectors, assessing impact on health system goals, root cause of performance problems identified; has been used to inform health financing policy	Reflects whether sophisticated assessment of current performance has been made that ideally identifies the causes of poor performance
Guidance notes	This question looks at the way current health system performance is assessed in your country, and how determinants of weak performance are identified in the context of health financing policy. Assessments may have been conducted by the government or by development partners. Interpret "recently" as within the last 3-4 years. If relevant, separate your responses in terms of 1) revenue raising; 2) pooling; 3) purchasing; and 4) benefits.					
Situation in your country						Click to score
References used						

	1. Policy Development Process	----------→ PROGRESS ----------→				Objectives/Goals
Q1.2	**Is there an up-to-date policy statement related to health financing, which has been converted into relevant legal documents/government orders?**	There is no clear policy statement with respect to health financing	An up-to-date policy statement is in place but little action to translate this into system change	An up-to-date policy statement exists, has been converted into relevant legal government order documents, despite weak evidence or consensus	A clear policy statement based on a diagnosis of the current situation exists, and necessary legislation/government orders are adopted based on *evidence* and the *participation* of relevant stakeholders	Reflects whether an up-to-date policy is formulated based on evidence and participation
Guidance notes	This question looks at how recently a health financing strategy has been formulated, and the underlying process used to formulate it. This may be in the form of a dedicated health financing strategic document or found within a broader health system document. If relevant, separate your responses in terms of 1) revenue raising; 2) pooling; 3) purchasing; and 4) benefits.					
Situation in your country						Click to score
References used						

	1. Policy Development Process	----------→ PROGRESS ----------→				Objectives/Goals
Q1.3	**Does a system exist to routinely monitor health financing, and are data used to track progress (e.g. on expenditure patterns and financial protection) and to strengthen public accountability?**	No routine monitoring mechanisms exist	Monitoring mechanisms exist but are not routinely implemented. Relevant work is largely donor-driven	A monitoring system exists, but the data e.g. NHA, financial protection studies are produced irregularly, are not considered to be good quality, do not explore distributional equity, and are not used for routine monitoring	A well-designed monitoring system for health financing exists, and high-quality data are available and used to inform health financing policy and report to the public on progress, including distributional equity issues.	Reflects the existence and quality of monitoring system
Guidance notes	If relevant, separate your responses in terms of 1) revenue raising; 2) pooling; 3) purchasing; and 4) benefits"	For example, national health accounts are not produced and financial protection has not been analysed during the past 10 years.			Reports to the public may take place for example in Parliament, or through annual reports on official websites. For example, in this scenario, expenditure analyses, typically in the form of National Health Accounts and/or public expenditure assessments, are produced annually and financial protection analyses at least once every 4-5 years. These are made publicly available.	
Situation in your country						**Click to score**
References used						
Q1.4	**Are evaluation studies undertaken on a systematic basis to assess the implementation of specific health financing reforms and their consequences for policy objectives, and are findings used to inform the design & revision of health financing policies?**	No evidence of applied policy research studies on health financing undertaken	Some specific studies undertaken on an irregular basis, but largely donor-driven, and little evidence of these informing policy decisions	Applied policy research is undertaken by a variety of actors, with some evidence of uptake by decision-makers although there may be only a nascent "system" for such arrangements.	Government/MoH-defined comprehensive policy research agenda linked to priority reforms. Relevant analytic work commissioned and/or implemented by health authorities, with independence for analysts and mechanisms in place to use findings to inform decision-making	Reflects the extent and relevance of evaluation mechanisms in the development of health financing policies / reforms

	1. Policy Development Process	----------→ PROGRESS ----------→				Objectives/Goals
Guidance notes	Evaluation studies include applied policy research.					
Situation in your country						Click to score
References used						

STAGE 2: REVENUE RAISING

	Guiding principle	2. Revenue Raising	----------→ PROGRESS ----------→				Objectives/Goals
Q2.1	RR1	**What is your country's approach to developing revenue raising policies and strategies, within an overall process of policy development and implementation planning for health financing?**	Policy/strategy for domestic resource mobilization reflects poor understanding of lessons from global experience.	Policy/strategy shows some limited/superficial understanding of the main lessons on the importance of public funding, but policy is not realistic or there is no clear plan for implementation	Policy/strategy reflects clear understanding of main lessons on importance of increasing public funding but still has problematic aspects	Policy/strategy recognizes need to move towards predominant reliance on public funding in a fiscally realistic manner over a defined time frame, reflects understanding of evidence on individual contributions, and embeds approach to private financing within an overall policy framework to enable complementarity.	Financial protection (G) Equity in finance (G); Transparency and accountability (being realistic) (IO)
Guidance notes			For example, the expectation is that it will be possible to mobilize significant revenues through voluntary contributions or to easily transform OOPS into prepayment, or planning simply to maximize revenues regardless of source.	For example, "compulsory sources" are interpreted as requiring everyone to make specific financial contributions as the basis for coverage rather than relying on some form of taxation; or there is an unrealistic use of the %GDP target for the country's fiscal capacity, or there are declarations that different funding sources should be complementary without a specific plan to achieve this.	Problematic aspects may include an unrealistic use of spending targets, and/or VHI increasingly viewed as desirable including the use of tax subsidies to encourage its uptake.	A realistic time period may be 5-10 years. The main lessons internationally regarding individual contributions is that they are generally not effective, regardless of whether or not they are officially "mandatory".	
Situation in your country							**Click to score**

	Guiding principle	2. Revenue Raising	----------→ PROGRESS ----------→				Objectives/Goals
References used							
Q2.2	RR1	**To what extent does health financing in your country rely on public/compulsory funding sources (e.g. taxation/public revenues, including mandatory contributions for national/social health insurance)?**	Public/ compulsory funding sources are minimal in health financing (e.g. over 60% of health spending comes from out-of-pocket payments), with health consistently a very low priority in public resource allocation (e.g. under 8% of public spending)	Health financing partly relies on public/ compulsory funding sources, but most revenues come from a combination of external (donor) sources and private sources (mainly out-of-pocket payment but also voluntary health insurance); health is low priority for public spending (between 8-10%)	Majority of revenues are from public/compulsory sources (e.g. government budget revenues and mandatory social health insurance contributions) but private sources play a significant role (e.g. 30% or more); health sector receives medium-high priority in public resource allocation (about 10-12%)	Most of health financing relies on public/compulsory funding sources, with private sources playing a minimal role (e.g. less than 20%) in total financing.	Financial protection Equity in finance(G);
Guidance notes		Evidence shows that prepaid, compulsory public financing reduces reliance on OOPs at the point of service and hence improves access to care. Please review the latest data for your country on the relative share of different revenue sources for the health sector.				For example, thanks to a clear policy framework, health is given a medium-high priority as a share of overall public spending e.g. greater than 11-12%), and inequitable subsidies for private health spending are avoided.	
Situation in your country							**Click to score**
References used							
Q2.3	RR2	**To what extent is public funding for health in your country predictable over a period of years?**	There are large or significant year-to-year fluctuations in the level of public funding for the health sector (and where relevant, external funding), suggesting poor predictability.	Although revenue and expenditure scenarios exist, predictability of the level of public funding for the health sector remains poor due to a variety of factors.	The level of public funding for health sector is relatively predictable due to well-functioning budgetary processes	The level of public funding for health is highly predictable	Utilization relative to need(G), Transparency and accountability(IO)

