User Manual
for
OASIS

Organizational Assessment for Improving and Strengthening Health Financing

A tool for
Health financing review
Performance assessment
Options for improvement

Department of Health Systems Financing

World Health Organization
© World Health Organization 2010

Working version 1.4, November 2011

This manual was prepared by Inke Mathauer, in collaboration with Guy Carrin, of the Health Financing Policy Team of the WHO Department of Health Systems Financing. Valuable inputs were also received from other members of the Team, specifically from Adelio Antunes and Sophie Wanert. Feedback and discussions resulting from an OASIS Health Financing Workshop held in Geneva from 4 to 6 May 2009 were also incorporated into the manual.

The authors alone are responsible for the views expressed in this publication. All remaining errors are the authors' responsibility.

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

All reasonable precautions have been taken to verify the information contained in this publication. However, the material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.


OASIS Help
Questions and comments on the concept and the application of OASIS can be addressed to the Health Financing Policy Team at the Department of Health Systems Financing in Geneva.
E-mail: healthfinancing@who.int
Contents

Acronyms ........................................................................................................................................ 4

1. Introduction ................................................................................................................................... 5

2. Summary of the OASIS approach ............................................................................................... 6
   2.1 OASIS in short .......................................................................................................................... 6
   2.2 Value added of OASIS .............................................................................................................. 6
   2.3 Purpose .................................................................................................................................... 6
   2.4 Scope ....................................................................................................................................... 7
   2.5 Users ........................................................................................................................................ 7
   2.6 Target audience of the OASIS analysis and recommendations ............................................ 7
   2.7 Methodology and data required .............................................................................................. 7
   2.8 Team, training and time requirements .................................................................................... 7
   2.9 Deliverables ............................................................................................................................ 8
   2.10 OASIS Excel Aid .................................................................................................................. 8

3. The core elements of the OASIS analytical framework ............................................................. 9
   3.1 Rationale .................................................................................................................................. 9
   3.2 Health financing functions and their respective objectives .................................................. 11
   3.3 Health financing performance indicators .............................................................................. 11
   3.4 Institutional design and organizational practice ..................................................................... 12
   3.5 Bottlenecks in institutional design and organizational practice and ways to address ..........13
   3.6 Feasibility check of proposed changes and improvement measures .................................... 15

4. Putting OASIS into practice ....................................................................................................... 16
   4.1 Overview of OASIS components and steps ......................................................................... 16
   4.2 Detailed contents of the components .................................................................................... 18
       Component 1. Health financing system review & performance assessment ......................... 18
       Component 2. Detailed institutional-organizational analysis .................................................. 19
       Component 3. Options, changes and improvement measures to increase health financing performance .......................................................... 21
   4.3 OASIS data collection methods and analysis ....................................................................... 23
   4.4 OASIS time requirements ....................................................................................................... 26
   4.5 OASIS Excel Aid: details, potential and limits .................................................................... 26
   4.6 From proposing policy options and improvement measures to policy decisions, strategy development and actual implementation .................................................................................................................. 28

References ......................................................................................................................................... 29
Annexes .................................................................................................................................................. 32
Annex 1. Further details and explanations of the analytical approach ............................. 33
Annex 2. Data sources .................................................................................................................................. 40
Annex 3. Suggestions for the OASIS in-country work .......................................................... 42
  1. Team composition ................................................................................................................................. 42
  2. Planning and preparation process .......................................................................................................... 42
  3. In-country work process ......................................................................................................................... 42
  4. Interviews and discussions ...................................................................................................................... 43
Annex 4. Information letter to health financing stakeholders and actors ....................... 44
Annex 5. Example of Terms of Reference for WHO APW .................................................... 46
Annex 7. Additional guidance for the use of the OASIS Excel Aid-Component 1 ... 50

Figures
Figure 3.1 Overview of the analytical framework
Figure 4.1 Analytical process steps

Boxes
Box 3.1 Institutions and organizations
Box 4.1 Component 1 – key questions
Box 4.2 Component 2 – key questions
Box 4.3 Component 3 – key questions

Tables
Table 3.1 Bottlenecks in institutional design and organizational practice and ways to address them
Table 4.1 OASIS data sources and methods of data collection and analysis
Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>benefit package</td>
</tr>
<tr>
<td>CBHI</td>
<td>community-based health insurance</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>GGE</td>
<td>general government expenditure</td>
</tr>
<tr>
<td>GGHE</td>
<td>general government health expenditure</td>
</tr>
<tr>
<td>govt.</td>
<td>government</td>
</tr>
<tr>
<td>HF</td>
<td>health financing</td>
</tr>
<tr>
<td>HMIS</td>
<td>health management information system</td>
</tr>
<tr>
<td>IP</td>
<td>inpatient care</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MOF</td>
<td>ministry of finance</td>
</tr>
<tr>
<td>MOH</td>
<td>ministry of health</td>
</tr>
<tr>
<td>MOL</td>
<td>ministry of labour</td>
</tr>
<tr>
<td>NCU</td>
<td>national currency unit</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NHA</td>
<td>national health accounts</td>
</tr>
<tr>
<td>OASIS</td>
<td>Organizational Assessment for Strengthening and Improving Health Financing</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation of Economic Cooperation and Development</td>
</tr>
<tr>
<td>OOP</td>
<td>out-of-pocket (expenditure)</td>
</tr>
<tr>
<td>OP</td>
<td>outpatient care</td>
</tr>
<tr>
<td>p.c.</td>
<td>per capita</td>
</tr>
<tr>
<td>PHE</td>
<td>private health expenditure</td>
</tr>
<tr>
<td>PHI</td>
<td>private health insurance</td>
</tr>
<tr>
<td>PPM</td>
<td>provider payment mechanism</td>
</tr>
<tr>
<td>PPP int. US$</td>
<td>purchasing power parity in international US dollars</td>
</tr>
<tr>
<td>QM</td>
<td>quality management</td>
</tr>
<tr>
<td>SHI</td>
<td>social health insurance</td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector-wide approach</td>
</tr>
<tr>
<td>THE</td>
<td>total health expenditure</td>
</tr>
<tr>
<td>US$</td>
<td>United States dollar</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>

1 Acronyms used in this manual and in the OASIS Excel Aid.
1. Introduction

OASIS is an approach that facilitates a systematic and comprehensive health financing review, including the identification of improvement measures and options for a health financing system to attain universal coverage. This approach is complementary to the World Health Report 2010 "Health systems financing: A path to universal coverage" (WHO 2010c) by providing practical guidance of how to identify appropriate country strategies for universal coverage. It is applicable to both low- and middle income countries as well as high-income countries, although the focuses chosen will be different. The OASIS approach is applicable to all types of health financing systems.

A distinctive feature of OASIS is its focus on the institutional design and organizational practice of health financing. The health financing review pays ample attention to the design and organizational set-up of a health financing system and this focus also facilitates the identification of alternative options for improvement. It can now be understood that OASIS is the acronym for

"Institutional and Organizational Assessment for Improving and Strengthening Health Financing"

This manual provides a detailed explanation of how to use the OASIS approach for a country’s health financing review. It builds upon the experience of the application of OASIS in Nicaragua (Mathauer et al. 2010), Cambodia (Antunes et al. 2009), France (Wanert 2009), the Republic of Korea (Mathauer et al. 2009), Rwanda (Antunes et al. 2009) and Uganda (RoU/MOH 2010).

The manual is structured as follows:

- Section 2 provides a brief overview of OASIS;
- Section 3 summarizes the analytical approach underlying OASIS;
- Section 4 outlines how to put OASIS into practice;
- The Annexes provide further detailed explanations and practical guidance for the OASIS country work proceedings as well as relevant sample documents.
2. Summary of the OASIS approach

2.1 OASIS in short

OASIS is an analytical approach that can be applied in a flexible way to systematically analyse the strengths and weaknesses of a health financing system and to identify suggestions for improving its performance in order to move towards universal coverage.

The distinctive characteristic of this approach is the focus on institutional design and organizational practice of health financing, upon which health financing performance is contingent. **Institutional design** is understood as formal rules, namely, legal and regulatory provisions relating to health financing; and **organizational practice** refers to the way organizational actors implement and comply with these rules. **Health financing performance** is further operationalized into nine health financing performance indicators.

Inadequate performance can be caused by six types of bottlenecks in institutional design and organizational practice. Accordingly, six types of improvement measures are proposed to address these bottlenecks. By understanding the incentive environment within a health financing system, the potential impact of the proposed changes can be anticipated.

The move towards universal coverage can be enhanced by actively developing the institutional design of the health financing system, for example, through changing and modifying legal and regulatory provisions. Likewise, there may be need to change or improve organizational practice by strengthening organizational capacity and enforcement practices.

In many cases, substantial improvement and progress towards universal coverage can be achieved within the prevailing health financing system by effectively implementing and enforcing the existing legal and regulatory provisions, and/or by strengthening organizational capacity.

2.2 Value added of OASIS

OASIS supports policy-decision making and facilitates implementation, as it stresses the formulation of adequate health financing rules and the establishment or availability of organizations that can implement these rules.

2.3 Purpose

The OASIS approach assists policy-makers to:
- acquire a detailed understanding of the strengths and weaknesses of a health financing system through a thorough review including a performance assessment;
- identify policy options with appropriate improvement measures in order to enhance health financing performance and make progress towards universal coverage;
- develop a health financing policy/strategy;
- assess the impact of recently implemented health financing reforms;
- review the adequacy and anticipate the impact of planned health financing reforms.

The OASIS approach does not provide guidance on the process of implementation of proposed health financing options and improvement measures.
2.4 Scope
OASIS reviews the totality of:
- a health financing system
- health financing sub-systems
- specific health financing schemes.

In particular, it reviews and assesses the three health financing functions of resource mobilization, pooling, and purchasing/provision. OASIS also examines the stewardship function in health systems.

2.5 Users
OASIS users include health financing experts and senior technical staff at ministries of health, finance, planning and labour, as well as other health financing stakeholders and actors outside government that have a policy advisory role in health financing.

2.6 Target audience of the OASIS analysis and recommendations
The target audience of OASIS comprises health financing policy-makers in ministries of health, finance, planning and labour, other ministries, health insurance organizations and other health financing actors.

2.7 Methodology and data required
- Qualitative data on health financing actors and organizations, their institutional design and organizational practice in health financing through interviews and discussions with key health financing stakeholders and actors.
- Content analysis of policies, legal provisions and regulations relating to health financing.
- Secondary analysis of quantitative data (inter alia, national health accounts (NHA) statistics; household expenditure survey results; government budgets, in particular, ministry of health (MOH) budgets; health management information system (HMIS) data, health service utilization data; and health insurance statistics).

2.8 Team, training and time requirements
An OASIS team is established, generally comprising two to four members of a so-called 'core' team. This team consults and reflects on the analysis of the data collected, together with the ministry of health and other key health financing actors.

Before a team starts to work, the ministry of health and the core team usually organize a half-day introductory session on OASIS. Normally, a three-day workshop is required for in-depth training on OASIS.

A comprehensive application of OASIS will take about 6–10 working days at country level, depending on the size of the team and analytical work already undertaken. Sufficient resources should be budgeted for additional time that may be needed for data analysis and the writing up of the findings and suggestions of the OASIS application.
2.9 Deliverables

- A report on the health financing system review, including:
  - recommendations and proposals to improve health financing;
  - discussion of policy options and appropriate improvement measures as well as proposed changes relating to health financing mechanisms/schemes.

2.10 OASIS Excel Aid

The OASIS Excel Aid consists of three parts:
- Component 1. Health financing system review and health financing performance assessment;
- Component 2. Detailed institutional-organizational analysis;
- Component 3. Options, changes and improvement measures to increase health financing performance

Each component contains several modules on specific health financing subjects with key questions to guide the analysis and the search for policy options, changes and improvement measures for health financing. Each module has its own worksheet.
3. The core elements of the OASIS analytical framework

3.1 Rationale

Common to many countries is their concern to establish a health financing system enabling them to move towards universal coverage – defined by WHO as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access” (WHO, 2005). This is particularly the case for low- and middle-income countries, in light of their heavy reliance on out-of-pocket (OOP) health care expenditure. The latter represents an important financial burden to many households. Universal coverage is therefore an attractive goal.

A better understanding of the core challenges of a country’s health financing system as well as its context is the starting point for conceptualizing sound health financing reforms or improvement measures with better outcomes for universal coverage. Such measures may range from incremental modifications (e.g. raising provider remuneration rates), to revised policy instruments and mechanisms (e.g. replacing one provider payment mechanism with another) to policy changes and larger reforms (e.g. moving from a tax-based health financing system to a social health insurance (SHI) scheme or vice versa). Changes in health financing are often the outcome of complex political processes and negotiations. However, prior and during such processes, it is necessary to search for the most appropriate measures and options to improve health financing in order to support the policy-making process.

OASIS provides an analytical framework with which to undertake a systematic review of an existing health financing system. This review enables the identification of measures to improve its performance and attain universal coverage. The framework’s value added lies in the systematic and comprehensive assessment of how well the health financing system is working and why it is working well or inadequately. This is the basis for identifying a set of policy options with improvement measures to address the observed failures. The focus on institutional design and organizational practice as proposed in OASIS thus goes beyond a descriptive analysis of a health financing system that records what does and does not currently work, by offering an analytical and explanatory perspective throughout. Mathauer & Carrin (2010) provide a detailed account of the OASIS analytical framework.2

Figure 1 provides an overview with the key conceptual elements of this framework: health financing functions are concretized by their institutional design, i.e. the rules, and their organizational practice. This determines the attainment of health financing performance indicators and health financing objectives, and ultimately the level of universal coverage. Figure 3.1 also features stewardship as an important overarching function in health financing, having an effect on the other three health financing functions. Each of these elements will be outlined below.

---

Figure 3.1 Overview of the analytical framework

Source: further developed from Carrin et al. 2008

- **Stewardship**
  - **Resource collection** and related tasks
    - **Institutional design**
    - **Organizational practice**
  - **Pooling** and related tasks
    - **Institutional design**
    - **Organizational practice**
  - **Purchasing/provision** and related tasks
    - **Institutional design**
    - **Organizational practice**

- **Level of funding**
- **Level of population coverage**
- **Level of equity in financing**
- **Degree of financial risk protection**
- **Level of pooling**
- **Level of administrative efficiency**
- **Equity in BP delivery**
- **Efficiency in BP delivery**
- **Cost-effectiveness & equity in BP definition**

- **Health financing functions**
- **Health financing performance indicators**
- **Health financing objectives**

- **Sufficient and sustainable resource generation**
- **Financial accessibility**
- **Optimal use of resources**

- **Universal coverage**

- **Improved and equitable health outcomes**

- **Ultimate health system goal**

- **BP = Benefit package**
3.2 Health financing functions and their respective objectives

Any health financing system is based on three key health financing functions to achieve the following health financing objectives:

1. **resource collection** to ensure sufficient and sustainable revenues in an equitable way;
2. **pooling of funds** to ensure that the costs of accessing health care are shared, thus ensuring financial accessibility;
3. **purchasing/provision** to ensure that funds to purchase and provide health-care services are used in the most efficient and equitable way (Kutzin 2001; Carrin & James 2005).

Achievement of all three health financing objectives ultimately contributes to arrive at the policy goal of universal coverage (WHO 2005). In turn universal coverage is a decisive factor in reaching the final health system goal. The latter is equated with improved and more equitable health outcomes, including the achievement of the health-related Millennium Development Goals. Monitoring of these health outcomes is imperative. However, the attainment of health financing objectives merits substantial attention for policy analysis and action.

