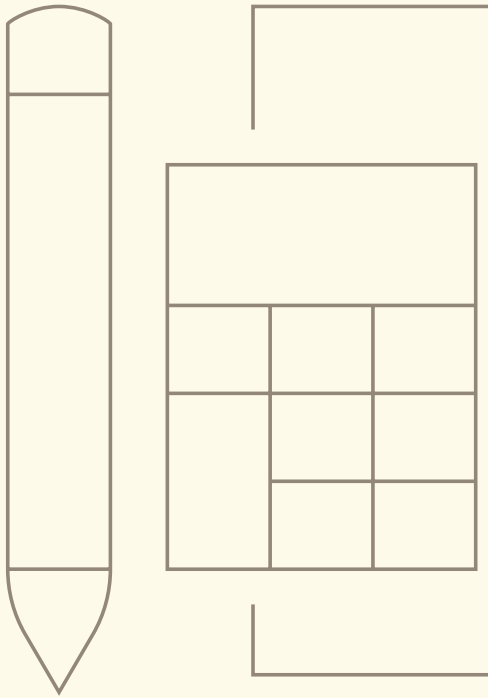

Health Priority Setting and Resource Allocation (HePRA)

OVERVIEW & 10 COUNTRY SUMMARY

2020

Joint Learning Network For Universal Health Coverage

iDSI Better decisions. Better health.

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JLN Efficiency Collaborative Systematic Priority Setting Stream

HePRA Disclaimer

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Health Priority Setting and Resource Allocation (HePRA) Benchmarking Tool and Database Overview

Countries have many mechanisms through which they can establish priorities for the health sector. However, unless resources can flow, be spent, and be tracked according to these priorities, the priorities themselves hold little influence. The Health Priority Setting and Resource Allocation (HePRA) Benchmarking Tool and Database aims to capture the current landscape of priority-setting practices that may be used to guide resource allocations for health across a set of 10 Joint Learning Network countries, and to explore whether and how resources are allocated, spent and tracked according to established health sector priorities.

With the budgetary process positioned as the backbone of resource allocation, the HePRA Tool uses a series of indicators and benchmarks to map the relationship between the budget and other major institutionalized aspects of health sector priority-setting, including decentralization, the health system and financing landscape, the structure of the benefits package, and donor resources for health. The HePRA Tool recognizes that priorities for health are largely established using the policy cycle, and that alignment between the policy and budget cycles in a country is one critical factor that determines whether policy priorities are adopted and funded.

As such, the HePRA Tool uses a combined policy and budget cycle to map the pathway from prioritization (agenda setting) to how and whether health priorities are used to make resource allocation decisions (formulation/adoption); payment decisions occur against priorities (implementation/execution); and allocations for health are assessed against set priorities (monitoring/evaluation; see Figure 1, Table 1, and "key terms").[1,2,3]

Table 1. *Policy and budget cycle*

Prioritization *agenda setting*	Evidence-based identification and prioritization of policy issues against a given forecast, budget ceiling or resource envelope, and occurring as a part of processes linked to budgeting, decentralization, health systems and financing, the benefits package and/or donor resources for health.
Resource allocation *formulation/adoption*	Adoption of policies and allocation of resources according to budgetary rules as guided by policy priorities and health sector targets and/or other decision-making principles.
Payment *implementation/ execution*	Financing and spending against planned priorities through various budget centers and ideally using strategic purchasing, including autonomy and flexibility to re-allocate funds according to emerging priorities.
Assessment *monitoring/evaluation*	Examination of whether spending has occurred against priorities to meet policy and fiscal objectives, which is made transparent and available for purposes of accountability and use in future planning and prioritization processes.

1 WHO (2017). Aligning Public Financial Management and Health Financing: Sustaining Progress Toward Universal Health Coverage. https://apps.who.int/iris/bitstream/handle/10665/254680/9789241512039-eng.pdf?sequence=1
World Health Organization. 2017. "Aligning public financial management and health financing: a process guide for identifying issues and fostering dialogue." Accessed April 5, 2019. https://www.r4d.org/wp-content/uploads/9789241513074-eng.pdf.

2 WHO (2016). Chapter 8: Budgeting for Health. https://apps.who.int/iris/bitstream/handle/10665/250221/9789241549745-chapter8-eng.pdf?sequence=11

3 Terwindt, F., Rajan, D. and Soucat, A. (2016). Chapter 4: Priority-setting for national health policies, strategies and plans. WHO https://apps.who.int/iris/bitstream/handle/10665/250221/9789241549745-chapter4-eng.pdf?sequence=36

GOALS

The HePRA Benchmarking Tool and Database is one part of the work undertaken in response to a need for knowledge sharing and joint learning on priority-setting and resource allocation for health expressed by members of the Efficiency Collaborative. HePRA complements its sister knowledge product, *Using Data and Evidence for Health Priority Setting: A Practitioner's Handbook*. The handbook provides practical guidance on strengthening the evidence-based priority-setting processes which feed into budget cycles and resource allocation pathways which may be identified through the HePRA Tool. In both the HePRA Tool and the *Handbook*, thinking around these budget cycles and resource allocation pathways are guided by the combined policy and budget cycle framework (Figure 1), which depicts the cyclical process of prioritization, allocation, payment, and assessment.