	Guiding principle	2. Revenue Raising	----------→ PROGRESS ----------→				Objectives/Goals
Guidance notes		This question considers how predictable public funding for the health sector is. Predictable revenues are critical to plan and deliver health services without disruptions. A Medium Expenditure Framework (MTEF) should help to make revenues more predictable, as would moving external funding on-budget i.e. flowing through domestic public systems, rather than through parallel channels. Consider both domestic public funds, as well as external funds flowing through domestic public systems. Cross-reference this question with Q3 in the PFM module, which has similarities.	For example, if there is no multi-year revenue scenario for government or expenditure framework for the sector, no longer-term plans for external funding, etc.	For example, there are frequent in-year budget adjustments, external aid flows are off-budget, there is no link between the MTEF and the annual budget process, public revenue scenarios are inaccurate, central government is unable to influence the planning and budgeting processes of devolved levels of government.	For example, there is reliable revenue forecasting, a clear budget formulation process, as well as links between medium-term plans and annual budget processes, regular engagement with sub-national governments on planning and budgeting, but some problems remain especially in relation to failures to consider aid fungibility etc.	Under this scenario, there is for example accurate revenue forecasting, an MTEF with clear links to annual budget formulation processes, close engagement between central and sub-national governments in planning and budgeting, and external aid flows are "on budget" with the potential for offsetting declines in domestic funding incorporated into negotiations and planning.	
Situation in your country							Click to score
References used							
Q2.4	RR3	**To what extent is the flow of public funds stable, as a result of regular execution i.e. timely release of funds in line with approved health budgets?**	Health budgets at central and sub-national levels (and those for social health insurance agencies, where relevant) are rarely executed as planned for a variety of reasons.	Health budgets are sometimes executed as planned	Health budgets (including SHI fund) are usually executed as planned	Flow of public funds to the health sector is highly stable.	Utilization relative to need(G) Financial protection & equity in finance(G); Efficiency (IO)

	Guiding principle	2. Revenue Raising	----------→ PROGRESS ----------→				Objectives/Goals
Guidance notes		This question looks at how well budgets are executed; delays or disruptions in budget execution negatively affects the stability of the flow of funds for health services.	Reasons may include poor revenue forecasts, late and/or irregular release of funds, rigid line item controls, and widely differing capacities of sub-national units.	Here, there are similar problems as in Level 1 but are not as severe; social health insurance (SHI) fund revenues (where relevant) flow irregularly with unclear policies in place regarding reserves, timeliness of contribution and budget transfers, etc.	Similar but less severe problems in comparison with level 2, but neither government nor SHI has strong counter-cyclical mechanisms in place to smooth expenditures when revenues fall unexpectedly.	Thanks to good revenue forecasting, budget formulation process, timely execution of approved budgets as planned, and reserves or other counter-cyclical allocation mechanisms in place to smooth financial flows during lower-than-expected revenue inflows.	
Situation in your country							**Click to score**
References used							
Q2.5	RR1 PR1	**To what extent are the different revenue sources raised in a progressive way (i.e. based on capacity to pay), and hence promote equity in the way the health system is funded?**	Most sources of revenues are highly regressive i.e., payment is not based on ability to pay due to, for e.g. low levels of public revenue leading to high reliance on OOPS	There is a greater reliance on public revenue sources which mitigates inequities in health payments to some extent, but significant inequities remain in policy design	Collection of revenue is designed in favour of equity but faces barriers to effective implementation.	Most revenue sources are highly equitable, i.e., payment is primarily based on ability to pay.	Utilization relative to need(G), Financial protection (G) Equity in finance(G)
Guidance notes		For more information on progressivity and regressivity in revenue sources, see the WHO website (who.int/health_financing/topics/revenue-raising/en); also see Module 2 of WHO's e-learning course: (who.int/health_financing/training/e-learning-course-on-health-financing-policy-for-uhc/en/)		For example, SHI contributions are a fixed amount, rather than percentage rates, there are low contribution ceilings which favour those with higher incomes, and tax subsidies exist for the uptake of voluntary private health insurance.	For example, tax evasion, non-compliance of tax payment or insurance contributions.		

	Guiding principle	2. Revenue Raising	----------→ PROGRESS ----------→	Objectives/Goals
Situation in your country				Click to score
References used				

STAGE 2: POOLING REVENUES

	Guiding principle	3. Pooling Revenues	----------→ PROGRESS ----------→				Objectives/Goals
Q3.1	n/a	**This question has now been replaced with the STAGE 1 overview table. Please ensure you have completed STAGE 1 as it will help you to answer the questions in this section.**					
Guidance notes		This is no longer a separate question. However, selected health expenditure data would also be useful when addressing the following questions.					
Q3.2	PR1/2/3	**What is your country's approach to arrangements for pooling revenues, within the overall process of policy development and implementation planning for health financing?**	Policy/strategy is contrary to key principles and lessons from international evidence	Policy/strategy shows some understanding of key lessons but still segments the population without supporting or compensatory measures, or changes to the flow of existing budgetary revenues.	Policy/strategy reflects a good understanding of main lessons from evidence, incorporating policies to reduce fragmentation or mitigate its consequences, but does not fully address key challenges such as tax subsidies for VHI or separate SHI schemes for civil servants	Policy/strategy reflects core evidence and principles on pooing, with explicit actions to address or mitigate fragmentation, and to monitor/adjust unintended equity consequences.	Financial protection (G,) Utilization relative to need (G) Efficiency (IO) Equity in resource distribution (IO)