3.3 Health financing performance indicators

The degree of attainment in three health financing objectives can be made further operational through nine generic performance indicators that are applicable to all types of health financing systems:

1. Level of funding
2. Level of population coverage
3. Degree of financial risk protection
4. Level of equity in health financing
5. Level of pooling across the health financing system
6. Level of efficiency in benefit package delivery
7. Level of equity in benefit package delivery
8. Degree of cost-effectiveness and equity considerations in benefit package definition
9. Level of administrative efficiency

Table A1 (Annex 1) presents these indicators with their detailed operationalization and provides guidance on how they could evolve for the purpose of universal coverage. Table A2 proposes indicators for the performance assessment of specific health financing sub-systems.

The indicators are not meant for cross-country comparison or ranking. Their purpose is to assess the performance of a given country's health financing system. As such, performance comparisons can be carried out within a country over time and particularly after changes within the health financing system have been introduced. Performance may be described as ‘inappropriate’ when a country fails to achieve the levels of health financing performance it could potentially attain, given its resources and priorities.
3.4 Institutional design and organizational practice

The achievement of universal coverage and of the health financing performance indicators is considered to be contingent upon two important aspects (Carrin, Mathauer, Xu & Evans 2008). The first one is the underlying institutional design of the three health financing functions, i.e. the set of institutions, or rules that in total make up the health financing system and guide health financing organizations. Box 3.1 provides a definition of institutions and organizations.

<table>
<thead>
<tr>
<th>Box 3.1 Institutions and organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on North's work (1989:1321), institutions are understood as &quot;formal and informal rules, enforcement characteristics of rules, and norms of behavior that structure repeated human interaction&quot;, between individuals, within or between organizations, through incentives, disincentives, constraints and enhancement. To be effective, rules need to incorporate enforcement characteristics to indicate how compliance is monitored and how non-compliance is enforced or penalized.</td>
</tr>
<tr>
<td>Organizations, on the other hand, can be defined as &quot;groups of individuals bound together by some common purpose to achieve certain objectives&quot; (North 1993).</td>
</tr>
</tbody>
</table>

Specifically, the institutional design refers to the formal (written) rules relating to the health financing functions, i.e. the resource collection rules, pooling rules and purchasing/provision rules. Such rules can be stipulated by health financing related policies, and in more concrete form are found in legislation and regulations. Table A3 (Annex 1) provides an overview of the various possible types of health financing rules and the diverse aspects they need to incorporate.

The second important aspect, equally crucial for the performance of a health financing system, are the organizations involved in health financing, for example the MOH, ministry of finance (MOF), insurance schemes, health service providers and others. Of specific interest are their activities and the specific tasks relating to the health financing functions – in other words their organizational practice relating to health financing.

Here, organizational practice is understood as the way organizations do or do not implement and comply with formal rules, which is also dependent upon their organizational capacity. In an ideal situation, organizations implement and comply with the rules, and have the capacities needed to work towards health financing objectives and performance indicators. In reality, however, organizational practice is not only influenced by the rules and the respective incentives these create, but also by the specific interests of organizations and individuals. These interests are shaped by a number of factors, including preferences, prevailing informal rules and cultural norms, the degree of self-
interest and profit maximization as well as motivations of solidarity and professionalism (DiMaggio & Powell 1991).

3.5 Bottlenecks in institutional design and organizational practice and ways to address these

As institutional design and organizational practice are fundamental determinants for health financing performance, one needs to understand their strengths as well as possible bottlenecks.

For a detailed situation analysis and understanding, performance weaknesses can be analysed along the six types of bottlenecks outlined in Table 3.1. These bottleneck factors exist because rules are not automatically implemented and complied with by organizations when they give important weight to their own interests. Thus, in order to identify the reasons for good or low performance, it is equally important to understand the prevailing incentive environment for organizations.

The bottleneck analysis is also the starting point to derive appropriate measures to improve health financing performance. Six types of improvement measures are proposed to remedy the six types of bottlenecks.
Table 3.1
Bottlenecks in institutional design and organizational practice and ways to address these

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>Changes and improvement measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Rule absence</strong></td>
<td>Where previously absent, the setting and introduction of a new rule or specific rule aspects serves to overcome a regulatory gap.</td>
</tr>
<tr>
<td>If a critical aspect of a health financing function is not specified by a rule, organizations operate without a regulatory basis or may not undertake an important health financing task because of lack of incentives.</td>
<td></td>
</tr>
<tr>
<td><strong>2. Inadequate rule</strong></td>
<td>A rule's purpose, or the detailed health financing aspects it specifies, may need to be reformulated, in order to create or strengthen the logical link(s) with the health financing performance indicator(s).</td>
</tr>
<tr>
<td>A rule may be inadequate, because it is not logically linked with the health financing performance indicators. As such, the rule in itself and the prevailing incentive environment would not contribute to attaining the health financing performance indicators.</td>
<td></td>
</tr>
<tr>
<td><strong>3. Confictive rule</strong></td>
<td>The prevailing rules may need to be aligned with the country context or with each other. Alternatively, public awareness raising and information dissemination may be required to overcome attitudes that are non-conducive to rule compliance and the achievement of the health financing performance indicators.</td>
</tr>
<tr>
<td>A rule and its incentive environment may be overridden by or conflict with other rules. The rule may also not be consistent with the country context, prevailing cultural norms and attitudes (for example, the notion of solidarity) or the country’s management and administration capacities.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Weak rule enforcement</strong></td>
<td>Rule enforcement can be reinforced by specifying the enforcement characteristics of a rule, so that the incentives to comply with the rule are more pronounced.</td>
</tr>
<tr>
<td>Lack of or weak rule enforcement is caused by absent or inappropriate enforcement characteristics within a rule, thus providing weak incentives to undertake a health financing task.</td>
<td></td>
</tr>
<tr>
<td><strong>5. Weak organizational capacity for rule implementation, monitoring and enforcement</strong></td>
<td>Organizational capacity of specific organizational actors can be enhanced through a number of organizational development measures. These include reinforcing management leadership, staff training, an improved financial basis, infrastructure improvements, or revisiting organizational procedures and structures, through which organizations gain the ability to better implement rules.</td>
</tr>
<tr>
<td>Organizations may be unable to implement, monitor or enforce a rule effectively due to weak organizational capacity. Weak organizational capacity may result from lack of leadership, inadequately skilled human resources, shortage of financial resources, poor (information technology) infrastructure or inappropriate organizational procedures and structures.</td>
<td></td>
</tr>
<tr>
<td><strong>6. Dysfunctional inter-organizational relationships</strong></td>
<td>Improving inter-organizational relationships, such as by introducing trust building and conflict management measures, inter alia, can all help enhance inter-organizational relationships and thus strengthen rule implementation and rule enforcement.</td>
</tr>
<tr>
<td>Conflicts, mistrust, inadequate communication and collaboration between organizations may negatively affect rule implementation or enforcement.</td>
<td></td>
</tr>
</tbody>
</table>
Most often, a combination of several improvement measures is necessary to increase health financing performance. A shift to another type of health financing sub-system, e.g. from a dominantly tax-based health financing system to a SHI system, or vice versa, might sometimes need to be examined as well.

For countries with a perceived gap in resources for health, it is crucial to not only assess the rules and organizational practice relating to resource mobilization, but also to have an idea of the potential additional financial volume that could be created. The mobilization of additional resources may in itself require changes in institutional design and organizational practice related to resource mobilization. Possible improvement measures, and changes in policy instruments and reforms relating to the other health financing functions (pooling and purchasing/provision) thus always have to be examined vis-à-vis the possible financial extension.

It is important to anticipate the impacts of proposed changes with respect to all performance indicators, as well as the overall health financing system. Effects also need to be assessed with respect to the overall health system (e.g. economic growth, the labour market, consumer prices, income distribution and poverty levels).

The institutional design of a health financing system can be actively shaped and developed by modifying legal and regulatory provisions. Likewise, health financing performance can be improved by strengthening organizational capacity and enforcement practices.

Table A4 (Annex 1) provides an illustration with hypothetical examples of bottlenecks and improvement measures for the collection of (voluntary) of social health insurance contributions from informal sector workers.

### 3.6 Feasibility check of proposed changes and improvement measures

When identifying the most appropriate changes in institutional design and organizational practice to achieve improvements in health financing, a number of feasibility considerations or constraints need to be taken into account. These include the steward's implementation capacity, as well as political and technical feasibility.

As mentioned above, the scope of any improvement in health financing performance is not independent of the country's financial situation, and proposed changes also need to be assessed with respect to financial sustainability (Kutzin 2008).

The feasibility check may also point to the need to adjust the proposed changes to ensure that these will lead to the desired enhancement in health financing performance.
4. Putting OASIS into practice

4.1 Overview of OASIS components and steps

When undertaking a comprehensive health financing system review with the OASIS approach, it is proposed to proceed through three components (see below). Each component provides analytical guidance with a set of questions to ensure a systematic and comprehensive assessment while applying an institutional-organizational perspective.

These questions are provided in the form of the OASIS Excel Aid (see Section 4.4). The Excel Aid aims to be as comprehensive as possible to cover a wide range of country contexts and thus offers all-inclusive sets of questions. Evidently, the Excel Aid may not capture each and every aspect in each country. On the other hand, many of the questions may not be relevant to every country setting and, therefore, may not need to be answered.

Component 2. Detailed institutional-organizational analysis.
Component 3. Options, changes and improvement measures to increase health financing performance.

When time is short, OASIS users could opt to move directly from Component 1 to Component 3. However, it is recommended that the logic and key questions of Component 2 (see Box 4.2) be applied in order to identify any of the core bottlenecks.

Figure 4.1 outlines the analytical steps involved in the components, in line with the analytical framework of OASIS outlined in Section 3.
Figure 4.1 Analytical process steps

1. Provide an overview of the HF system

2. Assess the performance of the HF system

3. Detailed situation analysis: identify bottlenecks in institutional design and organizational practice

4. Specify or confirm intermediate country-specific objectives/targets

5. Propose appropriate HF options and identify necessary inst./org. improvement measures to address bottlenecks and to realize options

6. Estimate resource mobilization potential of these options and measures

7. Review feasibility/constraints of proposed improvement measures

8. Anticipate impacts of options and improvement measures on performance, the health system and other areas

9. Possibly adapt and adjust proposed options and improvement measures

10. After implementation: evaluate health financing performance (Section 2)

Guided by the overall commitment and vision to move towards universal coverage
4.2 Detailed contents of the components

Component 1. Health financing system review & performance assessment

Purpose
Component 1 serves to obtain a thorough understanding of the key health financing stakeholders and actors and the way the health financing system is functioning and organized. It also assesses health financing performance.

Subjects
Component 1 consists of 10 modules, each with key questions that serve to collect both quantitative and qualitative data in order to analyse the following subjects.

<table>
<thead>
<tr>
<th>Component 1. Modules for health financing subjects</th>
<th>Module content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Country context and health system overview</td>
<td>Gross domestic product (GDP) growth rates, population growth rates, income</td>
</tr>
<tr>
<td></td>
<td>Human resources for health</td>
</tr>
<tr>
<td></td>
<td>Health infrastructure</td>
</tr>
<tr>
<td></td>
<td>Key actors in health financing</td>
</tr>
<tr>
<td>2. Resource collection</td>
<td>Policy, legal and regulatory framework for health financing</td>
</tr>
<tr>
<td>3. External funding</td>
<td>Key health expenditure statistics</td>
</tr>
<tr>
<td></td>
<td>Health financing schemes</td>
</tr>
<tr>
<td></td>
<td>Resource collection mechanisms</td>
</tr>
<tr>
<td></td>
<td>External funding for health</td>
</tr>
<tr>
<td>4. Pooling</td>
<td>Funding organizations</td>
</tr>
<tr>
<td></td>
<td>Funding type and purpose</td>
</tr>
<tr>
<td>5. Purchasing</td>
<td>Pooling agency, risk equalization agency</td>
</tr>
<tr>
<td></td>
<td>Level of fragmentation across the health financing system</td>
</tr>
<tr>
<td></td>
<td>Pool composition</td>
</tr>
<tr>
<td></td>
<td>Government resource allocation process and criteria</td>
</tr>
<tr>
<td>6. Benefit package</td>
<td>Purchasing structures</td>
</tr>
<tr>
<td></td>
<td>Provider payment mechanisms</td>
</tr>
<tr>
<td>7. Fund management</td>
<td>Benefit package definition process</td>
</tr>
<tr>
<td></td>
<td>Benefit package costing</td>
</tr>
<tr>
<td></td>
<td>Benefit package consumption</td>
</tr>
<tr>
<td>8. Stewardship and governance</td>
<td>Fund management procedures</td>
</tr>
<tr>
<td></td>
<td>Administrative efficiency of the system</td>
</tr>
<tr>
<td>9. Performance assessment</td>
<td>Legal and regulatory framework for health financing</td>
</tr>
<tr>
<td></td>
<td>Actors involved in stewardship functions</td>
</tr>
<tr>
<td></td>
<td>List of aspects being regulated or not being regulated</td>
</tr>
<tr>
<td>10. More details for health financing performance assessment</td>
<td>Assessment of health financing performance via</td>
</tr>
<tr>
<td></td>
<td>nine generic key health financing performance indicators.</td>
</tr>
<tr>
<td></td>
<td>Differentiated indicators by income quintiles and/or by health financing schemes</td>
</tr>
</tbody>
</table>
Component 2. Detailed institutional-organizational analysis

Purpose/objective
Component 2 serves to analyse in more detail the institutional design of the health financing system as well as the organizational practice of the organizations involved with respect to individual health financing functions and tasks. It aims to reveal the specific factors that enhance performance and the bottlenecks that cause poor performance. It is also designed to assess the impact of the bottlenecks on health financing performance.

The detailed institutional-organizational analysis may also reveal the potential achievement of health financing performance indicator targets, whether rules were effectively implemented and whether organizations had the capacity to implement these rules. In addition, this component could be used for an assessment of the anticipated impacts of a planned reform. Finally, OASIS points to a whole range of relevant issues relating to institutional design and organizational practice. Hence, Component 2 modules could, for example, also be used for the development of a detailed social health insurance proposal.

Subjects
Component 2 consists of several modules, each one focusing on one specific health financing task.

Component 2. Modules for health financing tasks
1. Health insurance membership registration and enrolment
2. Resource collection via health insurance
3. Targeted subsidization of health insurance premiums of low-income people
4. Exemption of cost sharing for low-income people for all types of health financing schemes
5. Provider payment mechanisms/claims management for all types of health financing schemes

Voucher schemes could equally be assessed with this module.
The purpose of Component 2 is to collect mainly qualitative data on the institutional design (legal and regulatory aspects) of the health financing functions, on organizational practice (i.e. rule implementation and rule compliance) as well as on incentives and interests of health financing actors. The key questions of each module help to identify bottlenecks in institutional design and organizational practice.

The six types of bottlenecks referred to in Table 3.1 include:
1. absence of a rule
2. inadequate rule
3. conflictive, non-aligned rule
4. weak rule enforcement
5. weak organizational capacity
6. non-conducive inter-organizational relationships.

Box 4.2 Component 2 – key questions

- What are the bottlenecks in institutional design and organizational practice?
  1. Does a rule exist? Are all elements of the rule specified? (If not: rule absence.)
  2. Is the rule adequate? Can the rule per se contribute to achieving the performance indicator(s)? (If not: inappropriate rule.)
  3. Is the rule in line with the country context and other rules? (If not: conflictive rule.)
  4. Do the different organizational actors involved have the necessary organizational capacity to properly implement and/or monitor and enforce the rule? (If not: weak organizational capacity.)
  5. Are there appropriate enforcement mechanisms? (If not: weak rule enforcement.)
  6. Do relationships among the organizational actors involved facilitate proper rule implementation/rule compliance and rule monitoring/enforcement? (If not: dysfunctional inter-organizational relationships.)

- What kind of incentives and interests operate for the different organizational actors?
- How does this affect the attainment of the health financing performance indicator(s)?
- What other impacts do these rules and their implementation trigger?

Component 2 modules provide detailed guiding questions for the various health financing subjects. When time is short, the user team may choose to apply the above key questions to assess specific health financing subjects, rather than making use of the specific Component 2 modules with detailed guiding questions.
Component 3. Options, changes and improvement measures to increase health financing performance

Purpose/objective
Component 3 serves to identify and develop appropriate policy options, changes and improvement measures relating to institutional design and organizational practice in order to improve health financing performance. As such, Component 3 is the core element of a policy assessment process.

The options, changes and improvement measures may relate to different levels ranging from incremental modifications (e.g. raising provider remuneration rates), to revised policy instruments (e.g. replacing a provider payment mechanism), to alternative formulations of policy options and larger reforms (e.g. moving from a tax-based health financing system to a social health insurance scheme or vice versa).

Component 3 modules attempt to cover a wide range of situations but cannot suggest all relevant options and improvement measures for a specific context.

Subjects
Component 3 consists of several modules, each focusing again on a specific health financing task, thus matching the respective Component 2 modules. These modules are applicable to all types of health financing sub-systems, apart from the first three on increased resource mobilization, which are specific to a health financing sub-system.

Component 3. Modules for health financing tasks
1. Increased (tax-related) domestic resource mobilization including innovative financing mechanisms*
2. Improved health insurance membership registration and enrolment
3. Increased resource collection via health insurance
4. Targeted subsidization of health insurance premiums of low-income people
5. Exemption of cost sharing for low-income people
6. Improved provider payment mechanisms and claims management
7. Improved strategic purchasing
8. Improved benefit package definition
9. Enhanced pooling
10. Strengthened stewardship
   * Tax-based and non-taxed based.

It is recommended that the search for (C3-1) "increased (tax-related) domestic resource mobilization including innovative financing mechanisms" be pursued in each OASIS country study given the importance of increased resource mobilization for most countries.
Component 3 is based on five steps with generic questions to develop recommended options, changes and improvement measures for institutional design and organizational practice in order to improve health financing performance.

Each of the six types of bottlenecks in institutional design and organizational practice can be addressed by their respective type of improvement measure (see Table 3.1):

1. rule setting (introduction of a new rule)
2. rule redesign
3. rule alignment
4. strengthening rule enforcement
5. strengthening organizational capacity
6. strengthening inter-organizational relation.

---

**Box 4.3 Component 3 – key steps and questions**

1. Ideally, the overall policy direction and objectives, and where possible intermediate health financing performance indicator targets, are set (or confirmed) by the country policy-makers, stakeholders and actors. The objective and target setting and confirmation are, in principle, guided by the insights from components 1 and 2. (The aspired targets can be entered into Component 1. Module 9.)

2. Identify appropriate health financing options that contribute to improving health financing performance. Specifically, determine what changes in institutional design and/or organizational practice will be necessary to realize these options.

3. Anticipate impacts resulting from these proposed options and changes.

   *What effects and impacts will the options and changes in institutional design and/or organizational practice have on the incentive environment and interests of organizational actors, and on compliance, enforcement and inter-organizational relationships?*

   *What is the anticipated effect of these options and changes on the health financing performance indicators? Can the quantitative effect be assessed? What is the anticipated effect of these changes on other health financing schemes and the overall health financing system?*

   *What is the anticipated effect of these options and changes on the health system and the country’s social and economic situation (e.g. effects on economic growth, the labour market, prices, poverty levels)?*

4. Assess the detailed financial sustainability and the financial implications of the proposed options and specific changes. This step may require particular attention as well as additional analysis.

5. Assess the feasibility of the proposed options and changes:

   - political feasibility with respect to interest groups and critical stakeholders and actors;
   - technical feasibility (e.g. capacity and wider institutional environment in place to realize changes and implement improvement measures);
   - capacity of stewards to monitor and steer implementation stakeholders and actors.
It is important to note that steps 1–5 will need to be undertaken in parallel and reiteratively.

Note related to components 1–3

Depending on the availability of information and data, some of these questions cannot be answered, or can only partially be answered.

For a given country context, some modules or certain questions may not be relevant and can be skipped. In particular, Component 2 covers a wide range of issues, but this detail may not be required for each health financing review.

4.3 OASIS data collection methods and analysis

This section provides an overview of the OASIS methodology and procedures. A summary of the data sources, data collection methods and analysis is given in Table 4.1 followed by more detailed methodological explanations for each component.

Table 4.1 OASIS data sources and methods of data collection and analysis

<table>
<thead>
<tr>
<th>Component</th>
<th>Data sources and methods of data collection and analysis</th>
<th>Type of data</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1 Health financing review &amp; performance assessment</td>
<td>• Mainly review of key documents (e.g. MOH policies, strategies, plans, country reports, literature)</td>
<td>Quantitative and qualitative</td>
<td>Prior and during in-country work</td>
</tr>
<tr>
<td></td>
<td>• Existing databases and statistics (e.g. NHA, household survey analyses, country statistics, HMIS/human resources statistics)</td>
<td>Mainly quantitative</td>
<td></td>
</tr>
<tr>
<td>Component 2 Detailed institutional and organizational analysis</td>
<td>• Review and content analysis of legal and regulatory provisions (e.g. health (financing) policy, health law, MOH regulations/decrees/ordinances, SHI act, SHI regulations, private health insurance act)</td>
<td>Qualitative</td>
<td>During and after in-country work</td>
</tr>
<tr>
<td></td>
<td>• Interview and discussions with key stakeholders and actors (e.g. MOH, MOF, social health insurance scheme, private health insurance schemes, providers)</td>
<td>Mainly qualitative</td>
<td>During in-country work</td>
</tr>
<tr>
<td>Component 3 Options, changes and improvement measures to increase performance</td>
<td>• Further reflection and data analysis for components 1 and 2 (possibly other country data (employment, economic growth))</td>
<td>Qualitative and quantitative</td>
<td>During and after in-country work</td>
</tr>
</tbody>
</table>

See also Annex 2 for further details on data sources and interview/discussion partners.
Component 1.

Health financing system review
Prior to the actual in-country work, the OASIS team should attempt to fill in Component 1 by reviewing available documents including published literature. The focus should be on the data collection questions.

Additionally or alternatively, a resource person or counterpart at country level (e.g. from the MOH) with detailed knowledge of the country's health financing system could assist in collecting and analysing information to fill in Component 1.

Essential missing information in Component 1 could be collected during the in-country work through interviews with key informants and health financing stakeholders and actors.

The ‘Questions for further reflection’ that form part of Component 1 may also be reserved for the actual in-country work.

Key findings and issues resulting from the Component 1 work should be discussed with senior officials of the MOH to determine the focus for the Component 2 work.

Health financing performance assessment
To assess the attainment of quantitative indicators (1–5, 9), the various databases, country statistics and reports usually provide the required information. Some further calculations of the primary data may be necessary (Annex 7 provides further explanation).

Attainment of qualitative performance indicators (6–8) can be assessed by reviewing country reports. Insights from the institutional-organizational analysis of the health financing system (through the interviews and discussions during the in-country work) may also feed into the assessment of the qualitative indicators. The health financing performance assessment may sometimes be completed only after Component 2 has been undertaken.

The operationalization of the indicators may need to be adjusted depending on the country context and data availability.

Module 9 also provides space to enter the desired targets of the health financing performance indicators into the right hand side column.

Component 2.

Detailed institutional-organizational analysis through contents analysis of legal and regulatory provisions
Policy documents as well as legal and regulatory provisions provide information on how the health financing system, specific schemes, or specific health financing functions and
activities are supposed to work in principle. In order to assess whether legal and regulatory provisions describe an institutional design that is conducive to health financing performance, the following steps are proposed:

- verify if the rule is clear and coherent;
- check whether definitions (e.g. ‘dependent’, ‘family’, ‘employee’) are clear, exclusive (versus overlapping) and coherent;
- check whether the rule is comprehensive, i.e. whether all relevant elements of the rule are covered (Component 2 modules provide a checklist with key questions);
- assess the legal/regulatory basis and scope of the rule, i.e. whether it is a law or a decree, and whether it needs to be complemented by another rule;
- check linkages and coherence (or overlaps and contradictions) with other existing rules;
- apply the rule to various concrete examples to understand its effects;
- assess the impacts of the rule under study;
- where possible, quantify the impacts and assess the implications of a rule;
- conclude whether the rule under study is adequate, i.e. conducive to the attainment of health financing performance.

Institutional-organizational analysis through interviews and discussions

The Component 2 generic key questions, as outlined in Box 4.2 above, are further detailed and specified for selected health financing tasks in the Excel Aid. These specific questionnaires facilitate the collection of all necessary information and help structure the discussion. Above all, the C2 modules help to verify whether all relevant elements of a rule are specified, i.e. are formulated in appropriate legal/regulatory provisions.

In most situations, Excel Aid questionnaires from several Component 2 modules will be relevant for an interview with a specific health financing actor, when more than one health financing task is being discussed. They thus need to be combined in a flexible way. It is also important to note that the questionnaires may need to be reformulated in line with the specific country context.

The interviews and discussions mainly provide qualitative data. These need to be triangulated. The team also needs to check whether the information from interviews and discussions is consistent with practice. Likewise, the interviews and discussions with key health financing stakeholders and actors provide an idea of whether rules are well understood, considered adequate, accepted and ultimately complied with.

**Component 3.**

Reflection and discussion process on options, changes and improvement measures

Component 3 basically presents a reflection and discussion process. This process is guided by five analytical steps and key questions. In order to assess and anticipate the impact of proposed options, changes and improvement measures as well as to review their feasibility, it may be necessary to make use of data beyond this health financing system review, e.g. labour market or trade data.
Options, changes and improvement measures relating to institutional design and organizational practice should be formulated as meticulously as possible. Rather than proposing general recommendations, Component 3 should trigger concrete and implementable measures.

Implementation oriented measures should be clear on the following aspects:
- Who should do what, how, when, why, under what conditions?
- How should the new/revised rule read in order to comprehensively cover all relevant elements of the rule?
- Which actors have the necessary organizational capacity to carry out the health financing task under question?
- How can their organizational capacity be strengthened?
- Which actors should be in charge of monitoring and enforcement?

4.4 OASIS time requirements
A full country health systems financing review with OASIS and with a team of two to four individuals will take about 6–10 working days for the actual in-country work, but is contingent on the analytical work already available. Additional time may be necessary for the external team members to become familiarized with the country as well as for the data analysis and report writing (a total of approximately 10–15 work days). Further recommendations regarding the planning and procedures of the OASIS work including the proposed team composition are provided in Annex 3.

4.5 OASIS Excel Aid: details, potential and limits
The OASIS components and modules are provided in Microsoft Office Excel software, version 2003. Each module is presented as a separate worksheet.

Each Excel worksheet contains the guiding questions for a specific health financing subject, which are presented in white boxes. The information collected can be typed into grey response boxes. Alternatively, Excel sheets can be printed out and information can be written in manually.

It is important to note that the OASIS Excel Aid does not produce any results by itself. The Excel worksheets are a mere aid to guide the analysis and reflection as well as to organize the information collected.

When opening the Excel Aid, a ‘switchboard’ appears which allows the user to easily navigate through the components by clicking on the hyperlinked boxes for each module.

---

4 The core work of OASIS consists of interviews and discussions with key health financing stakeholders and actors as well as the collection of key documents, including legal/regulatory provisions and policies. We refer to this as in-country work, i.e. a concise period for a country team exercise. It does not necessarily imply the participation of external ‘mission’ members.

5 In Component 1, ‘Questions for further reflection’ are presented in blue boxes.

6 Note that the Excel cell size does not automatically adjust to the cell contents. For longer answers, the Excel answer cells need to be enlarged manually, if necessary.
Each module contains a ‘Back to switchboard’ hyperlink at the top right-hand corner as well as at the end in order to get back to the switchboard. Alternatively, the user may move from one module to the next by using the Excel provided worksheet task bar.

Format of Component 1 modules

Most questions are provided in table format to collect information across the various health financing schemes operating in the country.

- Module 1 serves to collect general country and health systems data, which is mostly in table format.
- For modules 2–8, the respective health financing performance indicators, which relate to the health financing subject covered in that module, are presented at the top. This is followed by questions on the health financing subject under study (mostly in table format).
- ‘Questions for further reflection’ guide the team's brainstorming to identify key concerns and challenges and how these could be addressed. During the Component 2 work, the team may review again these questions and responses.
- Module 9 contains the health financing performance indicators and provides space to enter the country’s level of attainment as well as the desired targets over the country’s defined time horizon.

The respective indicator operationalizations are spelt out (column A).

(Additional indicator operationalizations are presented in normal font. Specific indicators relating to specific health financing schemes are presented in italics.)

The Guidance on indicator levels is presented in column B.

Country results (the actual attainment in these indicators) can be entered in column C.

Basic observations and further guidance are provided in column D.

- Module 10 provides the opportunity to enter more detailed data on performance indicators in order to differentiate by income quintiles and/or by health financing schemes.

Format of Component 2 modules

The format of each Component 2 module is set out below.

- The respective health financing performance indicators, which relate to the health financing subject covered in that module, are presented at the top.
- The following ‘Bottleneck analysis’ consists of six sections on the six types of bottlenecks, each with a set of questions to identify the bottleneck(s). A detailed list of essential rule elements that should be specified in the regulations is provided in order to check and understand whether a rule is formulated comprehensively.
- The ‘Assessment of impacts’ of these bottlenecks on health financing performance follows. Guiding questions are provided to judge the bottlenecks, their impact on health financing performance as well as other impacts and possible trade-offs.
- Scoring questions complement the bottleneck analysis.

Some of the key questions in the OASIS Excel Aid are complemented by a scoring question, asking the OASIS user to score the extent/degree/adequacy/appropriateness of a certain aspect relating to a rule or rule implementation. A scale of five levels is provided: The score (5) describes the most appropriate or ideal situation, whereas the score (1) refers to the least appropriate or worst situation.

The main purpose of the scoring process is to reveal whether the OASIS team members have a similar view and understanding of the bottlenecks and the causes of poor performance. Experience from prior OASIS applications has shown that the scoring process helps to develop a common viewpoint. In case of scoring differences (two or more scoring points) among the OASIS team, discussion and clarification of the issue usually helps to reveal the reasons for the differing viewpoints.

While this scoring process appears to have a subjective element to it, in practice the OASIS team may come across objective qualitative indications for most of the scoring questions.

In the OASIS Excel Aid, scores for each of the Component 2 sections (i.e. the six bottleneck factors) are automatically summed up. This provides an idea of the importance of the bottleneck problem. However, the scores have no statistical value and can neither be compared across bottlenecks nor across health financing schemes.
Furthermore, the bottleneck(s) that received the lowest score(s) may not necessarily be the one(s) that need(s) to be addressed with highest priority. Also, feasibility concerns as well as the anticipation of impacts from proposed changes may call for a different entry point than suggested by the scoring.

Examples

To what extent are membership rules appropriate in contributing to maximizing the membership basis?

<table>
<thead>
<tr>
<th>1 = not appropriate</th>
<th>2 = rather not</th>
<th>3 = somewhat</th>
<th>4 = rather appropr.</th>
<th>5 = fully appropriate</th>
</tr>
</thead>
</table>

How well does monitoring of membership enrolment work in practice?

<table>
<thead>
<tr>
<th>1 = not at all</th>
<th>2 = rather not</th>
<th>3 = somewhat</th>
<th>4 = works well</th>
<th>5 = fully appropriate</th>
</tr>
</thead>
</table>

If a score for a specific bottleneck is below 65%, it is recommended that ways of improving registration be found. In general, however, it is suggested that improvements for all six types of bottlenecks are found, as they are interrelated.

Also, while a score may suggest that a specific bottleneck requires particular attention, realizing improvements may be more difficult and costly than improving other bottlenecks.