Guiding principle	3. Pooling Revenues	----------→ PROGRESS ----------→				Objectives/Goals
Guidance notes		For example, does the country plan to have different schemes for different population groups; to rely on voluntary affiliation to coverage schemes; to promote private VHI in a way that will add to greater segmentation of the population into different schemes; to have separate information systems and other administrative arrangements for each scheme or government coverage programme.	A lack of supporting measures means that the policy assumes that people will eventually contribute and join a scheme, but there is no incentive or other policy action to support this. Lack of compensatory measures means that the policy does not address the likelihood some schemes – for higher income persons in particular – will be funded at a much higher level per capita than others. Changes to the flow of budget revenues would include pooling of budget and health insurance revenues, and financial compensation for poorer regions in devolved settings.	examples of mitigating the consequences of fragmentation can include consolidation/merger of schemes, compensating schemes funded at lower levels with increased budget subsidies, and "as-if pooling" mechanisms such as the establishment of common databases /data platform across all schemes which allow monitoring for example of differences in service use.	As with level 3, measures to address fragmentation can include risk adjustment mechanisms, merger of schemes, compensation across schemes, common information and other systems. In terms of monitoring or adjusting for unintended consequences, an example would be that a unified pool may contribute to greater inequity in service use if there are large inequalities in supply-side service availability, and provider payment mechanisms direct resources from the pool to where the services and providers are.	
Situation in your country						Click to score
References used						

	Guiding principle	3. Pooling Revenues	----------→ PROGRESS ----------→				Objectives/Goals
Q3.3	PR1/3	**To what extent are there limits to the re-distributional capacity of prepaid funds in your country, which arise from health financing institutional arrangements?**	Potential to redistribute available prepaid funds from lower to higher need populations is greatly constrained by structural barriers, and few/no mechanisms exist to compensate.	Some redistribution of available prepaid funds exists, but schemes reflect lack of diversity in population coverage and an over-reliance on voluntary participation.	System enables a good degree of redistribution of prepaid funds, but fails to include the entire population	Highly effective re-distributional mechanisms in place that include the entire population	Financial protection (G), Efficiency(IO) Equity in resource distribution (IO), Utilization relative to need(G)
	Guidance notes	This question draws on evidence that pooling arrangements which are large in size, based on a diverse risk mix, and in which participation is automatic/mandatory, enable greater redistributive capacity with respect to pre-paid revenues in the health sector. A review of financial flows in your health system will be useful when discussing this question.	For example, due to multiple programs or schemes funded and managed separately, fiscal decentralization with little/no equalization, etc.)	Redistribution may take place through a central gov't allocation formula, or some form of equalization mechanism. A lack of diversity in population coverage is seen when separate schemes exist for specific groups e.g. civil servants, private sector workers, and the rest of population, with no pooling or compensation across these schemes. Examples of voluntary participation are when people decide whether or not to join a CBHI scheme, or informal sector workers to join SHI) for the rest of the population.	For example, redistribution may take place by pooling some budget revenues with SHI contributions to cover non-contributors; a common SHI scheme for civil services and private sector workers is another example; a fiscal revenue redistribution formula that reduces variation in public spending on health per capita by region; compensation from budget funding may enable reduction of large inequalities in per capita funding across schemes.	Examples for this scenario include a unified single pool with budget transfers that enable inclusion or coverage of the entire population; risk adjusted transfers across pools, whether defined as "insurance" or geographic sub-national units, to enable a virtual single pool.	
Situation in your country							**Click to score**
References used							

	Guiding principle	3. Pooling Revenues	----------→ PROGRESS ----------→				Objectives/Goals
Q3.4	PR3	**To what extent are there measures, related to benefit design, provider payment, or non-financial underlying systems, that address problems arising from fragmented pools?**	There are no compensating measures to address inequity and inefficiency arising from fragmentation.	Some measures in place to address inequity and inefficiency arising from fragmentation	Substantial measures in place, though with room for improvement, to address inequity and inefficiency arising from fragmentation	Compensation measures fully implemented to enable equity and efficiency challenges arising from pool fragmentation to be fully addressed	Efficiency (IO), Equity in resource distribution (IO), Utilization relative to need(G), Financial protection Equity in finance(G)
	Guidance notes	If relevant in your country, this question aims to capture any policy measures which compensate for fragmentation in pooling, where the merger of coverage schemes and related fund pools, is limited or not possible.	For example, no mechanisms to address common problems arising from pool fragmentation, such as when separate health coverage schemes (separate pools), have separate and unequal benefit entitlements, separate governance arrangements, separate information systems, etc.	Examples of such measures may be that benefits are harmonized across some schemes, steps are taken towards unified approach to information management across some schemes, etc.)	Examples of such "substantial measures" go beyond those of level 2, such as harmonizing benefits for most of the population, having a single information platform that includes most patients regardless of scheme or insurance status, explicit channels for coordination across the different schemes and MOH, reduction of supply-side imbalances, etc.)	Examples of such measures would be the harmonization of common/standard or minimum benefit, unified forms and information platform for all patients regardless of scheme or insurance status, single provider payment system even if multiple pools, etc.	
Situation in your country							**Click to score**
References used							
Q3.5	PR2	**To what extent are different revenue sources and funding streams organized in a complementary manner, for the purpose of financing a benefit package for the entire population**	There is no coordination of fund flows from different revenue sources	Complementarity exists among some revenue sources, but there is no population-wide (universal) framework of health benefit entitlements indicating the specific role of different funding sources/streams	A benefit framework exists for most of the population with funding responsibilities clearly defined across different revenue streams, but private prepayment still not well-integrated	There is explicit complementarity of different revenue sources to fund a defined benefit package for the population.	Efficiency(IO), Equity in resource distribution (IO), Utilization relative to need (G), Financial protection (G)

	Guiding principle	3. Pooling Revenues	----------→ PROGRESS ----------→				Objectives/Goals
	Guidance notes	Different revenue sources and fund flow within a health system may or may not complement each other. Public funding streams include health budgets, compulsory health insurance contributions, and external/donor funds; these various revenue sources need to complement each other; private revenues include voluntary health insurance contributions whether for profit or non-profit schemes.	A common example is that payments from a social health insurance fund to providers do not account for direct gov't budget funding to the same providers. Other examples include governments at different levels funding different budget line items, the lack of a well-defined minimum benefit framework that indicates funding sources, and RBF operating as a vertical initiative uncoordinated with other funding streams.	For example, there is some pooling of budget allocations and SHI contributions but only for small part of the population, and other mechanisms such as donor-funded RBF are not well-integrated with, or defined in a way which complements other flows; there is no clear or explicit complementary role defined for voluntary / private sources to what is funded from public revenues.	Examples of complementarity are where SHI contributions for formal sector employees are pooled with budget transfers to fund a common benefit for most of the population; or where RBF/P4P mechanisms are designed and implemented in a where which recognises and is complementary to "base payment" funding flows, for e.g. budget funding of salaries. In many cases, voluntary private health insurance is not explicitly supplementary or complementary to benefit entitlements funded by the main public system, but rather overlaps with them. [If voluntary health insurance does not exist or is minimal, this can be ignored]	Examples include the state health budget and SHI contributions jointly funding benefit entitlements for all, possibly with an explicit (but small) role for individual prepaid contributions. Another example is where funds flowing under a SHI scheme cover variable cost inputs, with the government budget directly funding fixed costs such as salaries; if co-payments are defined as necessary for certain (partially) publicly funded services, these are clearly organized to be complementary. A third example would be where the benefit framework and public funding responsibilities for it leave explicit gaps in either service coverage or cost coverage (i.e. co-payments) that establish the space for complementary voluntary health insurance (as compared to VHI that covers the same services and costs as are also covered by the public benefit framework).	
Situation in your country							**Click to score**
References used							