Format of Component 3 modules

- A list of possible improvement measures (changes in institutional design and organizational practice) for the health financing task under study) is presented. Whether the proposed options, changes and improvement measures are actually appropriate for a given country context needs to be assessed during the Component 3 work.
- This is followed by guiding key questions around the five analytical steps (as outlined in Section 4.2) to identify and assess options, changes and improvement measures.

4.6 From proposing policy options and improvement measures to policy decisions, strategy development and actual implementation

The options with their respective improvement measures or changes need to be discussed in detail with the country's key health financing stakeholders and actors. This consultation and negotiation process is important and it will take time to decide and agree on the health financing strategy and the specific activities to be undertaken in a defined time period. Once these decisions are taken, a strategy document outlining the key axes for the health financing system to pursue as well as an implementation plan can be drawn up. In some instances, a legal expert may be required for the reformulation of legislative and regulatory provisions. Capacity strengthening measures may equally be necessary to implement the proposed options, changes and improvement measures.

Once implementation of the proposed health financing options, changes and improvement measures is under way, regular monitoring and evaluation as well as reviewing may be required. After the initial reform implementation phase, the OASIS approach can be applied again to assess the impacts on the health financing performance indicators.
References


Devlin J (2007). *The administration costs of social health insurance in developing countries: may be high, maybe why (trying to guess and clarify)* [thesis], York, UK, University of York.


Annex

Further detailed explanations, practical guidance for the OASIS in-country proceedings and sample documents
## Annex 1. Further details and explanations of the analytical approach

Table A1 Health financing performance indicators and their operationalization (more detailed indicator operationalizations are listed in *italics*).

<table>
<thead>
<tr>
<th>Health financing performance indicator</th>
<th>Operationalization</th>
<th>Guidance</th>
<th>Further observations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Level of funding</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total health expenditure (THE) per capita</td>
<td></td>
<td>† For low income countries</td>
<td>Costs to provide a package to reach MDGs and strengthen health systems: US$ 54 per capita (2005 prices) (High Level Task Force, 2009)</td>
</tr>
<tr>
<td>THE/GDP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time trends &amp; comparison with similar countries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· General government health expenditure (GGHE)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· GGHE/THE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· General government expenditure (GGE)/GDP (fiscal space)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· GGHE/GGE (fiscal space for health)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· External funding for health/THE (donor dependency)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Level of population coverage</strong></td>
<td></td>
<td>100%</td>
<td>Carrin &amp; James (2005)*</td>
</tr>
<tr>
<td>Percentage of population covered by a financial risk protection mechanism (this means that a person is not put at financial risk due to the costs of care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Differentiated by quintiles/population groups:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· percentage of people covered by a financial risk protection mechanism in each quintile or population group</td>
<td>Equal population coverage across quintiles or population groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Degree of financial risk protection</strong></td>
<td></td>
<td>≥ 70%</td>
<td>The average prepayment ratio among OECD countries is 72.5% (OECD data from 1990–2006); the minimum and maximum for 2006 is 44.2% and 90.9%, respectively. 21 OECD countries report having a prepayment ratio ≥ 70% since 2000 (Carrin &amp; James 2005). °</td>
</tr>
<tr>
<td>· Prepayment ratio: GGHE/THE (in %)</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>· Percentage of households experiencing catastrophic expenditure in each scheme</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>· Percentage of households impoverished by out-of-pocket (OOP) expenditures on health</td>
<td></td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Differentiated by quintiles/population group:</td>
<td></td>
<td>0% in all quintiles/population groups</td>
<td>Average THE minus OOPs as a share of THE is ≥ 79% in OECD countries (data from 1990–2007)</td>
</tr>
<tr>
<td>· percentage of households experiencing catastrophic expenditure in each income quintile/population group</td>
<td></td>
<td>0% in all quintiles/population groups</td>
<td></td>
</tr>
</tbody>
</table>

*AFR*: Africa; *AMR*: Americas; *EMR*: Eastern Mediterranean; *EUR*: Europe; *SEAR*: Southeast Asia; *WPR*: Western Pacific

° Carrin & James (2005)
<table>
<thead>
<tr>
<th><strong>4. Level of equity in health financing</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Total and specific health financing payments (e.g. taxes, contributions, insurance premiums, co-payments, OOP health expenditure)/household income</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
</tr>
<tr>
<td><strong>How to assess:</strong> analysis of household survey data, or else approximation through available data on tax burden and share in national income per quintile, OOPs per quintile and insurance contribution rules</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5. Level of pooling across the health financing system</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care spending per pool member set in relation to overall health risks of pool members</td>
</tr>
<tr>
<td><strong>Within health financing schemes:</strong></td>
</tr>
<tr>
<td>- link between resource allocation to sub-pools and health care needs/costs</td>
</tr>
<tr>
<td><strong>How to assess:</strong> 1st step – estimate health care spending per member, divide estimated total health care spending per pool by estimated number of pool members; 2nd step – compare average pool spending per member with overall health risk profile of pool members Higher health risks should go hand in hand with higher average spending per pool member</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6. Level of operational efficiency and</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7. Level of equity in the delivery of a given benefit package</strong> at a given level of quality standards</td>
</tr>
<tr>
<td>For each health financing scheme:</td>
</tr>
<tr>
<td>- absence of over-provision (e.g. providing too many services and medicines, up-coding), under-provision (e.g. providing too few services and medicines, or of substandard quality), cost-shifting, cream-skimming</td>
</tr>
<tr>
<td>- absence of over-consumption and under-consumption of services in relation to real health needs</td>
</tr>
<tr>
<td><strong>How to assess:</strong> qualitative analysis through discussion with purchasers and providers, as well as assessment of incentives set by provider remuneration schemes</td>
</tr>
</tbody>
</table>

| Countries with an OOP share below 15% have few households experiencing catastrophic expenditure (Xu et al. 2003) Note that so far no OECD country has a percentage of 0% households, but the share is below 1% (Xu et al. 2007) | |

| **percentage of households impoverished by OOP health expenditures in all income quintiles/population groups** | | |
Utilization rates equal across quintiles when accounting for health-care needs, and not lower for poorer quintiles

### 8. Degree of cost-effectiveness and equity considerations in benefit package definition

<table>
<thead>
<tr>
<th>For each health financing scheme:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• cost-effectiveness and equity considerations as part of benefit package definition logic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The benefit package fulfills cost-effectiveness and equity considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost-effectiveness analyses are being undertaken or its results are being considered</td>
</tr>
</tbody>
</table>

See also explanations under indicator No. 5

*Cf. Carrin & James (2005)*

*How to assess:* analysis of actual contents of the benefit package in order to check, inter alia, for services addressing chronic diseases and the disease burden of the poor, services with positive externalities, preventive health services or those with demonstrated high cost-effectiveness

### 9. Level of administrative efficiency

<table>
<thead>
<tr>
<th>Total administrative costs for all health financing schemes as a share of total health expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>↓</td>
</tr>
</tbody>
</table>

The average from national health accounts data for low- and middle-income countries for 2008 is < 8%, with similar averages since 1995 (Nicolle/Mathauer 2010).

---

*AFR=WHO African Region; AMR=WHO Region of the Americas; EMR=WHO Eastern Mediterranean Region; EUR=WHO European Region; SEAR=WHO South-East Asia Region; WPR=WHO Western Pacific Region.*


*Recommendation by WHO SEARO/WPRO (2010); population coverage > 90% for countries in the Asia Pacific region.*

*Here, the prepayment ratio is understood as the share of general government health expenditure in total health expenditure (THE) rather than THE minus out-of-pocket expenditure as a share of THE. The former implies a higher degree of pooling among the population and quasi-government organization or regulation. The latter also involves private, voluntary prepayment, with a lower degree of pooling of health risks and across different income groups.*

*Catastrophic expenditure occurs with health care payments at or exceeding 40% of a household's capacity to pay in any year (Xu et al. 2003). A non-poor household is impoverished by health OOP expenditure when it becomes poor after paying for health services (cf. Wagstaff & Van Doorslaer 2003).*


*Here, the term benefit package is used in a generic way, referring to a specified package of services, as defined by a health financing scheme. This means that the scheme promises to secure the provision of these services to its member population or to ensure the reimbursement of part of the costs of these services.*
<table>
<thead>
<tr>
<th>Performance indicator</th>
<th>Operationalization</th>
<th>Guidance</th>
<th>Further observations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Level of funding</strong></td>
<td>For health insurance (HI) scheme(s):  &lt;br&gt; • contribution rates  &lt;br&gt; • actual HI revenues as a % of potential HI revenues</td>
<td>100%</td>
<td>This reveals financial burden</td>
</tr>
<tr>
<td></td>
<td>• total expenditure (incl. reserves payments) as a share of revenues (financial balance of the HI scheme)</td>
<td>&lt; 100%</td>
<td>This indicates whether fiscal space creation via HI contributions is fully realized</td>
</tr>
<tr>
<td></td>
<td>For tax-based financing:  &lt;br&gt; • tax evasion rate</td>
<td>Constant downward trend</td>
<td>How to assess: estimate potential HI revenues by considering potentially eligible members, absence of underreported salaries, maximum number of members paying full contribution rate and government compliance with subsidy obligations</td>
</tr>
<tr>
<td><strong>2. Level of population coverage</strong></td>
<td>For health insurance scheme(s):  &lt;br&gt; • actual members enrolled as a share of eligible members</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>3. Degree of financial risk protection</strong></td>
<td>For health insurance scheme(s):  &lt;br&gt; • total treatment costs minus cost sharing as a share of total treatment costs</td>
<td>≥ 70%</td>
<td>Cf. Carrin and James (2005)</td>
</tr>
<tr>
<td><strong>4. Level of equity in health financing</strong></td>
<td>For health insurance scheme(s):  &lt;br&gt; • insurance premiums + co-payments as a share of household income</td>
<td>Insurance premiums and co-payments for insurance covered services as a share of household income are at least proportional. Premium subsidies, different co-payment rates and exemption mechanisms for the poor and low-income people are in place</td>
<td>Ct. WHO (2000)</td>
</tr>
<tr>
<td><strong>5. Level of pooling across the health financing system</strong></td>
<td>For tax-financed MOH service provision:  &lt;br&gt; • MOH/GGHE minus SHI funds (role and importance of MOH)</td>
<td>≥ 90%</td>
<td>UK’s National Health System expenditure as a share of GGHE is 90% and can be used as a benchmark (2007 NHA data; WHO 2010b). If lower, fragmentation within government may be a concern</td>
</tr>
</tbody>
</table>

While these indicators cannot be considered as health financing performance indicators for the system as a whole, they do point to more effective functioning and performance of a specific health financing scheme.
6. Level of operational efficiency and
7. Level of equity in the delivery/consumption of a given benefit package at a given level of quality standards

8. Degree of cost effectiveness and equity considerations in benefit package definition

9. Level of administrative efficiency

For all health insurance schemes of the same type:
- total administrative costs as a share of total expenditure per year ≤15% (in first years), then declining by 0.1% per year on average, in mature stage: 6–7%

For each health insurance scheme:
- administrative costs as a share of total expenditure per year ≤15% (early years), then declining 0.1% per year on average, in mature stage: 6–7%
- total accumulated reserves as a share of expected total expenditure per year 25% for very small schemes or those in their initial years, 8% for more established systems
- amount of benefits as a share of total expenditure per year 100 - (administrative costs + annual reserves payment as share of total expenditure per year)

Table A3 Types of health financing rules and respective rule elements

<table>
<thead>
<tr>
<th>Types of rules related to health financing functions</th>
<th>Elements to be specified by the rules inter alia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue collection</strong></td>
<td></td>
</tr>
<tr>
<td>Taxation rules</td>
<td>Tax types, taxation rates, tax basis, population/income groups eligible for taxation</td>
</tr>
<tr>
<td>Resource allocation rules</td>
<td>Level of public spending on health (e.g. mandated, historical, needs-oriented, aligned with population growth/inflation); resource allocation criteria for decentralized health financing schemes; MOH budget formulation procedures (e.g. top-down, bottom-up), and MOH budgeting formulas (e.g. line items, programmes, other)</td>
</tr>
<tr>
<td>Insurance enrolment rules</td>
<td>Population groups covered, membership basis (e.g. individual, group, family), membership type (voluntary or mandatory), enrolment procedures</td>
</tr>
<tr>
<td>Insurance collection rules</td>
<td>Contribution rates, contribution basis, calculation methods, contribution shares of employee/employer, ceilings, collection methods/points/schedule, exemption criteria, opting out criteria</td>
</tr>
<tr>
<td>Co-payment/user fee rules</td>
<td>Services/benefits requiring co-payments, co-payment schedules, ceilings, fee exemption/waiver criteria and procedures</td>
</tr>
<tr>
<td><strong>Pooling</strong></td>
<td></td>
</tr>
<tr>
<td>Pooling rules</td>
<td>Pools/funds and amounts to be pooled, use of donor funds</td>
</tr>
<tr>
<td>Risk equalization rules</td>
<td>Risk equalization mechanisms and fund transfer procedures, criteria for risk equalization</td>
</tr>
<tr>
<td><strong>Purchasing and provision of services</strong></td>
<td></td>
</tr>
<tr>
<td>Purchasing and provision rules:</td>
<td>Purchasing structure (single or multiple, competing or non-competing), eligibility of providers, provider accreditation, contracting (selective or collective), performance contracts, level of autonomy of providers and decentralized purchasers</td>
</tr>
<tr>
<td>Provider payment rules</td>
<td>Unit being purchased (e.g. inputs, services, outcomes), provider payment mechanism (e.g. capitation, fee for service, diagnostic-related groups), remuneration rates (uniformity or regional differentiation), retrospective or prospective price setting, retrospective or prospective payment, claims management schedule and procedures, claims review, utilization review, payment schedule and transfer procedures</td>
</tr>
<tr>
<td>Rules relating to the benefit package (BP)</td>
<td>Contents, BP limits (e.g. maximum of days, maximum amount, deductibles), definition process and criteria applied, referral system, costing procedures of services and of benefit package</td>
</tr>
<tr>
<td>Rules relating to benefit package consumption</td>
<td>Co-payment rules (see above), patient appeal mechanisms, patient rights, deductibles to induce desired patient behaviour</td>
</tr>
<tr>
<td>Rules relating to fund management</td>
<td>Auditing and other accountability activities, public reporting, performance management, internalization or externalization of surplus or deficit, building up reserves</td>
</tr>
<tr>
<td>Relating and applicable to all of the above rules</td>
<td>Rule monitoring, rule enforcement, penalties in case of non-compliance, data/information management, impact monitoring</td>
</tr>
</tbody>
</table>
Table A4: Examples of bottlenecks in institutional design and organizational practice, possible improvement measures and anticipated impacts on health financing performance related to the collection of (voluntary) informal sector insurance contributions