	Guiding principle	3. Pooling Revenues	----------→ PROGRESS ----------→				Objectives/Goals
Q3.6	PR4	**To what extent are voluntary health insurance (VHI) arrangements a source of inequity, creating potentially harmful spillover effects for the wider health system?**	VHI coverage largely benefits the rich, fragments the system, and has a large inequity impact by raising prices of key inputs and diverting scarce health workforce to serve the private system, whilst the main public system suffers from staff shortages	VHI coverage benefits the richer population and is a source of segmentation; overall impact on the system important but not large because the spillover effects are limited; but government still promotes VHI growth with inequitable tax subsidies.	Public policy on health financing enables VHI to play a supplementary role for faster access or to obtain services from providers not contracted by the main/public system, but this does not have major spillover effects.	VHI either does not have negative effects (coverage and expenditures very low) or plays a clear complementary role within a publicly defined benefit package, with subsidized coverage for the poor.	Financial protection Equity in finance (G); Equity in resource distribution (IO)
	Guidance notes	This question is based on the experience in certain countries that voluntary health insurance schemes divert scarce health workforce, or otherwise skew system resources, in order to serve the privately insured population.	In this scenario there is much higher level of total health spending flows through VHI than the population covered by such schemes, such as VHI population coverage at only 1-2% but accounting for 10% of expenditures). In this scenario, government may also promote VHI growth through tax subsidies that favour the rich	For example, there is a closer relation between the percent of population with VHI and the percent of expenditure flowing through VHI.	For example, either VHI coverage and expenditures are small e.g. less than 5%; or, even if population coverage is larger, expenditures through this source are small/less than population coverage.	For example, VHI covers co-payments or those benefits excluded from the public system. In this scenario, the percent of expenditures from VHI typically is much less than the percent of population covered.	
Situation in your country							**Click to score**
References used							

	Guiding principle	3. Pooling Revenues	----------→ PROGRESS ----------→				Objectives/Goals
Q3.7	PR3	**To what extent are fund flows incoherent and duplicative, limiting the potential to use the government budget and donor funds effectively?**	Domestic (and where relevant, donor) financial architecture is highly fragmented, inhibiting efficient system-wide planning, and resulting in waste due to duplication and overlap of functional responsibilities.	Pooling and funds flow arrangements reflect important areas of duplication and overlap that constrain the ability to use resources efficiently	Pooling and funds flows enable some coordination of functions across different revenue sources	Coherent health financing architecture is in place with clearly delineated responsibilities of key actors/agencies organized by function rather than by scheme, program, or revenue source.	Efficiency(IO)
Guidance notes			For example, the structure of pooling is fragmented by budget line/inputs, programs, and schemes; donor flows exacerbate the problems; multiple agencies are responsible for purchasing services or inputs within the same geographic area in an uncoordinated manner.	For example, vertical program flows – including external sources where relevant – are not coordinated with other fund flows, either to the same or separate providers, or with poor alignment of accountabilities among program, facility and system managers; budget-funded and SHI pools are completely separate and co-exist in the same geographic area, driving duplication of functional responsibilities and potentially also service delivery arrangements.	For example, budget and SHI contributions are aligned within a single geographic area to enable unified responsibility for pooling and purchasing; there is pooling of some "public health program" funds with other sources to enable more unified management and reporting, etc.)	Individual service elements of "public health programs" such as HIV or TB are integrated within a unified benefit package and funds are pooled in a purchasing agency responsible for other/all individual services; different revenue sources are pooled in a common agency (e.g. "insurance fund") with pooling and purchasing organized on a geographic basis.	
Situation in your country							**Click to score**
References used							

STAGE 2: PURCHASING AND PROVIDER PAYMENT

(If there exist multiple schemes in your country, please respond to the questions based on the characteristics of one or two major/large schemes.)

	Guiding principle	4. Purchasing and Provider Payment	----------→ PROGRESS ----------→			Objectives/Goals
Q4.1	PS1	**To what extent do fund allocations to lower-level purchasers e.g. local governments, and/or payment rates to providers, reflect population health needs?**	Input-based line item budgeting dominates without adjustments to reflect population health needs	There is some flexibility in budget structure to account for service output, and payment methods and allocation formulae to some extent take account of health needs	All payment methods and allocation formulae take full account of health needs, health risks and other relevant factors (e.g. risk-adjusted case payments, risk-adjusted capitation rates, age, gender, poverty level, health status, disease burden)	Equity in resource distribution(IO) Utilization relative to need(G)
Guidance notes		This question looks at one dimension of how purchasing policy can influence how equitably the health system performs. Evidence from your country on public spending per capita across geographic regions, would be particularly useful here.				
Situation in your country						**Click to score**
References used						

	Guiding principle	4. Purchasing and Provider Payment	----------→ PROGRESS ----------→			Objectives/Goals
Q4.2	PS1	**To what extent are provider payments harmonized across schemes/revenue sources, and across public and private sectors, to ensure coherent incentives for providers?**	Different payment methods and/or rates are used across different schemes, e.g., better- off individuals are covered by a health coverage scheme with financially more attractive payment methods and higher rates	Payment methods and/or rates are harmonized in the basic structure but still differentiated depending on schemes, etc. and not fully harmonized with each other	Provider payment methods and rates are unified or fully harmonized across different schemes/ purchasers and for different sectors (public/private), regardless of the revenue source.	*Equity in resource distribution(IO)* Quality (G)
Guidance notes		When multiple payment systems exist e.g. across different coverage schemes, it is important that these are harmonized and coordinated in order to influence provider behavior more effectively. If necessary, separate this question into two i.e. first address payment methods; and then payment levels/rates. Some further analysis may be required, and you identify this as an action point. Refer to Q11 in the PFM module.				
Situation in your country						**Click to score**
References used						