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>Improvement measures</th>
<th>Anticipated effects on health financing performance indicators</th>
<th>Other possible impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rule absence</strong></td>
<td>Introduction and setting of a new rule or specific rule elements</td>
<td>A new rule is established, ensuring a transparent and predictable collection mechanism.</td>
<td>May overlook need for regional differentiation according to poverty and Other profile.</td>
</tr>
<tr>
<td>There are no specific rules for setting the amount of contributions of informal sector workers. In practice, contributions are set arbitrarily and thus vary from SHI regional office to office.</td>
<td>Specify contribution logic for informal sector workers and define/set contribution amounts.</td>
<td>Increased health financing equity.</td>
<td></td>
</tr>
<tr>
<td><strong>Inadequate rule</strong></td>
<td>Rule redesign</td>
<td>Revisit the contribution logic and informal sector worker contributions and adjust them to their ability to pay.</td>
<td>Increased population coverage, as more informal sector workers may afford to enrol.</td>
</tr>
<tr>
<td>Informal sector worker contributions are set at too high a level, so that membership is unaffordable for most of them.</td>
<td>Revisit the contribution logic and informal sector worker contributions and adjust them to their ability to pay.</td>
<td>Increased resource mobilization. Increased financial risk protection.</td>
<td>More demand for health-care services. Poverty reduction.</td>
</tr>
<tr>
<td><strong>Conflicting or non-aligned rule</strong></td>
<td>Rule alignment</td>
<td>Assess whether other decentralized or local organizations (e.g. NGOs, post-offices) could collect contributions; or set up transparency mechanisms at local government offices to overcome reluctance.</td>
<td>Increased population coverage. Increased resource mobilization through pre-payment.</td>
</tr>
<tr>
<td>Informal sector workers do not like to make contribution payments to the local government offices, which are in charge of local collection. Many therefore refrain from enrolling.</td>
<td>Assess whether other decentralized or local organizations (e.g. NGOs, post-offices) could collect contributions; or set up transparency mechanisms at local government offices to overcome reluctance.</td>
<td>Increased population coverage. Increased resource mobilization through pre-payment.</td>
<td>Strengthening of civil society. Transferring this task to another organization may perpetuate mistrust in local government. Alternatively, improve trust and thus enhance tax morale.</td>
</tr>
<tr>
<td><strong>Weak rule enforcement</strong></td>
<td>Strengthening rule enforcement</td>
<td>Introduce and specify fines for defaulters and increase the number of inspectors/collectors to ensure rule compliance.</td>
<td>Increased population coverage and financial risk protection. Increased resource mobilization through pre-payment.</td>
</tr>
<tr>
<td>Taxi drivers specifically are mandatory members, yet there are no compliance mechanisms to ensure that they register. As a result, many evade enrolment.</td>
<td>Introduce and specify fines for defaulters and increase the number of inspectors/collectors to ensure rule compliance.</td>
<td>Increased population coverage and financial risk protection. Increased resource mobilization through pre-payment.</td>
<td>Some additional employment; other strategies of default will merge.</td>
</tr>
<tr>
<td><strong>Weak organizational capacity</strong></td>
<td>Strengthening organizational capacity</td>
<td>Train or recruit staff with appropriate skills.</td>
<td>More efficient resource mobilization. Reduced administration costs. Other local government functions may equally benefit from the skills enhancement.</td>
</tr>
<tr>
<td>Local government offices are not able to effectively collect contributions from informal sector workers due to lack of skilled staff.</td>
<td>Train or recruit staff with appropriate skills.</td>
<td>More efficient resource mobilization. Reduced administration costs.</td>
<td>Other local government functions may equally benefit from the skills enhancement.</td>
</tr>
<tr>
<td><strong>Dysfunctional inter-organizational relations</strong></td>
<td>Improving inter-organizational relationships</td>
<td>Clarify and specify reporting and communication requirements between the two organizations; identify reasons for misunderstandings.</td>
<td>Reduced administration costs. The local government's experience of improved collaboration and communication practices may also trigger synergies in other areas.</td>
</tr>
<tr>
<td>Working relations between the SHI regional offices and local government offices are poor resulting in delays in exchanging necessary data and information between the two organizations, which slows down the process of collecting contributions and thus increases administration costs.</td>
<td>Clarify and specify reporting and communication requirements between the two organizations; identify reasons for misunderstandings.</td>
<td>Reduced administration costs. The local government's experience of improved collaboration and communication practices may also trigger synergies in other areas.</td>
<td></td>
</tr>
</tbody>
</table>
Annex 2. Data sources

**Legal and regulatory provisions (rules)**
- Health policy, health financing policy.
- Health law.
- MOH regulations/decrees/ordinances.
- Social health insurance act.
- Social health insurance regulations, e.g. relating to:
  - income assessment of the self-employed;
  - calculations of contributions;
  - provider reimbursement schemes and fee rates;
  - benefit package definition process.
- Regulation on pharmaceutical products (price setting, marketing, etc.).
- Private health insurance act, insurance act.
- Summary of tax regulations including income tax, value added tax, and others taxes.

**Other publications, reports and documents**
- Health policy/strategy, health sector plan, health financing policy/strategy and related policy documents (e.g. on user fees, on the essential health packages, quality management).
- Medium-term expenditure plan, public expenditure review.
- Government budget, health sector budget.
- Country databases and statistics (e.g. health management information system for utilization, overview of health workers and facility types and numbers).
- Published literature and non-published country reports.
- Social health insurance reports and statistics.
- National health accounts statistics/reports.
- Household survey, in particular information on:
  - out-of-pocket payments as a share of total household consumption per quintile;
  - out-of-pocket payments components;
  - health care seeking behaviour and health service utilization;
  - catastrophic health expenditure;
  - fairness or equity of health payments.
- Social health insurance strategy plan and annual operation plan.
- SHI statistical yearbooks, with routine statistics for the past 15 years, including for example claims analysis:
  - claims by income group, age group, regions
  - claims by disease classification
  - claims by services (inpatient, outpatient, drugs and tests).
- Joint health sector assessment reports.

During the meetings with the various health financing stakeholders and actors, additional need for reports and data may arise.
**Interviews and discussions**

Depending on the country context and country issues, key health financing stakeholders and actors, key informants and resource persons may comprise the following:

- Ministry of health:
  - departments/divisions of policy/planning, health financing, budgeting;
- Ministry of finance:
  - departments/divisions in charge of budget planning and management, persons in charge of health sector budget;
- Social health insurance scheme(s):
  - departments/divisions of planning, registration, contracting, claims management, quality management, claims management;
- Risk equalization fund managers;
- Revenue authority;
- Social security institutions (including pension schemes;
- Professional associations (e.g. medical doctors, nurses);
- Provider associations;
- Hospital associations;
- Informal sector associations;
- Employer associations;
- Trade unions.
Annex 3. Suggestions for the OASIS in-country work

This section provides suggestions on how to plan and organize the OASIS in-country work and the follow-up work. These suggestions will need to be adapted to the actual country context.

1. Team composition
   - The core team could consist of two to four members: at least one member should be familiar with the OASIS approach; at least one member should be external (i.e. not from the MOH)
   - Members can be drawn from the MOH, MOF and MOL, as well as from social security institutions, or other health financing actors that have a good understanding of the health financing system.
   - All members should be well versed in health financing issues.
   - An extended team could consist of four to six members for internal consultations and reflections, with specific insider knowledge.

2. Planning and preparation process
   - Presentation and explanation of objectives of the OASIS health financing exercise among the MOH counterparts.
   - Alignment and adjustment with the MOH objectives.
   - Clarification of priorities and focus of the analysis.
   - Ensuring that there is a focal point from the MOH.
   - Preparation and agreement of Terms of Reference.
   - Agreement on dates for the in-country work, team members, responsibilities (team leader, senior technical staff as key focal point from the MOH), administrative support (transportation, arranging meetings and appointments with interview/discussion partners, place for the team to meet/work).
   - Preparation and discussion of a draft programme and preliminary time schedule with the key focal point so that some meetings with key health financing stakeholders and actors can be organized in advance (for a sample information letter and a sample Performance of Work Agreement see Annexes 4 and 5).

3. In-country work process
   There are a number of elements that may guide the proceedings of in-country work.
   - Initial, short meeting on the first day at the MOH to brief and discuss objectives, expectations and planning with senior management/directors responsible for health financing.
   - Larger meeting (following the first day’s session) with involved MOH staff and other stakeholders and actors (e.g. representatives of the MOF, SHI agency, etc.) to discuss:
     - the OASIS approach and proceedings;
     - expectations;
     - proposed time schedule for in-country work;
     - key priorities, health financing concerns and focus issues of the OASIS;
     - briefing/wrap-up meeting at the end of the in-country work.
• Updating of programme and time schedule with the key focal point so that meetings with health financing stakeholders and actors are well organized.
• Planning of the briefing/wrap-up meeting: inform and invite participants (key health financing stakeholders and actors); maximum of 20 participants.
• Convening three to five interviews/discussions per day – the team may split into two groups, so that a maximum of three team members attend a meeting.
• Team members should also visit sub-national offices and at least one health facility at lower level.
• Preparation of the questionnaires for next day's meeting.
• Review and completion of the meeting notes; and discussion of initial findings, ideas, contradictions within the team.
• On Day 4 or 5: data entry of collected information into Component 1–3; brainstorming, and possible options and improvement measures relating to institutional design/organizational practice.
• On Day 7 or 8: further completion of Component 1–3, further brainstorming, and possible options and improvement measures relating to institutional design/organizational practice.
• Towards the end of the in-country work: wrap-up meeting to discuss findings and recommendations, and to receive and reflect on stakeholder feedback.
• Final day’s activities: meeting with MOH senior management; discussion of next steps, draft report submission, etc.

4. Interviews and discussions
• Discussion partners should receive a letter that briefly outlines the background and objectives of OASIS and the type of information required.
• The size of the group during interviews/discussions should not be too large to allow for detailed and flexible discussions and questions/answers.
• Ideally, a maximum of three team members should meet a maximum of four discussion partners.
• Meetings should last one to two hours.
• Objectives and the type of questions that the team would like to pursue should be explained.
• Confidentiality needs to be ensured, i.e. information provided cannot be traced back to the originator.
• The division of labour among team members needs to be clarified, e.g. who guides/initiates/closes the discussion, and who addresses which discussion topic.
• All team members should take detailed notes (also quotes if possible), particularly those members not leading the discussion/interview.

5. Report writing and data analysis
• Discuss report writing process and division of labour/responsibilities of each team member – ensure that each team member has a copy of the relevant documents.
• Write report over a period of approximately six weeks.
• Receive comments from MOH and other health financing stakeholders and actors.
• Finalize report by including their comments and feedback.
(See Annex 6 for a standard structure of the OASIS report.)
Annex 4. Information letter to health financing stakeholders and actors

with whom the OASIS team would like to meet

The Ministry of Health of [country] has requested the World Health Organization (WHO) to assist them in undertaking a detailed health financing review as a basis for the further development of a health financing policy.

A team from the WHO regional office and headquarters together with staff from the WHO country office will undertake in-country work in [country] from [dates].

The objective of the work is to:
- assess the performance of the overall health financing system of [country];
- identify and suggest options and improvement measures to increase performance of the overall health financing system or of its respective health financing schemes;
- provide a detailed analysis on the functioning of the health financing system to inform the development of a health financing policy.

A conceptual framework has been developed by WHO for such work to enable a health financing review to be conducted in a systematic and detailed manner.

This health financing review will primarily be based on discussions with different stakeholders and actors for the collection of mainly qualitative information, but will also require the collection of health financing data.

Therefore, the team plans to meet with a wide range of stakeholders and actors (e.g. divisions of the Ministry of Health, district health authorities, community-based health insurance, donor representatives, social health insurance, health-care providers, inter alia) in order to discuss and analyse the current practice in resource collection, pooling and purchasing as well as governance issues, which include:
- collection of resources;
- membership registration by health insurance schemes;
- the process of exemption;
- the level and flows of government funding;
- the flows of donor funding;
- the level of fragmentation between the various health financing schemes;
- the different benefit packages and equity and efficiency considerations related thereto;
- financial risk protection and the level of prepayment versus out-of-pocket payments;
- provider payment mechanisms and claims management;
- mechanisms for rational benefit package consumption;
- overall coordination within the health financing system;
- the role of donors;
- administration and management of health insurance schemes;
- the degree of fair financing and solidarity within the overall health financing system.
A detailed report will be produced after the in-country work and shared among all stakeholders and actors for discussion.

It is assumed that meetings with the various stakeholders will last 1–1.5 hours. For those meetings where specific information and quantitative data is required, WHO will inform the discussion partners accordingly before the meeting.
Annex 5. Example of Terms of Reference for WHO APW

Terms of Reference for
Agreement for Performance of Work (APW)
between World Health Organization
and [name of consultant]

We are glad to collaborate with you in undertaking a health financing systems review in [country]. You will be in charge of collecting information and data on the [country] health financing system and its specific health financing schemes (e.g. tax-financing, social health insurance). This will involve a toolkit called OASIS (Organizational Assessment for Improving and Strengthening Health Financing), which contains key questions to allow for a systematic analysis. Another task is to contribute to the final report of the health financing review. The total sum paid for this work will be US$ [fee] for [xx] days of work.

Detailed Terms of Reference

1. Collecting information and data on key issues relating to health financing, to be filled into the OASIS Excel Aid and by means of a series of key questions provided in Component 1 (Worksheets 1–10)

1. Country information and health systems overview
2. Resource collection
3. External funding
4. Resource pooling
5. Purchasing
6. Benefit package
7. Fund management
8. Governance and stewardship
9. Health financing performance assessment
10. Additional data for performance assessment.

(xx days)

2. Analysis of information and identification of key challenges facing the [country] health financing system

The OASIS Excel Aid Component 1 provides questions for further reflection. These questions can be found in Worksheets 1–10 under the heading of ‘Further questions for reflection’.

(1 day)

3. Contribution to writing analysis report including

• Data description, stakeholders and actors met, methodology.
Results of analysis (include all aspects mentioned above).

(XX days)

4. Submitting the following products to WHO

- OASIS-Excel Aid Component 1 with data entered.
- Specified contributions to the analysis report.

Additional tasks in parallel
WHO’s Department of Health Systems Financing (HSF) seeks to further develop user friendliness of OASIS. The consultant is asked to stay in close contact with the OASIS team, provide feedback on the application process and raise any questions or comments regarding Component 1. Unclear issues should be clarified during this work process.

Requirements
The consultant should have ample and in-depth knowledge of the [country’s] health sector and the health financing system. S/he should also be familiar with the [country’s] health policy and health financing policy as well as with household survey results and national health accounts. Finally, s/he should able to read and understand English and be conversant with the text functions of Excel.

Please note that the results of this review will be used in an official publication. Therefore, it is essential that any data and information obtained has the necessary release authorization for publication and that any of the findings using WHO methodology will not be used for other purposes or publications without prior consent from WHO. Authority for finalization of the results for use in an official publication will reside with WHO.
Annex 6. Standard structure and table of contents of the OASIS health financing system review report

Table of contents
List of tables and figures
Abbreviations
Acknowledgement
Executive Summary

Section I: Introduction

Chapter 1: Overview
1.1. Objectives of the report
1.2. Conceptual framework and methodology

Chapter 2: The health system
2.1. Health system inputs
   2.1.1. Health care infrastructure
   2.1.2. Human resources
   2.1.3. Other inputs
2.2. Health indicators and health system outputs
   2.2.1 Health outcomes
   2.2.2 Health service utilization
2.3. Health care expenditure
2.4. Summary

Section II: Institutional and organizational analysis of the health financing system

Chapter 3: Overview of the health financing system
3.1. Current situation and challenges-Korea's quick move to universal coverage
3.2. Key health financing actors
3.3. Previous health financing reforms and remaining key issues

Chapter 4: (for example) Tax-based health care financing
4.1. Resource mobilization
4.2. Pooling and degree of fragmentation in tax-based health financing
4.3. Benefit package
4.4. Purchasing and payment mechanisms
4.5. Social assistance programs-Medical Aid

Chapter 5: (for example) Social Health Insurance
5.1. Resource mobilization
   5.1.1. Enrolment and membership basis
   5.1.2. Collection of contributions
   5.1.3. Government subsidies
5.2. Pooling and level of fragmentation
   5.2.1. Pool composition
   5.2.2. Cross-subsidization and government subsidies
5.3. Purchasing
   5.3.1. SHI benefit package
   5.3.2. Purchasing structure and mechanisms
   5.3.3. Provider payment mechanisms
   5.3.4. Claims management and review
   5.3.5. Quality management
   5.3.6. Rational benefit package consumption

Chapter 6: (for example) Private health insurance
6.1. The development of private health insurance
6.2. Role of PHI and challenges

Chapter 7: Stewardship of the social health protection system
7.1. Regulation and monitoring of providers
7.2. Governance and administration structures
7.3. Stewardship tools and decision-making space

Section III: Assessment and the Way Forward
Chapter 8: Health financing performance assessment
8.1. Sufficient resource mobilization
8.2. Population coverage
8.3. Degree of pooling within the health financing system
8.4. Financial risk protection
   8.4.1. Prepayment ratio
   8.4.2. Out-of-pocket payments and catastrophic expenditure
8.5. Equity in health financing
8.6. Efficient delivery of the benefit package

Chapter 9: The Way Forward
9.1. Summary of achievements and challenges
9.2. Reflections on the way forward
9.3. Anticipation of future issues
References

Annex
Annex 7. Additional guidance for the use of the OASIS Excel Aid – Component 1

Health financing review and performance assessment

with a definition and rationale of health expenditure indicators and explanations of guiding questions

Module 1. Basic economic and health system information

Note that, unless otherwise stated, all definitions are those of the National Health Accounts (NHA) framework (WHO 2003).

1. Currency
   Indicate the national currency and its exchange rate in US dollars.

2. Gross domestic product (GDP) growth rates
   Annual percentage growth rate of GDP measures the growth of overall economic resources per capita and, thus, provides an indication of whether resources for health per capita would be able to grow as well.

3. Population data
   
   Total population
   This is the total population of a country including all residents regardless of their legal status or citizenship. This indicator is one of the determinants of general health-care needs in the country.

   Population growth rate (%)
   Population growth rate ordinarily refers to the change in population over a time period, expressed as a percentage of the number of individuals in the population at the beginning of that period. This indicator captures the number of births and deaths during the period, and the number of people migrating into and out of a country.

   Economically active population
   The economically active population comprises all persons of either sex above a specified age who provide the supply of labour for the production of economic goods and services (employed and unemployed, including those seeking work for the first time) during a specified time period.

---

8 Prepared by Sophie Wanert in collaboration with Inke Mathauer.
Informal sector (%)  
The informal sector comprises all individuals not working in the public service, in parastatals or in the formal sector (the latter comprising all registered companies that pay corporate tax). This also includes subsistence farmers. It is given as a share of the economically active population.

Formal sector (%)  
The formal sector comprises all individuals working in the public service, in parastatals or in the formal sector (the latter comprising all registered companies that pay corporate tax). It is given as a share of the economically active population.


4. Income  
Average household income of income quintiles in national currency unit (NCU)  
Income can be defined as ‘gross’ (before taxation) and ‘disposable’ (after taxation). This table refers to disposable income that households in each income quintile have on average for expenditure (in NCU).

The society under investigation can be split into five segments, i.e. into quintiles (or any other percentage of population). Each segment contains the same share of income earners (households).

Household income of income quintiles in % of total national income  
In case of unequal income distribution, the shares of income available in each segment are different.

Suggested data sources: country household survey data and reports.

5. Health infrastructure  
Total number of facilities  
Total number of facilities at different levels: health posts, health centres, district hospitals, provincial/referral hospitals and national hospitals.

Total number of facilities in different sectors: public, private for-profit, private not-for-profit (including NGO/faith-based organizations), other, and differentiated along urban and rural locations.

Total number of hospital facilities  
Number of hospital beds per 10 000 population.

\[
\left( \frac{\text{Total number of beds in hospitals of all levels}}{\text{Total population of country}} \right) \times 10,000
\]
Hospital beds include inpatient beds available in public, private, general, and specialized hospitals and rehabilitation centres. In most cases, beds for both acute and chronic care are included. Inpatient bed density can serve as one of the proxies for availability of health service delivery. The greater the number of hospital beds, the greater availability of inpatient health services (Islam 2007).


6. Human resources for health

In this table, the numbers for each of the health worker categories is to be entered, ideally differentiated for the public, private-for-profit, private-not-for-profit sector, or other type of sector.

**Physicians**
This includes generalists and specialists.

**Nursing and midwifery personnel**
This includes professional nurses, professional midwives, auxiliary nurses, auxiliary midwives, enrolled nurses, enrolled midwives and other personnel, such as dental nurses and primary care nurses. Traditional birth attendants are not included here but are included as community/traditional health workers (see below).

**Dentistry personnel**
This includes dentists, as well as dental assistants and technicians.

**Pharmaceutical personnel**
This includes pharmacists, pharmaceutical assistants and technicians, and related occupations.

**Environment and public health workers**
This includes environmental and public health officers, environmental and public health technicians, sanitarians, hygienists, district health officers, public health inspectors, food inspectors, malaria inspectors and similar professions.

**Community health workers**
This includes community health officers, community health education workers, community health aides, family health workers, health extension package workers, community midwives, and associated occupations.

**Laboratory health workers**
This includes laboratory scientists, laboratory assistants and technicians, radiographers and related occupations.

**Traditional health workers**
This includes traditional and complementary medicine practitioners, traditional birth attendants and associated occupations.

**Other health workers**
This includes a large range of other cadres of health-service provider such as medical assistants, dieticians and nutritionists, occupational therapists, operators of medical and dentistry equipment, optometrists and opticians, physiotherapists, podiatrists, personal care workers, psychologists, respiratory therapists, speech pathologists, and medical trainees and interns.

**Staff ratios per 1000 population**
The density of health personnel, typically measured as the ratio of health workers (i.e. the number of nurses and doctors) to total population, expressed per 1000 inhabitants, is a simple yet highly informative measure of the population’s access to health-service providers. The regional averages allow for comparison to see how a country performs in this respect.


7. **Structure of (government) health-care provision**
The description of the structure of government health-care provision (e.g. the degree of financial and administrative decentralization; the number of sub-national units, such as provinces and districts; and the degree of hospital/health centre autonomy) is important to understand the context for health financing.

*Suggested data sources: legal provisions and reports on decentralization of health districts.

8. **Overview of health financing actors involved in health financing functions**

*In this table, for each health financing function (resource collection, pooling and purchasing), note all the relevant health financing actors as well as groups involved. Examples are provided in the table.*

This table serves to provide an initial overview of the actors involved, their (multiple) involvement in the three health financing functions, and possible overlaps or gaps. There is a multitude of actors, with different roles in health financing as beneficiaries, payers, providers, policy-makers and stewards. This also includes the health financing agents that directly manage funds (resource collection, pooling and purchasing).
Module 2. Resource collection

1. Key health expenditure statistics

*Suggested sources for all key health expenditure data:* WHO National health accounts estimates (NHA) [http://www.who.int/nha/en/] or detailed NHA country reports. These data can be compared with expenditure levels of countries from the same region or of countries at similar income level.

The following definitions are taken from the WHO *Guide to producing national health accounts* (WHO 2003) and *WHO national health accounts* [http://www.who.int/whosis/indicators/compendium/2008/3exo/en/].

**Total health expenditure (THE) as % of GDP**
Total health expenditure is equal to the sum of general government health expenditure (GGHE) and private health expenditure (both include expenditure by donors).

THE as % of GDP measures how much a nation spends on its health system.

**THE per capita (p.c.) in US dollars (exchange rate)**
Total health expenditure per capita is derived by dividing per capita total health expenditure in local currency units by the ‘international dollar exchange rate’, which is an estimate of the purchasing power parity of the local currency compared to US dollars. It is an exchange rate that minimizes the consequences arising from differences in price levels between countries. Higher THE per capita is generally (but not always) associated with better availability and quality of health care.

**GGHE as % of general government expenditure (GGE)**
General government expenditure (GGE) corresponds to the consolidated outlays of all levels of government – territorial authorities, social security institutions – and extra-budgetary funds, including capital outlays.

The share of GGHE in GGE provides information on the importance governments place on health.

This indicator illustrates the commitment of governments to the health sector relative to other commitments reflected in the total government budget. The allocation of government budget to health is subject to political influences and judgments about the value of health spending relative to other demands for public sector spending. Note here that for the African region, the Abuja Declaration proposes a minimum share of 15% (Kirigia et al. 2006).

**General government health expenditure (GGHE) as % of THE**
General government health expenditure comprises the sum of outlays for health maintenance, restoration or enhancement paid for in cash or supplied in kind by government entities, such as the ministry of health, other ministries, parastatal organizations and social security agencies. It also includes transfer payments to households to offset medical care costs and extra-budgetary funds to finance health services and goods. The revenue base of these entities may comprise multiple sources, including external funds.
General government health expenditure as a percentage of the total health expenditure is a measure of the contribution of central and local government relative to total health spending.

**GGHE p.c. in US dollars**
The general government health expenditure per capita is derived by dividing GGHE by population.

**Out-of-pocket health expenditure (OOP) per capita**
Out-of-pocket health expenditure is the direct outlay of households, including gratuities and payments in kind, made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances and other goods and services, whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. It includes household payments to public services, non-profit institutions and nongovernmental organizations. It includes non-reimbursable cost sharing, deductibles, co-payments and fee-for-service, but excludes payments made by companies that deliver medical and paramedical benefits, whether required by law or not, to their employees. It excludes payments for overseas treatment.

Out-of-pocket health expenditures per capita are derived by dividing total OOPs by the total population. The level of OOP health expenditure per capita signals to what extent households need to pay directly at the time of seeking care. A relatively high level of OOP per capita is likely to be a barrier to accessing health services and can threaten the financial status of the households and push them into poverty.

**Out-of-pocket health expenditure as % of THE**
This indicator measures private, non-pooled expenditure relative to total spending on health. The higher this percentage, the less people are financially risk-protected. In general, it also points to a limited level of pooling of resources for health.

**GGE as % of GDP**
General government expenditure as percentage of gross domestic product measures the total resources in the economy that are spent by the government and parastatal agencies.

**Social security funds for social health insurance (SHI) as % of GGHE**
Social security funds for health comprise the expenditure on health by social security institutions. Social security or national health insurance schemes are imposed and controlled by government agencies for the purpose of providing social benefits to members of the community as a whole or to particular segments of the community. They include direct outlays to medical-care providers and to suppliers of medical goods as well as reimbursements to households and the supply of services in kind to the enrollees.

This indicator measures in particular the relative importance of social health insurance in the total of general government health expenditure.

**GGHE minus SHI funds as % of THE**
This indicator gives an idea on the amount of general government expenditure on health usually from tax revenues. In other words, it is the amount directly spent by government (usually the ministry of health, the ministry of education, or the ministry of defence, etc.).
Private health expenditure (PHE) as % of THE
Private health expenditure is the sum of outlays for health by private entities, such as commercial or mutual health-insurance providers, non-profit institutions serving households, resident corporations and quasi-corporations not controlled by government with health services delivery or financing, and direct household out-of-pocket payments (NHA definition, WHO 2003).
This indicator points to the role of the private health financing in total health expenditure and the further challenge to develop prepayment schemes with compulsory membership.

Estimated tax evasion rate (%)
Tax evasion may be substantial in a number of countries depending on the level of enforcement of tax collection rules.

Suggested data source: country MOF analysis, IMF and World Bank reports

Foregone GGHE given the estimated tax evasion rate (in NCU)
This can be calculated by multiplying GGHE with the estimated tax evasion rate.

Estimated evasion in social security funds collection (in NCU)
Incomplete registration of eligible SHI members and underreporting of salaries/income are the main factors for resource collection below actual potential. Evasions can be estimated by the following steps: (1) multiplying the estimated number of non-enrolled members by their mean contribution amount; (2) multiplying estimated total underreported incomes by the average contribution rate.

2. Health financing sub-systems (health financing agents)

This table provides examples of key health financing subsystems. The term health financing subsystem is used to refer to the type of health financing, in contrast to a specific health financing scheme, which relates to a specific entity/organization within a subsystem.

Health financing subsystems comprise health financing agents, which are organizations and entities that pay for or purchase health care, including organizations that pool health resources collected from different sources, as well as entities (such as firms) that pay directly for health care from their own resources (WHO 2003). Households paying out-of-pocket expenditure constitute health financing agents, but are not considered for the following table (Section 3), which only looks at explicit health financing organizations.

Examples given include tax-based health-care provision via the ministry of health, local governments or other central ministries, private health insurance, social health insurance, community-based health insurance, employer-based health service provision, and not-for-profit organizations financing health service provision. In reality, these categories may not be so clear cut.
3. Resource collection

In order to gather information on resource collection, list the dominant and relevant health financing subsystems in the column headings. The examples from the previous section may provide guidance. Questions relate to each health financing subsystem.

Stewardship aspects

Legal status (public or private)
What is the legal status and ownership of the organization (public, semi-public, private)?

Actor in charge of oversight
Which body or organization is in charge of overseeing the health financing sub-system?

Collection aspects

Collected funds as % of THE
What is the amount of revenue collected by this health financing subsystem as a share of THE? The NHA figures, in particular the Health Financing Source-Health Financing Agent-table will help answer this question. National health accounts figures are expenditure-based. It is important to note that in most cases, expenditure corresponds to revenue collected, but there may be differences, especially in a health insurance fund with a surplus/deficit running.

Revenues collected (NCU)
What is the actual amount of financial resources or funds collected (in national currency units)?

Potential revenues (NCU)
What is the estimated potential amount of funds that could be collected (in national currency units)? The difference from actual revenues may be due to, for example, tax evasion (for tax-based financing), evasion from paying premiums\(^9\) or incomplete member registration of eligible beneficiaries (for health insurance schemes), or other factors that decrease revenue collection.

Main collection mechanism
How are resources collected and through which collection mechanism? This may include general taxes, specified taxes, payroll deductions, enterprise funds for health care of employees, etc.

Collecting organization
Which organization is in charge of collecting funds? This may be the health financing scheme itself, or other organizations specifically in charge of mobilizing resources for health insurance schemes, for example, the revenue authority (for tax-based financing), intermediaries like post-offices, banks or NGOs.

---

\(^9\) The term ‘premium’ is used for health insurance contributions, whether for private insurance schemes, community-based health insurance, or social health insurance schemes.
**Contribution amount/rates**
What is the level of prepaid payments/contributions by beneficiaries – expressed as % of income or salary, where appropriate (for taxes and health insurance premiums). Alternatively, prepaid contributions/payments may be fixed (flat amount).

**Contribution maximum (where relevant)**
What is the maximum payment/contribution? What is the ceiling?

**Contribution minimum (where relevant)**
What is the minimum payment/contribution?

**Health financing sources**
Where are the resources coming from that are going to the health financing subsystem/scheme? They could come from subsidies from government revenue or from health insurance revenues, taxes, premiums (through payroll deductions or direct collection), grants from donors, or donations from the private sector.

**If relevant, source of subsidies**
If the health financing subsystem receives subsidies, where do they come from? For example, they could come from general or specified taxes (from government), or specific donor funds (external resources).

**Amount of subsidies (in NCU)**
If the health financing subsystem or scheme receives subsidies, what is the amount (in national currency units)?

**External resources**
Does the health financing subsystem receive external resources, if so, from whom and how much?

**Coverage aspects**

**Type of ‘membership’**
What is the basis for and type of ‘membership’, i.e. on what basis are people eligible for access to care by the health financing subsystem? This could be by residency for tax-based financing, or mandatory for specific population groups for health insurance schemes, or voluntary.

**Number of persons actually covered**
How many people are actually covered by this health financing subsystem?

**Number of eligible persons to be covered**
This information indicates how many persons are actually eligible, yet are not covered. The reasons could be multiple, for example, they are neither registered (in insurance schemes) nor reached (in tax-based financing).

**Suggested data sources:** reports, health financing reviews, NHA statistics/report), and interviews and discussions with representatives from health financing schemes.
4. External resources for health

This section and the data on external resources for health serve to assess the financial importance of external funding for health and its sustainability.

*External resources for health as a percentage of THE*

The share of total health spending financed by external funding from international agencies and foreign governments gives an idea of the country's current reliance on external funding for health. The total amount of external funding on health comprises all funding provided from external health financing sources.

*Budget support as a share of GGE*

The amount of budget support as a share of general government expenditure provides an idea of the government's dependency.

*Sector budget support for health as a share of GGHE*

The amount of sector budget support as a share of general government expenditure for health provides an idea of the government's dependency.