	Guiding principle	4. Purchasing and Provider Payment	----------→ PROGRESS ----------→			Objectives/Goals
Q4.3	PS2	**To what extent do provider payment methods and purchasing in general, promote quality of care, and care coordination across specialties and different levels of care?**	Payment methods do not provide incentives to promote better quality, or better coordination of care	Payment system includes a component to promote quality and care coordination in a limited scope, but payment system is not fully aligned with continuous quality improvement over a continuum of care	Financial incentives (e.g., add-on payment method) to improve quality of care and coordination are integrated into the payment system; information and indicators which measure both elements are routinely available.	Quality(G)
Guidance notes		For example, are there specific incentives which promote quality improvement, and better coordination of care? You may want to address each of the two elements separately when you record your responses.				
Situation in your country						**Click to score**
References used						
Q4.4	PS2	**To what extent do purchasing contracts specify quality of care requirements, including the availability and appropriateness of care, and then monitor/enforce these on a regular basis?**	There is no purchasing contract between purchaser(s) and providers, or purchasing is very passive and does not take into account quality of care	Purchasing contracts include quality requirements, but with limited scope, and/or they are not monitored and enforced in a systematic way	Strategic purchasing is implemented based on detailed quality requirements which are monitored and enforced through review and assessment systems.	Quality(G) Transparency & accountability(IO)
Guidance notes					In this scenario, payments may be refused based on a review / assessment process which refers to a quality standard.	

	Guiding principle	4. Purchasing and Provider Payment	----------→ PROGRESS ----------→			Objectives/Goals
Situation in your country						Click to score
References used						
Q4.5	PS3	**To what extent do provider payment methods promote efficiency in resource allocation e.g. reduce over- or under-provision of services, and manage expenditure growth?**	Payment methods do not provide incentives for efficiency (e.g. input-based line item budgeting and/or unmanaged fee for service payment is dominant)	Output-based criteria are sometimes used to determine budget-line items, and some form of case-based payment methods are in place	Blended payment methods and/or bundled payment methods are used in a full-fledged manner and purchasers/providers are accountable for using funds efficiently	Efficiency(IO)
Guidance notes		If necessary, separate your responses into 1) primary care; and 2) hospital care			This scenario captures the sharing of financial risk between purchasers and providers. Blended or bundled payment methods include case-based or other innovative payment mechanisms.	
Situation in your country						Click to score
References used						
Q4.6	PS4	**To what extent are patient encounter forms standardized across the health system and used to review and assess activity across the population**	Very limited data collected during patient visits, and not based on a common format across the health system. No unique ID exists for either patients or facilities, and procedures and diagnostics are not standardized. No system wide database exists.	Patient encounter forms exist, including claims forms, but data captured is not detailed, not for all patients, and not used by all providers. Initial measures to build national patient activity database with unique IDs and standardized diagnostic & procedure codes.	Extensive standardization of forms e.g. fewer forms than number of schemes/ programmes. Patient data increasingly standardized e.g. minimum data requirements (data fields), and common form fields (e.g. data structure and coding). National database emerging.	Standardized patient form used by all health providers for all patients, across all coverage schemes/programmes, public and private facilities, with unified national database allowing policy-relevant analysis.	Quality (G)

Guidance notes	This question reflects the importance of capturing data in a common way across different coverage schemes, health programmes etc., whether in the public or private sector, and whether insurance or non-insurance, claims or non-claims based. A common data platform allows policy-relevant analysis of service use and payment to improve national financing policy decisions. Patient encounter or contact forms capture information about the patient, the health facility, the health care procedures accessed, and any payment made during the patient encounter.	In this scenario data collected during the patient visit is patchy, and provides very limited insight about patient's conditions, the procedures undertaken or on the payments made. National policy makers have no common database to analysis usage and spending across the system.	In this scenario there is some improvement; while multiple patient encounter forms exist, these are only for some patients, because they are covered by a scheme or programme, and/or are used only in a limited set of providers (e.g. only public facilities, only hospital level). Each scheme or programme has its own "unique" ID for patients and/or facilities and use its own coding procedures (no standards apply across programmes or schemes for identification of members or providers, or for procedures, diagnostics, etc.)	Greater harmonization is seen through the establishment of data collection standards or data submission, by introducing minimum data requirements (e.g. data fields to be present on each form) and some standards (data structure to be used for all encounter forms e.g. unique ID for patients across purchasers, unique ID for facilities across purchasers). With an emerging database, some analysis of utilization and payment patterns across the health system is possible.	In this scenario, whatever the level of fragmentation in the health system in terms of coverage schemes, national policy makers have data on patient usage of health services, and payments made, allowing e.g. of equity and efficiency analysis to be made, and to inform policy development.	

Situation in your country						**Click to score**
References used						
Q4.7		**To what extent do provider payments cover only a portion of total costs, or cover total costs including salary, recurrent expenditures etc.**	Provider payments pay only a small portion of recurrent costs	Provider payments pay a significant portion of total cost	Provider payments pay total costs of providing health care, so that quality of care is not unduly sacrificed, and informal payments are avoided	Quality (G)
Guidance notes		If necessary, you can separate this question into two in terms of 1) primary care; 2) hospital care				

Situation in your country						**Click to score**
References used						
Q4.8		**To what extent are providers given financial autonomy, and held accountable, to an extent which is realistic and in line with their capacities?**	Health care providers have no managerial/ financial autonomy and are not in a position to respond to incentives from the purchaser i.e. full command-and-control system	Providers have a certain level of managerial/financial autonomy, with limited incentives, and the effect of autonomy on provider behavior is not well monitored	Providers enjoy substantial managerial/financial autonomy and have strong incentives to improve efficiency, and they are also held accountable for their performance	Efficiency(IO) Transparency & accountability(IO) Quality (G)
Guidance notes		This question looks at the incentive environment for providers to promote improvements in performance.				
Situation in your country						**Click to score**
References used						
Q4.9		**To what extent is provider accreditation or selective contracting established, functioning, and used for purchasing?**	Accreditation system for service provider is not in place	Accreditation or selective contracting with service providers are established but with limited effectiveness and not functioning as the basis for purchasing	There is a rigorous process of accreditation or selective contracting of providers, which is effectively used for contracting	Efficiency (IO) Quality (G)

Guidance notes		This question is interested in whether purchasers within the health system can influence provider behavior, for example by deciding whether or not to enter an agreement, or to vary the terms of that agreement, based on the range and quality of services a provider offers, their location relative to communities which need to be served, and other relevant factors.				
Situation in your country						**Click to score**
References used						
Q4.10		**To what extent is purchasing and payment for pharmaceuticals implemented to promote efficient medicines use (e.g. generics rather than originator) and also to improve financial protection for patients?**	There is no purchasing or payment mechanism for which specifically promotes the efficient use of pharmaceuticals or addresses financial protection for patients.	Some measures are in place to purchase and price pharmaceuticals in a way which promotes efficient use and patient financial protection but are effective to a varying degree e.g. expenditure on pharmaceuticals is still high and a cause of poor financial protection, due to ineffective pricing policy.	Purchasing and pricing of pharmaceuticals have been developed in order to promote the efficient use of medicines and to reduce problems of financial protection for patients resulting from spending on pharmaceuticals.	Efficiency (IO), Financial protection Equity in finance(G)
Guidance notes				Evidence shows that in many countries, paying for medicines is a major driver of out-of-pocket payments by patients. Purchasing policy can, for example, promote the use of lower-cost generic medicines.		
Situation in your country						**Click to score**

References used	

STAGE 2: BENEFITS AND ENTITLEMENTS

(If there exist multiple schemes in your country, please respond to the questions based on the characteristics of one or two major/large schemes.)