*Suggested data sources:* national health accounts, government budgets and MOH reports/statistics on external funding.
Module 3. External resources for health and coordination of development partners

1. Coordination of development partners in the field of health financing

This table helps to outline the government's coordination of development partners in the field of health financing. If there are several organizational actors in charge of coordination (i.e. ministerial or other government divisions), please use both columns provided. If there is no specific actor in charge of donor coordination relating to health financing, take note of this and respond to the questions relating to coordination in the health sector.

*Which ministerial division(s) is in charge of coordination of development partners?*
This helps to assess whether there is a clearly defined unit in charge of coordination.

*What are the key activities of the division?*
Describe how and through what means and instruments the donor coordination division operates. For example, this could involve conducting a SWAp, the organization of regular donor meetings, the management of a database and reporting system of donor activities, etc.

*Are there sufficient staff for coordination?*
Describe how many staff work in the coordination division(s) and assess whether these resources are sufficient.

*Is there a database of all information on development partners?*
This reveals whether the coordinating division is on track with the development partners' activities.

*Is there a SWAP or aid coordination framework for health (financing) in place?*
This indicates whether there are efforts to coordinate activities in the field of health (financing).

*What are the key issues in donor coordination for health financing?*
List the key issues on which government coordination focuses in the field of health financing.

2. Overview of development partners in health financing

This table will provide an overview of donors/development partners and the level of funding they provide as well as their activities in the field of health financing.

*Donor/development partner (Column B)*
List the name of the donor/development partner.

*Amount of funding (Column C)*
List the amount of funding provided by this donor/development partner (in NCU).
**Type of funding (Column D)**
Describe the type of funding. This could be general budget support, health sector budget support, programme financing subsidies or in-kind (staff, medical supplies).

**Receiving agent (Column E)**
Specify which organization receives the external funding. This could be the ministry of health at the central level, a province or a specific health district at sub-national level, the ministry of finance, as well as NGOs.

**What is being funded with the donor/development partner's funding? (Column F)**
Explain which programmes, activities or items are being financially supported.

**Are health services directly purchased or provided by the development partner? (Column G)**
Specify whether the donor or development partner directly purchases services.

**Other issues (Column H):**
Any other issue of relevance can be noted here.

### 3. Coordination among (within) development partners

This section serves to collect information on the coordination efforts among and within the group of development partners working in the field of health financing.
Module 4. Pooling

While one specific pool may be composed of a good balance of high and low risks, the overall health financing system may still suffer from a high degree of segmentation, as its different pools may differ substantially in risk composition and available resources per risk unit. Thus, there is a need to look at both the system and the subsystem level.

This module is divided in two parts:
1. the level of risk pooling **across** the health financing system;
2. the level of risk pooling **within** specific health financing subsystems.

Indicators for higher level of segmentation across the health financing system:
- several funds, no pooling, no risk equalization;
- despite lack of pooling and risk equalization, fragmentation may be less of a concern, if a similar benefits amount is available per beneficiary, when taking into account their health risk profile.

1. Segmentation across the health financing system

The table and set of questions facilitate the assessment of the level of fragmentation across the health financing system.

*How many pools/schemes are there in each subsystem?*
There may be several, separate pools in a health financing subsystem. In a primarily SHI-dominant scheme, there may be one SHI fund, several or several hundred (as in some countries). Or a SHI scheme may be based on several sub-pools. The same may be the case for other types of health insurance schemes.

Tax-financed government health care provision may be divided across sub-national units (e.g. territorial local governments or health districts), thus operating as sub-pools, or even as a separate pool with no linkages to other sub-national units.

*What links are there between the pools/schemes within a subsystem?*
There may be several (sub-)pools within a health financing subsystem. These may operate as separate pools, or they may be linked to each other (through risk equalization or ex-post risk sharing) and/or to the central pool through central allocations.

*How many beneficiaries are there as % of population?*
Estimate the share of the population covered by this health financing subsystem. This figure was already collected in Module 2 (Resource collection).

*What is the expenditure as % of THE?*
What is the expenditure by this health financing subsystem as a share of THE? This figure was already collected in Module 2 (Resource collection). The expenditure-based NHA figures, in particular the Health financing sources-Health financing agents-table will help answer this question. In most cases, these correspond to revenue collected, but there may be differences, especially in a health insurance fund with a surplus.
Comparing the percentages of expenditure and beneficiaries for each subsystem and across subsystems gives an initial idea of whether resources are equally spent across the population. If proportions are not similar, then the amount spent per person is not equal. This is particularly the case if health financing schemes with higher expenditure per pool member have lower health risks in their pool.

The comparisons may need to take into account the fact that certain health financing schemes provide only limited coverage. Consequently, fund members may also seek care from other health financing schemes, for example, from tax-financed government health services or from the private sector.

**What is the average amount spent per beneficiary (excluding administrative costs)?**

This can be calculated as follows:

\[
\frac{\text{Yearly pool expenditure} - \text{administration costs}}{\text{Number of beneficiaries}}
\]

This formula is the operationalization of the health financing performance indicator ‘Level of pooling’ (compare also with Module 9. Health financing performance assessment).

Together with the following two questions on the health risk profile of pool membership, it can be estimated whether differences in spending per member between pools assumingly increase or decrease. This reveals the inequity in health spending per member.

**Suggested sources:** national health accounts, MOH reports and health insurance statistics.

**What occupation groups are there in this pool?**

These could be, for example, civil servants, teachers, private sector employees, mine workers, informal sector workers and the unemployed. The type of key occupational groups in a pool can provide an idea of the health risk composition of this pool.

**Which of these subsystems contains the lowest health risks?**

In accordance with the previous question, please rank the different health financing subsystems.

A score of 1 could be given to the sub-system with a pool of low risk persons (usually a pool of primarily younger and healthier people), and the highest score to the sub-system with the pool that contains the highest health risks (usually a pool of primarily older and less healthy people, or workers with greater exposure to health hazards).

**Are there differences between pools of the same sub-system?**

Schemes/pools within a sub-system may show differences, e.g. in terms of contribution rates, membership eligibility, enrolment regulations, benefit package contents etc.

**Does cream-skimming take place?**

Do the schemes engage in cream-skimming (risk selection) efforts in order to have only pool members with low health risks?
2. Pooling / risk equalization mechanism(s)

This table and set of questions seek to collect information on the existence and governance of a pooling agency or risk equalization agency.

*What is the name of the organization or mechanism?*
Spell out the name of the pooling or risk equalization organization / mechanism.

*What legal provisions are in place (specify act, decree, other)?*
Is there a legal provision for pooling or risk equalization mechanism? For your reference, note down the specific paragraph, act, decree, other.

*What is the type of ownership (semi-/public, private)?*
Specify whether the agency is a (semi-)public or private organization.

*Which body is in charge of oversight?*
Describe which organization oversees and is being reported to by the pooling/risk equalization agency.

*How much and what types of funds go into pooling or risk equalization?*
Specify which health financing subsystems or schemes are part of the pooling / risk equalization mechanism.

*What are the criteria being used for risk equalization?*
List the key criteria (risk adjusters) being used for the risk equalization mechanism.

3. Pool composition: level of fragmentation within a health financing scheme

This section serves to analyse the fragmentation with a health financing scheme.

3.1 Health insurance

Table 3.1 may need to be completed several times if there are several insurance scheme types or different insurance schemes with differing pooling rules. Two tables are provided (see ‘For a second, different health insurance scheme’).

*For additional schemes to be assessed, you may copy this table.*

To assess fragmentation within a health insurance scheme, the indicators below assist. *You can then mark the relevant cells. The overall degree of pooling is higher if most criteria related to a higher degree of pooling are fulfilled.*

*Type of membership*
Is membership compulsory or voluntary? Compulsory membership tends to lower fragmentation; voluntary membership may cause adverse selection, thus increasing the level of fragmentation.

*Membership unit*
Is the membership unit the family, is it via groups, or is it individual membership? Family membership (covering dependents) or group membership usually increases both income and risk solidarity and thus enhances pooling, whereas individual membership increases fragmentation.
If voluntary, do individuals have to join via any type of group? Yes or No. While voluntary membership is associated with a higher level of fragmentation, voluntary membership via a group reduces this effect. Group affiliation may be based on or related to one's employer, profession or a professional association, membership of a self-help group/income generating group, or of a village community, etc. Membership via a group increases both income and risk solidarity.

Contribution rules
Are contributions proportional to wages/salaries or income, or is it a flat rate contribution? A scheme based on contributions that are proportional to wages/salaries or income enhances income solidarity and thus reduces fragmentation.

Is opting out possible for certain (income) groups?
Can certain population/income groups (e.g. civil servants, persons above a certain income threshold) opt out? If opting out of high-income groups is allowed, income solidarity reduces and hence the level of fragmentation increases.

3.2 Resource allocation in tax-based health financing

Table 3.2 assesses the level of fragmentation within tax-based health financing for health service provision, specifically in relation to how resources are allocated to sub-national government purchasers (e.g. health districts).

The indicators below assist in the assessment of fragmentation.

What are the criteria for resource allocation to sub-national units?
What resource allocation criteria are applied to allocate resources to sub-national purchasers? When criteria take account of socioeconomic and epidemiological profiles, health-care needs, population data and related aspects, expenditure per pool member adjusted for health risks will be more equal across sub-national pools, hence fragmentation will be lower. In contrast, if resource allocation is mainly based on historical budgeting, expenditure per pool member adjusted for health risks will be less equal across sub-national pools, hence fragmentation will be higher.

What is the level of pooling?
If funds are pooled at national level rather than at sub-national level, the degree of pooling is higher.

Is there (ex-post) adjustment of resource allocation?
If there is some ex-post adjustment of resource allocation to account for unexpected or high cost expenditure, the degree of pooling is higher. However, ex-post adjustment may lower incentives for efficient fund management.
Module 5. Purchasing and provider payment mechanisms

1. Purchasing structures

The questions below should be answered for each respective health financing subsystem. Therefore, please type the relevant health financing subsystems into the column headings (these should be the same as in C1-Module 3. Resource collection). Add more columns if necessary. Answers should be provided for the dominant scheme or the most common schemes within each subsystem.

For outpatient care

Stewardship aspects

What are the legal provisions for purchasing?
Indicate the legal provisions and regulations for purchasing. The purchasing structure, process and mechanisms may be specified in a legal document.

Which organization is in charge of regulating the purchasing function?
This may be the steward or the organization overseeing the health financing subsystem/scheme, or it may be another organization.

Which purchasing aspects are being regulated?
Legal provisions including regulations may be very detailed and provide specifications on a wide range of purchasing aspects, i.e. on the overall structure (see below), the provider payment mechanisms, the contracting process and contract types, and on the remuneration rates and how they are determined, etc. However, these aspects may not be defined in detail.

Purchasing aspects

Which organization is purchasing?
Does the health financing scheme undertake the purchasing or is this task delegated or transferred to another organization?

Are there single or multiple purchasers? At what levels (centralized or decentralized)?
What is the market structure of purchasing organizations? Is there a ‘single payer’ covering the population in a defined geographical area? Or are there multiple insurers (Kutzin 2001:181)?

If there are multiple purchasers, are they competing or non-competing?
When there is a multiple purchaser system, purchasers may compete for ‘market share’, or persons may be assigned to them in a non-competitive way (Kutzin 2001:181).

Is there in-house service provision or a purchaser-provider split?
Does the health financing scheme provide services directly, or is there a split, i.e. are providers organizationally separate from the purchaser?

If split, is there selective or collective contracting?
Do purchasers (have to) apply one uniform contract with all (eligible) providers or can they have specific contracts with selected providers?
How many contracts do purchasers have to manage?
If selective contracting is in place, then the purchaser has to manage and administer a much larger amount of contracts.

From which provider types can purchasers buy services (i.e. which providers are eligible)?
Are all providers or provider types eligible, or can services be purchased only from selected (pre-accredited) providers or specific provider types? There may also be limits to the numbers or geographical locations.

Is there competition or a monopoly in service provision?
Do patients have a choice between different providers within their area, i.e. do providers compete with each other for patients within their catchment area? Or do patients have, in practice, little choice of a provider, i.e. a provider has a ‘monopoly’ in practice?

Are services available across all geographical areas?
It is important to know whether beneficiaries of a certain health financing sub-system have access to services wherever they are, even in remote areas.

How much financial autonomy do the service providers have?
Can providers take their own financial and managerial decisions, or do they depend upon a higher level organizational unit?

Are contract negotiations with individual providers or provider association?
Does the health financing scheme negotiate contracts directly with providers or with an umbrella organization of providers?

Are contract negotiations carried out by individual purchasing actors or by an association of purchasers?
Social health insurance funds may be represented by an umbrella organization. If several schemes belong to one health financing sub-system, there may be an umbrella organization that negotiates collectively for them or, alternatively, each scheme may negotiate separately. Likewise, in tax-based financing, provincial health authorities may have the discretion to design contracts with health providers, or alternatively all have to apply one contract type.

For inpatient care or tertiary care
If these levels of care are organized differently, please answer the same questions as above for higher levels of care.

2. Provider payment mechanism (PPM)

List the health financing sub-system with which each provider type deals.
The column headings suggest a number of provider types that may be relevant in a country.
• Government health centres.
• Government hospitals.
• Private clinics.
• Private hospitals.
• Not-for-profit clinics.
• Not-for-profit hospitals.

However, you may want to change the column headings to include the provider types important in your context – you may also want to add columns. As a next step, list the main PPM relating to each of the above health financing sub-systems.

Suggested data source: Interviews/discussions with key health financing stakeholders, legal provisions, and country study reports.
Module 6. Benefit package

The questions below should be answered for each health financing sub-system. Therefore, please type the relevant health financing sub-systems into the column headings (these should be the same as in C1-3. Resource collection). Add more columns if necessary. Answers should be provided for the dominant scheme or the most common schemes within each sub-system.

1. Benefit package (BP) contents, definition process and costing

Please note that a benefit package (BP) is not (re-)defined every year. A BP may be in place for several years before being redefined or revised. However, each year, there may be reflections on whether to add new services or medicines.

Contents

What is the policy basis of the benefit package content?
Is there a policy basis or further policy specifications for the benefit package contents? Please outline these.

What are the legal provisions/regulations of the BP content/definition process?
Are there further legal provisions or regulations for the BP content or definition process and, if so, what do they say?

Summarize the BP contents. Which services are (not) covered?
Please outline the BP contents. Are included services explicitly listed and, if so, which one? Are excluded services explicitly listed and, if so, which ones?

Are there different BPs for different population groups?
Does the health financing sub-system/scheme differentiate the BP for different population groups?

How is secondary and tertiary care accessed?
Can beneficiaries directly use health services at secondary and tertiary care level or is there a functional referral system in place, a gatekeeper, or pre-authorization required to access higher level care?

Is there a limit on the benefits that form part of the BP? (If so, see next question.)
Are benefits and BP services limited?

What type of limit is it (e.g. maximum number of inpatient days, financial maximum, co-payments, and deductibles)?
These limits could constitute a financial maximum, a number of maximum (inpatient) days to be covered, or deductibles / co-payments.

Summarize co-payment system. What rates are applied?
Please outline the principle of the co-payment system. Is it a flat rate amount, or is it a percentage applied to the total health service costs? Please specify the rates.

What is the rationale for the BP definition and contents?
Is it about rationing or about providing a (minimum) essential package?
**Definition process**

*Which organizations or actors are in charge of defining the BP?*
Does the health financing scheme define and specify its BP (within the policy framework and legal/regulatory provisions) or is this task delegated or transferred to another organization/body?

*What are the specific criteria used to define the BP?*
Which criteria guide the definition process? These could include, for example, cost-effectiveness, equity, or the disease burden of the poor.

*What are the procedures for BP definition?*
Are there specific procedures or guidelines that direct the process of defining (or revising) the BP?

*Which organization(s) finally endorses the BP?*
Which organization finally decides on what the BP contains, i.e. which services are covered?

**Assessment of BP**

*Does the BP include ‘essential services’?*
What is defined as ‘essential services’ may differ between countries. The toolkit users should therefore interpret this question accordingly.

*Is the BP composed of cost-effective services?*
Cost-effectiveness analysis is a tool that decision-makers can use to assess and potentially improve the performance of their health systems. It indicates which interventions provide the best ‘value for money’ and helps them choose the interventions and programmes, which maximize health outcomes with the available resources.

The World Health Organization’s CHOosing Interventions are Cost Effective (WHO-CHOICE) toolkit reports the costs and effects of a wide range of health interventions in the 14 epidemiological sub-regions (world divisions that are based on geographical location and epidemiological profiles). The results of these cost-effectiveness analyses are assembled in regional databases, which policy-makers can adapt to their specific country setting (WHO 2010a).

*Are services with high externalities for public health included?*
This question serves to assess whether the benefit package aims to contribute to efficiency.

*Does BP focus on the poor and severely, chronically sick (other vulnerable groups)?*
This question serves to assess whether the benefit package aims to contribute to equity.

*What is the average benefit package amount per capita?*
(See also C1-Module 4. Pooling.)
This can be calculated as follows:

\[
\text{Yearly pool expenditure} - \text{administration costs} \over \text{Number of beneficiaries}
\]
This formula is the operationalization of the respective health financing performance indicator ‘Level of pooling’ (compare also with C1-Module 9. Health financing performance assessment).

Together with the following two questions on the health risk profile of pool membership, it can be estimated whether differences in spending per member between pools increase or decrease, which reveals the inequity in health spending per member.

What is the benefit amount as a share of the total treatment costs?
This ratio is a key indicator, as it reveals the level of financial risk protection provided through the health financing sub-system/scheme.

The benefit amount relates to the amount of health service benefits covered by the health financing sub-system/scheme during a year. The total treatment amount refers to the total health expenditure incurred, thus including cost-sharing.

The information may only be available in health financing schemes with well-developed information systems.

Where do people seek services not included in the BP?
When a benefit package provided by a health financing sub-system/scheme does not provide full coverage, it is important where and/or how people obtain access to non-covered services. They may have to pay OOP or seek care at government health facilities.

Benefit package costing

Benefit package costing also requires information on utilization rates for the services covered by the package.

Has the BP been costed?
It is important to know whether the BP has been costed or whether resource allocation and remuneration rate setting is based on estimations.

Which organizations are involved in the costing process?
There may be several organizations involved in and responsible for the costing process.

2. Rational benefit package consumption

Questions can be answered with yes or no, but additional explanations should also be provided.

Is a patient appeals mechanism in place and used?
Are there patient appeals/complaints mechanisms in place and do patients make use of them? This indicates whether patients or beneficiaries can and do refer to effective
patient appeals/complaints mechanisms to ensure that they get access to the services to which they are entitled.

**Do patients have incentives for preventive behaviour?**
Other than the existence of user fees, some specific health financing sub-systems/schemes may provide specific incentives for preventive behaviour.

**Are mechanisms to reduce impersonation in place?**
Impersonation refers to a situation where non-eligible persons pretend to be eligible to obtain access to services, e.g. by using somebody else's insurance membership or exemption card. Thus, the question is whether there are (control) mechanisms in place to avoid or reduce this.

**Is moral hazard a problem?**
The tendency to use more services than required or more than if one were not insured is called moral hazard.
Are there indications of moral hazard, or is it adequately offset, e.g. through co-payments and other measures, such as through information systems?

**Is under-utilization a problem?**
Are certain population groups consuming fewer services than required in relation to their health needs due to unaffordable co-payments?

**Are there other problems with rationale BP consumption?**
Note down any other issues or problems relating to rationale BP consumption, if necessary.
Module 7. Fund management

1. Fund management by health financing sub-systems/schemes

The way funds are managed within a health financing sub-system/scheme is important in order to contribute to administrative efficiency and the efficient delivery of the benefit package. Administrative efficiency here refers to the total administrative costs for all health financing sub-systems as a share of total health expenditure. However, it would be too simplistic to equate better performance with lower administrative costs only. Certain administrative activities can be beneficial to the system by contributing to health financing objectives, above all the optimal use of resources, while they increase administrative costs. These activities include, inter alia, information on claimant rights and claims reviews, appeals mechanisms, risk equalization (Carrin & James 2005, Nicolle & Mathauer 2010).

The questions below should be answered for each health financing sub-system. Therefore, please type the relevant health financing sub-systems into the column headings (these should be the same as in C1-3. Resource collection). Add more columns if necessary. Answers should be provided for the dominant scheme or the most common schemes within each sub-system.

What incentives exist for fund managers to purchase efficiently (e.g. benefits maximization or cost containment)?
Management practices and remuneration of fund managers may create and imply incentives to purchase efficiently. For example, fund managers may be rewarded for benefits maximization efforts or for cost containment activities.

What share are the administrative costs of the overall scheme expenditure?
This ratio provides an idea of how much of the total resources collected are not used for expenditure on health service benefits.

The NHA manual defines “health administration and health insurance as activities performed by private insurers and by central, regional and local authorities including social security funds. They include the planning, management, regulation, and collection of funds and handling of claims of the delivery system. This excludes the administration of healthcare providers” (WHO 2003). Thus, the general core cost ingredients of administration include staff costs (e.g. salaries, training), buildings and equipment, information technology (IT) soft and hardware, maintenance, utility charges and other operational costs (e.g. paper, printing material) (Nicolle & Mathauer 2010). Detailed national health accounts or other country statistics and reports provide information on administrative expenditure.

Is there a maximum share/amount for administrative costs?
The steward, the oversight bodies or the executive management may have set a maximum amount or percentage to be spent on administrative costs by the health financing sub-system/scheme.
What accountability/transparency rules are there in place (e.g. audits, performance reports, publications)?
Rules relating to accountability and transparency, such as audits, reporting, publications, and performance reports, are assumed to contribute to efficient and effective financial management.

If there is ex-post risk sharing, does it undermine the cost-containment incentives?
Depending on how the ex-post risk sharing mechanism is designed, it may undermine any cost-containment incentives.

What happens with a surplus / a deficit?
The regulations that determine how a surplus or deficit is dealt with also set incentives for fund managers to be more or less effective and efficient.

2. Administrative efficiency of the health financing system

With an increasing number of health financing sub-systems, administrative functions may be duplicated. In contrast, a single fund system reduces costs through economies of scale, standardized procedures, avoidance of enrolment/disenrollment processes or eligibility concerns and overall simplified management, while allowing for a broader pooling of funds.
Furthermore, the degree of fragmentation within a sub-system equally affects administrative efficiency. The questions in the table of the Excel Aid enable the assessment of the level of duplication within and across health financing sub-systems.

How many pools are there in each HF sub-system? (see C1-4)
With the exception of tax-based financing, the greater the number of sub-pools within a health financing sub-system the greater the degree of fragmentation, unless there is a risk equalization mechanism in place.

What is the average number of beneficiaries per pool?
The average number of beneficiaries per pool in a health financing sub-system may reveal a degree of fragmentation. While it is difficult to set an absolute minimum number per sub-pool, comparisons across different health financing sub-systems may help identify those pools suffering from high fragmentation.

How many different provider payment mechanisms are there in place?
An increasing number of different PPMs operating within a health financing sub-system may point to administrative inefficiencies, as each PPM requires its own information and management system.
Module 8. Stewardship

Stewardship is an important overarching function in health financing, having an effect on the other three health financing functions. Stewardship involves setting the meta rules, which define who sets the specific health financing rules, and how and when these rules can be changed. Furthermore, stewardship entails the provision of strategic direction and coordination for all the different health financing actors involved. Stewardship is usually exercised by government or quasi-government agencies (WHO 2000, WHO 2008)

1. Health financing stewardship

The questions in Table 1 are to be answered for each respective health financing sub-system. Therefore, please type the relevant health financing sub-systems into the column headings (these should be the same as in Component 1-Module 3. Resource collection). Add more columns if necessary. You may want to draw a map, which is useful in getting a clearer overview of the stewardship relations.

Which ministry/organization is the overall steward?
Each health financing sub-system normally has a steward that is ultimately responsible for its guidance and steering. In addition to the ministry of health, other ministries may be involved in stewardship, such as the ministries of labour or social security for a social health insurance sub-system, or the ministries of finance or industry for private health insurance. Stewardship tasks may also be delegated to specific organizations, such as a SHI umbrella organization, a provider umbrella association, or medical associations.

Which legal/regulatory provisions specify the stewardship assignment?
Whether stewardship is based on a law or a decree may be important information in order to judge its long-term stability. For your reference, note down the specific paragraph, act, decree, other.

What are the steward's responsibilities, what are the health financing aspects the steward is in charge of?
What issues and aspects is the steward in charge of? Is there a comprehensive range of issues, or just selected aspects?

What are the observed weaknesses in stewardship?
What are the steward’s weaknesses in exercising its stewardship duties and tasks?

Is there an oversight/governing body to supervise the health financing sub-system/scheme?
Apart from the steward's role, is there a specific governing body (e.g. a board) in place that steers the health financing sub-system/scheme?

What is the composition of the oversight/governing body? Which organizations are represented?
This question provides an idea of the range of stakeholder representation (or under-representation) in this body.
What are the responsibilities of the oversight body and which health financing aspects is it in charge of?
Apart from the steward's duties, the oversight body may have specific responsibilities and duties.

What are the observed weaknesses of the oversight/governing body?
What are the oversight body's weaknesses in exercising its oversight duties and tasks?

2. Areas being regulated or missing regulation

This section aims to reveal those areas that are not or only insufficiently regulated and thus affect the health financing function, namely resource mobilization, pooling and particularly purchasing. The table contains aspects that are not covered in the other modules.
Module 9. Performance assessment

The health financing performance indicators including their operationalization as well as guidance as to their attainment and further observations are outlined in Table A1 (Annex 1). The table below proposes potential data sources on these indicators.

Table 9.1 Health financing performance indicators and potential data sources

<table>
<thead>
<tr>
<th>Health financing performance indicator</th>
<th>Operationalization</th>
<th>Useful data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Level of funding</td>
<td>• THE (total health expenditure per capita) per capita (p.c.)</td>
<td>WHO national health account estimates (WHO 2010b), detailed NHA country data, country statistics, government budget reports</td>
</tr>
<tr>
<td></td>
<td>• THE/GDP (gross domestic product)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Time trends and comparison with similar countries:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• GGHE (general government expenditure on health) p.c.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• GGHE/THE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• GGE (general govt. expenditure)/GDP (fiscal space)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• GGHE/GGE (fiscal space for health)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• External funding for health / THE (donor dependency).</td>
<td></td>
</tr>
<tr>
<td>2. Level of population coverage</td>
<td>• % of population covered by a financial risk protection mechanism. (This means that a person is not put at financial risk due to the costs of care.)</td>
<td>To be compiled from various sources: country studies, household survey studies, MOH reports, insurance statistics, insurance reports</td>
</tr>
<tr>
<td></td>
<td><strong>Differentiated by quintiles/population groups:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• % of people covered by a financial risk protection mechanism in each quintile or population group.</td>
<td>Household survey studies for detailed information on specific population groups and quintiles</td>
</tr>
<tr>
<td>3. Degree of financial risk protection</td>
<td>• Prepayment ratio : GGHE/THE (in %)</td>
<td>WHO NHA estimates (WHO 2010b)</td>
</tr>
<tr>
<td></td>
<td>• % of households experiencing catastrophic expenditure in each scheme)</td>
<td>Household survey study</td>
</tr>
<tr>
<td></td>
<td>• % of households impoverished through out-of-pocket (OOP) expenditure on health</td>
<td>Household survey study</td>
</tr>
<tr>
<td></td>
<td><strong>Differentiated by quintiles/population group:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• % of households experiencing catastrophic expenditure in each income quintile/population group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• % of households impoverished through OOPs in all income quintiles/population groups.</td>
<td></td>
</tr>
<tr>
<td>4. Level of equity in health financing</td>
<td>• Total and specific health financing payments (e.g. taxes, contributions, insurance premiums, co-payments, out-of-pocket expenditure for health)/household income</td>
<td>How to assess: analysis of household survey data, or approximation through available data on tax burden and share in national income per quintile, OOP per quintile and insurance contribution rules</td>
</tr>
<tr>
<td>5. Level of pooling across the health financing system</td>
<td>Health care spending per pool member set in relation to overall health risks of pool members</td>
<td>How to assess: 1st step – estimate health care spending per member, divide estimated total health care spending per pool by estimated number of pool members; 2nd step – compare average pool spending per member with overall health risk profile of pool members. Higher health risks should go hand in hand with higher average spending per pool member</td>
</tr>
</tbody>
</table>
### 6. Level of operational efficiency and
### 7. Level of equity in the delivery of a given benefit package at a given level of quality standards

<table>
<thead>
<tr>
<th>For each health financing scheme:</th>
<th>Qualitative analysis through discussion with purchasers and providers, as well as assessment of incentives set by provider remuneration schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Absence of over-provision (e.g. providing too many services and medicines, up-coding), under-provision (e.g. providing too few services and medicines, or of substandard quality), cost-shifting, cream-skimming</td>
<td>Comparison of outpatient and inpatient utilization rates with regional levels</td>
</tr>
<tr>
<td>▪ Absence of over-consumption and under-consumption of services in relation to real health needs</td>
<td>Comparison of actual service quality with the country's quality standards</td>
</tr>
<tr>
<td>▪ Health-care seeking rate as a percentage of illness reporting rate compared across population groups/quintiles; Comparison of utilization rates across quintiles and accounting for health-care needs</td>
<td>Assessment of health workers' pay</td>
</tr>
<tr>
<td>▪ Comparison of remuneration rates with costs</td>
<td>Comparison of remuneration rates with costs</td>
</tr>
</tbody>
</table>

### 8. Degree of cost-effectiveness and equity considerations in benefit package definition

<table>
<thead>
<tr>
<th>For each health financing scheme:</th>
<th>Analysis of actual contents of the benefit package in order to check, inter alia, for services addressing chronic diseases and the disease burden of the poor, services with positive externalities, preventive health services or those with demonstrated high cost-effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Cost-effectiveness and equity considerations as part of benefit package definition logic.</td>
<td>Detailed NHA country data, country statistics/reports</td>
</tr>
</tbody>
</table>

### 9. Level of administrative efficiency

| ▪ Total administrative costs for all health financing schemes as a share of total health expenditure | Detailed NHA country data, country statistics/reports |
Module 10. Annex - more detailed data for the performance assessment

This annex provides the opportunity to assess the health financing performance in more detail by differentiating various performance indicators along income quintiles or different population groups. This depends on data availability and thus usually requires the existence of detailed household surveys (e.g. demographic health surveys, living standards measurement studies) as well as further analysis of such household survey data.

Many of the cells in this module will thus probably remain empty. However, if such country analysis has been undertaken, this module will of great use.

Some additional explanations

Health-care seeking rate
All persons seeking care as a share of population in the last 12 months who sought care at a service provider.

\[
\frac{\text{Total number of men and women seeking care}}{\text{Total population}}
\]

Outpatient utilization rate
Outpatient care comprises all medical and paramedical services delivered to patients who are not formally admitted to the facility (physician’s private office, hospital outpatient centre or ambulatory care centre) and do not stay overnight (OECD 2000). The outpatient utilization rate is obtained by dividing the total number of outpatient visits in a year by the total population

Inpatient utilization rate
Inpatient care refers to a patient who is formally admitted to an institution or ‘hospitalized’ for treatment and/or care and stays for a minimum of one night in the hospital or other institution providing inpatient care (OECD 2000). The inpatient utilization rate is obtained by dividing the total number of admissions in a year by the total population.

Suggested sources: health management information systems and demographic health survey reports.