	Guiding principle	4. Benefits and Entitlements	----------→ PROGRESS ----------→			Objectives/Goals
Q5.1		**This question has now been replaced with the STAGE 1 overview table. Please ensure you have completed STAGE 1 as it will help you to answer the questions in this section.**				
Guidance notes		This is no longer a separate question. However, selected health expenditure data would also be useful when addressing the following questions.				
Q5.2	BR1	**To what extent are benefit decisions and revisions made in a transparent way, based on a clearly-defined process, and agreed criteria e.g. cost-effectiveness, financial protection, budget impact?**	Benefit decisions/ revisions are not made in a transparent way, with no criteria or process formally defined	Benefits decisions/revisions take into account some criteria and process, but are still dominated by experts, and made in an implicit way with little input from stakeholders	Benefits decisions/revisions are made in a transparent way based on clearly-defined criteria and process with the participation of stakeholders to assure accountability	Transparency & accountability(IO)

	Guiding principle	4. Benefits and Entitlements	----------→ PROGRESS ----------→			Objectives/Goals
Guidance notes		Whilst benefit design can influence health system performance e.g. efficiency, equity, decisions are inherently political and hence need to be made in a transparent way, based on both technical and social value priorities.				
Situation in your country						**Click to score**
References used						
Q5.3	BR1	**To what extent do benefits entitlements explicitly reflect population health needs?**	There is no explicit health criteria on which the benefit decisions are made. Benefits coverage does not explicitly reflect population health needs	Differences in benefit coverage across population groups are to some extent reduced and redistributed based on criteria, e.g. age, gender, etc. is in place to improve equity	Benefits coverage fully addresses population health needs and promotes equity in access to health care (e.g., benefit entitlements and health service needs for those bearing the greatest burden of ill-health are matched by including essential/catastrophic package and exemptions in co-payment)	Utilization relative to need(G)
Guidance notes		International experience shows that general declarations of benefit entitlements are often not enough; rather greater clarity about entitlements allows for money to be spent in a more targeted way, and for rights to be enforced.				

	Guiding principle	4. Benefits and Entitlements	----------→ PROGRESS ----------→			Objectives/Goals
Situation in your country						**Click to score**
References used						
Q5.4	BR1	**To what extent do benefits prioritize priority population groups e.g. for improved use of high priority services and financial protection**	There is no mechanism/policy for prioritizing benefits coverage to certain population groups or certain services.	Benefits are targeted/prioritized for population groups with limited capacity to pay or for certain services, but the accuracy of targeting can be improved, or related cost can be reduced	Benefits are prioritized to certain population groups taking into account their financial needs or certain services considering health system/policy goals	Utilization relative to need(G), Financial protection & equity in finance(G)
Guidance notes		Priority groups may be identified in terms of their income status, or demographic characteristics; high priority services may also be defined.				
Situation in your country						**Click to score**
References used						
Q5.5	BR2	**To what extent are population entitlements and obligations explicitly defined and understood by people?**	Entitlements and obligations are not explicitly defined and people do not understand them	Entitlements and obligations are loosely defined and not well communicated with people, leading to potential misunderstanding	Entitlements and obligations are clearly defined with high level of specifications including the basis for entitlement, conditions attached, and means of rationing, and clearly communicated/understood by the population.	Transparency & accountability(IO) *Utilization relative to need(G)*

	Guiding principle	4. Benefits and Entitlements	----------→ PROGRESS ----------→			Objectives/Goals
Guidance notes		This question focuses on how aware the population is, and how well it understands, its entitlements. Obligations may include the need to make a co-payment, to follow a referral system, or to obtain only generic medicines etc.				
Situation in your country						**Click to score**
References used						
Q5.6	BR3	**To what extent are benefits aligned with provider payment, to ensure that they are delivered and that there is financial protection for patients?**	Benefits are not aligned with provider payment, leading to underuse (unmet need) or limited financial protection	Benefits coverage and provider payment are not fully aligned, and sometimes providers do not have incentives to provide promised services	Benefits are designed and well aligned with provider payment system to ensure providers deliver promised services and to provide patients with financial protection	Utilization relative to need(G), Financial protection (G) Equity in finance(G)

	Guiding principle	4. Benefits and Entitlements	----------→ PROGRESS ----------→			Objectives/Goals
Guidance notes		This question aims to understand how well aligned policy on health benefits are with the way providers are paid. For example, when providers are permitted to "balance bill", in other words they can charge the patient a higher amount than the amount they receive from the purchaser e.g. the MoH or insurance agency. This can lead to a high financial burden falling on the patient.				
Situation in your country						**Click to score**
References used						
Q5.7		**To what extent are benefits, including cost-sharing for patients, aligned with revenues, to ensure adequate funding for approved benefit entitlements**	Decisions on benefit entitlements are made without due consideration of the financial implications / budgetary impact	There is no critical shortage of revenue arising from benefits coverage, but benefits and revenues can be better aligned and revenues could be more predictable to meet stated/promised benefits coverage	Benefits coverage is closely aligned with revenues, decisions takes full account of their impact on financial sustainability, and as a result, benefits are delivered as promised, patients have incentives for the rational utilization of health care, and financial sustainability is not affected unexpectedly	Utilization relative to need(G) *Transparency & accountability(IO)*
Guidance notes						

	Guiding principle	4. Benefits and Entitlements	----------→ PROGRESS ----------→	Objectives/Goals
Situation in your country				Click to score
References used				

STAGE 2: PUBLIC FINANCIAL MANAGEMENT (PFM)

		6. PFM	----------→ PROGRESS ----------→				Objectives/Goals
Q6.1		**Has an in-depth diagnosis/ assessment of health-sector specific PFM bottlenecks been recently conducted e.g. within last 3 years?**	Neither a general nor health-specific diagnosis/ assessment has been recently conducted	Rapid health-specific diagnosis / assessment conducted recently	Health-specific diagnosis/assessment recently conducted, and examined some bottlenecks in health spending	Extensive, up-to-date health-specific diagnosis/assessment conducted; key bottlenecks identified (from budget formulation to execution and reporting) that undermine quality of health spending	
Guidance notes		In order to effectively address bottlenecks in the health sector budgeting process, a detailed health-specific diagnostic analysis is required, rather than general PFM assessment.	A general PFM assessment may have some relevance for health sector PFM issue, but usually this is very limited. For "recently", think in terms of the past 3-4 years.				
Situation in your country							Click to score
References used							
Q6.2		**Capacity of MOH staff to understand (new) PFM rules and apply these to the health sector budgetary process**	No PFM capacity building for MoH staff; limited understanding of how PFM processes and possible reforms are applicable to the health sector.	Very few MoH staff trained in PFM issues, and only at central level; limited financial management skills at sub-national administrative levels.	Significant number of staff trained, with ongoing / future training activities for MOH staff at central and sub-national levels.	MOH staff trained (at all administrative levels & frontline providers) and understand how new PFM rules change budgetary and expenditure processes.	
Guidance notes							
Situation in your country							Click to score
References used							

		6. PFM	----------→ PROGRESS ----------→				Objectives/Goals
Q6.3	**RR2**	**A multi-year budgetary process exists and is being implemented effectively**	No systematic forward budgetary planning exists, and the future health sector resource envelope is unpredictable.	An MTEF exists but is of poor quality, with over-estimation of revenues and poor predictability	A good quality generic MTEF exists, and a health-specific MTEF is being piloted.	A good quality MTEF exists, with dialogue between health and finance jointly defining a health-specific used for rolling 3-year budgets	
Guidance notes		An example would be the existence of a recent Mid-Term Expenditure Framework, eventually applied specifically to the health sector. This question has similarities with Q3 in the revenue raising module, so cross-check your answers.	In this situation, there is no MTEF used for multi-year public sector budgeting.	In this case, there is a general MTEF, but with no or limited link with the annual budget process.		A good quality MTEF includes accurate revenue projections and information on sector-specific budget ceilings.	
Situation in your country							**Click to score**
References used							
Q6.4		**Extent to which annual health budget allocations are aligned with health sector priorities (level, structure, nature/focus)**	Health policy priorities are poorly defined, and not reflected in the budget; rigid input-based line-item budget dominates.	Input-based line-item budget and rigid ex-ante financial control still dominate, but there is some piloting of programme-based budgets to reflect sector priorities		Health sector priorities and MTEF are fully reflected in budget allocations, and stable/ predictable funds are directed to areas of high health sector priority	Utilization relative to need(G) Equity in resource distribution (IO)
Guidance notes		When considering this question please refer to this WHO webpage which provides a mapping of budget classifications for your country.					
Situation in your country							**Click to score**

		6. PFM	----------→ PROGRESS ----------→				Objectives/Goals
References used							
Q6.5		**Extent to which the budget process is consultative, transparent, and a mid-term budget review and adjustment process is established.**	Current budget process often by-passes the MoH, with no or very limited dialogue between MoH and MoF.	Budget process is consultative and transparent but to a limited extent, and input from health sector is reflected at a minimal level. Mid-year re-allocations happen without MOH consultation.	Budget process is being institutionalized through formal budget meetings, systematic and broad consultation process with sector stakeholders, inclusive process with civil society, development of citizen budgets etc.	Formal budget process is consultative and transparent, with joint MoH/MoF dialogue around budget definition, implementation mid-term review etc. Lower administrative levels consulted and engaged in budget definition process (in centralized systems).	Transparency & accountability(IO)
Guidance notes		Of particular relevance to this issue is the relationship between the MoH and Ministry of Finance (or the relevant budget authority).					
Situation in your country							**Click to score**
References used							
Q6.6	**PS1**	**Extent to which fiscal transfers are designed and implemented to improve equity in resource distribution in the health sector**	No clear policy or implementation mechanism exists which reflects equity concerns.	Fiscal transfer/fund allocation formula allows for some equalization but not health sector specific.	Fiscal transfer/fund allocation formula makes some adjustment for differing health sector needs across geographical areas.	Equity-driven budget formula in place for fiscal transfers; conditional grants earmarked for health; equity in resource distribution monitored at all levels	Equity in resource distribution (IO) *Utilization relative to need(G)*
Guidance notes			In this case, budgeting is largely historical and structured in terms of inputs.	An example is multi-sector block grants to regional governments based on a simple capitation formula.	For example, a capitation-based formula is used with some adjustment for age and income.	For example, the allocation formula takes into account additional evidence which reflects health needs e.g. burden of disease.	
Situation in your country							**Click to score**

		6. PFM	----------→ PROGRESS ----------→				Objectives/Goals
References used							
Q6.7		**Extent to which the health budget rules allow for flexibility in spending**	Budgets are structured by administrative and input lines without mechanisms for adjustment/re-allocation, and with tight line-item ex-ante expenditure control.	Some flexibility in spending exist but rigid budget allocations and input-based budgeting remains dominant, with tight ex-ante expenditure controls.	Change in budget formulation is accompanied by more flexible rules for expenditure management (e.g. flexible release and re-allocation of funds, with ex-post reporting)	Budgets are structured and executed to ensure that budget spending is flexible. Program managers and providers have the flexibility to reallocate resources.	Transparency & accountability(IO) Efficiency (IO) *Utilization relative to need(G)*
Guidance notes		When discussing this question, it may be useful to think separately about flexibility in budget structure, and flexibility in budget execution.					
Situation in your country							**Click to score**
References used							
Q6.8		**Flexibility in resource use is provided at/delegated to the right level**	No flexibility in resource use and rigid ex-ante central controls; spending responsibility remains in Treasury	Central MOH has some degree of flexibility to use and reallocate across budget lines; institutional arrangements being made in MoH to take on greater responsibility for spending	Spending authority fully transferred to MOH and central funds managers allowed to use resource envelopes (e.g. budgetary program) in a flexible and responsive manner, but constraints remain at lower levels of government.	Fund-holders are able to re-allocate across budget lines, including frontline providers, to better respond to health needs	*Efficiency (IO)*
Guidance notes		For example, where a Programme Budget exists, Programme Managers are also given the authority to use funds flexibly within a given envelope. Similarly, where the system is					

		6. PFM	----------→ PROGRESS ----------→				Objectives/Goals
		decentralized, this is backed up by giving the appropriate authority over spending decisions to lower levels of government. At the provider / facility level, managers have the authority to retain and use funds.					
Situation in your country							Click to score
References used							
Q6.9		**Budget discipline policies to control spending are in place (e.g. cash management, compliance with procurement rules) and implemented effectively.**	Health budget frequently fails to comply with basic budget discipline due to poor planning, insufficient /unpredictable revenue streams, etc.	Health budgets implementation complies with basic budget discipline, but with occasional shortfalls, under-spending or exceptional procedures	Limited under-spending/ over-spending on a yearly basis, but delays remain in quarterly fund releases	Health budgets are fully executed and comply fully with budget discipline based on accurate forecasts/plans, risk analysis, stable revenue, etc. Significant under-spending rarely happens	Transparency & accountability(IO) Efficiency (IO)
Guidance notes		In many countries health budget underspending is a significant problem. Think about the underlying reasons for this such as over-estimated revenues, a disconnect between planning and budgeting, the lack of a formal budget preparation process, delays in operationalizing PFM reforms, or unrealistic plans with poor data. Other reasons may include late or misaligned disbursements, limited MoH capacity to plan expenditures, & procurement delays.	Cash budgeting in place putting sector at risks of funds shortage, unpredictability etc.			For example, there is a planned, transparent and reliable cash management system, allowing the timely release of funds to frontline service providers.	

		6. PFM	----------→ PROGRESS ----------→				Objectives/Goals
Situation in your country							Click to score
References used							
Q6.10		**Extent to which information systems are in place to both meet financial accountability needs and to monitor health sector performance**	No computerized systems for performance or expenditure monitoring; numerous parallel reporting streams; no central reconciliation of information exists.	Computerized system being developed and strengthened, but with limited or poor quality routine data	Functional financial information system, but not aligned with sector accountability requirements and not used to inform budget decisions	Tailored and integrated FMIS-type information systems, allowing consolidation of cross-category monitoring (by programme/ inputs/costs centers/facilities etc), up to lower levels of government, and to providers.	
Guidance notes							
Situation in your country							Click to score
References used							
Q6.11		**Extent to which multiple fund flows, budget structure and PFM rules are aligned with strategic purchasing policies**	There is no alignment between PFM rules and purchasing, and input-based budgets are dominant, with parallel, conflicting systems for budgeting & accounting of parallel fund flows.	PFM rules are only partially aligned with strategic purchasing, and as a result the impact on health financing performance is limited Pooled funds are managed in accordance with domestic PFM rules	Change in budget formulation is coordinated with payment system reforms to improve consistency / complementarity in incentives for providers	Budget structure and PFM rules are fully aligned with strategic purchasing allowing performance-based allocations, timely/ predictable release of funds, budget flexibility, provider autonomy, etc.	Efficiency(IO) Equity in resource distribution (IO) *Utilization relative to need(G)*
Guidance notes		This question looks at whether PFM rules, for example those relating to budget formulation and expenditure control, are well aligned with policies for purchasing health services; it				Furthermore, domestic platforms are consolidated and used by external funding agencies.	

		6. PFM	----------→ PROGRESS ----------→				Objectives/Goals
		is also concerned with the possible fragmentation which can result from multiple fund flows. Refer to Q2 in the Purchasing and Provider Payment module which is related.					
Situation in your country							Click to score
References used							

MATRIX 7: GOVERNANCE

7. Governance		----------→ PROGRESS ----------→			Objectives/Goals
Q7.1	**Extent to which roles and responsibilities (related to health financing goals and performance in revenue raising, pooling, purchasing, benefits, etc.) are clearly defined and divided across governing institutions in health financing.**	Roles and responsibilities are not clearly defined across governing institutions, resulting in duplications or conflicts among health financing organizations	Roles and responsibilities are defined and divided across governing institutions, but they are not well coordinated to achieve health financing goals	Roles and responsibilities are clearly defined/ divided across governing institutions in health financing, and PFM and health sector are closely coordinated in accomplishing health financing goals	Transparency & accountability(IO)
	Guidance notes				
	Situation in your country				Click to score
	References used				
Q7.2	**Extent to which governing institutions in health financing have adequate capacity, including human resources (technical and managerial capacity) and ICT?**	Health financing institutions overall have limited capacity to perform health financing functions	Health financing institutions have some capacities to perform health financing functions but they still need to improve their capacity to progress effectively toward UHC	Health financing institutions overall have high capacity to perform all important financing functions and achieve UHC goals effectively	Transparency & accountability(IO), Quality (G)

7. Governance		----------→ PROGRESS ----------→			Objectives/Goals
	Guidance notes				
	Situation in your country				Click to score
	References used				
Q7.3	**Extent to which accountability mechanisms for purchaser/financing agencies, including autonomy and governing board of purchaser, rewards/sanctions, etc. are in place to ensure that health financing policy supports progress towards sector goals, and funds are used effectively for priority populations, programs, and services.**	No mechanism to hold health financing institutions and individual managers accountable	Mechanisms or agency are in place to make health financing agencies accountable for key performance indicators, but there still exists a room to enhance accountability, and mechanisms (e.g., committees) for government to take proper actions to address poor performance do not function effectively	There are explicit mechanisms or agency to hold the full range of health financing institutions and individual managers accountable with regular public reporting, and mechanisms are in place to address poor performance with oversight from the public, including civil society	Transparency & accountability(IO)
	Guidance notes				

7. Governance		----------→ PROGRESS ----------→			Objectives/Goals
Situation in your country					Click to score
References used					
Q7.4	Extent to which the use of funds or performance of national health care purchasing agency or health budget reported to the public (e.g., annual report)?	No reporting to the public of the use of funds and the performance of national health care purchasing agency or health budget	The use of funds and performance of health care purchasing agency or health budget are reported to the public, but not in a full scale, nor communicated effectively for the public to easily understand them	The use of funds and the performance of health care purchasing agency or health budget are reported to the public on a regular basis and in the form that the public can easily understand	Transparency & accountability(IO)
Guidance notes					
Situation in your country					Click to score
References used					
Q7.5	Extent to which MoF, MoH, and national purchasing e.g. health insurance organisation is engaged in the health financing policy process.	No proper engagement and communication among MoF, MoH, and national purchasing / insurance agency in health financing policy	MoF, MoH, and national purchasing / insurance agency are to some extent engaged and communicated with each other, but not in a very effective way to achieve health financing goals	MoF, MoH, and national purchasing / insurance agency are fully engaged and communicated with each other, health sector policies and priorities are well reflected during the process, and health sector financing is effectively integrated with PFM	Transparency & accountability(IO)

7. Governance		----------→ PROGRESS ----------→			Objectives/Goals
	Guidance notes				
	Situation in your country				Click to score
	References used				
Q7.6	**Extent to which policy making process for health financing is transparent and participative**	Policy making process for health financing is very closed, and general public rarely have an opportunity to participate	Health financing policy process is not closed, but more active participation of general public and stakeholders are called for	Health financing policy is made in a transparent way, and general public as well as related public and private stakeholders participate in the policy process	Transparency & accountability(IO)
	Guidance notes				
	Situation in your country				Click to score
	References used				