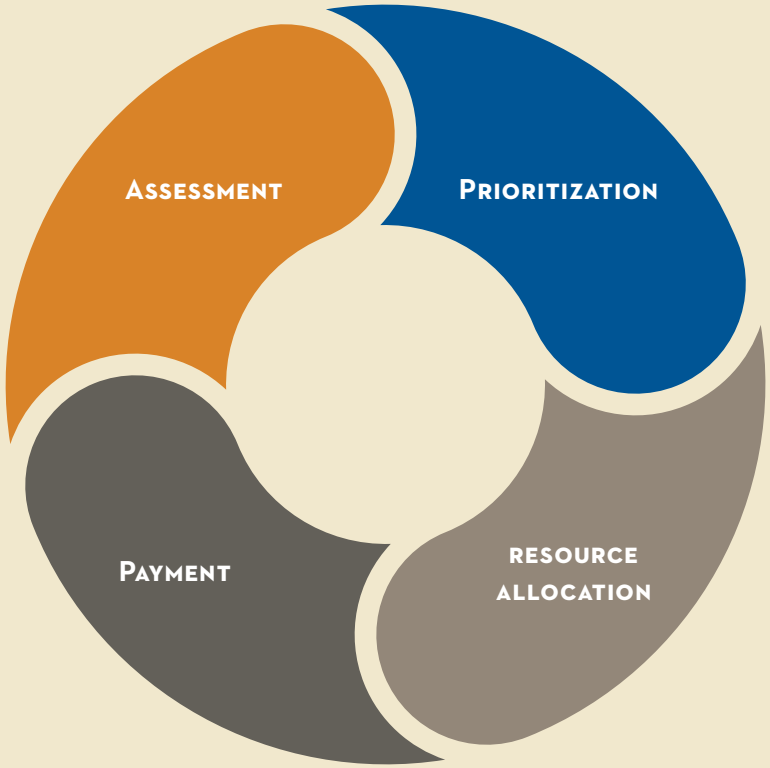
The intention of the HePRA Tool is to:

01. **Identify areas for focused efforts:** Distinct areas can be identified for each respondent country where efforts including in policy dialogue, support through technical assistance, capacity building, and knowledge exchange may be useful in promoting use of evidence in priority-setting for resource allocation in the health sector.

02. **Monitor progress over time:** Countries can capture the priority-setting and resource allocation landscape at present and future points in time by populating the tool and monitoring changes in priority-setting over time.

03. **Benchmark and contrast with comparator countries:** Ultimately, country responses to the HePRA Tool will feed into an interactive online database, where JLN countries can reflect on their own experiences in priority setting, benchmark against or understand resource allocation approaches used by comparator countries, and engage in peer learning and dialogue about how to promote evidence-informed priority-setting in country practices around resource allocation for health.

Figure 1. *Combined policy and budget cycle*



METHODS: DEVELOPING HePRA

Formative work to populate the HePRA Tool and Database began at a February 2018 Efficiency Collaborative meeting in Nairobi, where a questionnaire about resource allocation frameworks and challenges in making resource allocation decisions was administered to 10 member countries. In the course of the following months, data was collected over multiple virtual interactions in the form of structured verbal and written interviews. Analysis of data collected through the initial questionnaire revealed that there were multiple factors impacting how health priorities are established and how resources are allocated for health, and that these needed to be examined systematically and more in depth.

Analysis also revealed that there was a need to understand both these priority-setting processes as well as how and whether resources are actually used according to established priorities during the budget cycle. These findings were presented during the following meeting of the Efficiency Collaborative in New Delhi in February 2019. Discussions during the New Delhi meeting pointed to a need to restructure the questions as well as the underlying database so that it could more clearly classify national resource allocation processes and facilitate cross-country comparisons.

Through expert consultation and a review of the literature, the HePRA Database and related prioritization questions were re-organized into two parts. The first part dealt with the **PRIORITIZATION** step under the combined policy and budget cycle (see blue step under Figure 1) and included five clear "processes" – broad areas, topic or components of a countries landscape that have potential impacts on how health priorities are established and funded. Each of these different processes can be described according to a standard set of areas (Table 2).

A second part assesses how and whether the priorities established during these processes inform later phases of the joint cycle: **RESOURCE ALLOCATION**, **PAYMENT** and **ASSESSMENT**.

FIGURE 2: *Concepts embodied in Section 1 of the HePRA Tool; "Prioritization" (Part 1)*

HePRA PROCESSES	
Budgeting	The process of assigning resources to priorities, units, or individuals within a given resource envelope
Decentral-ization	The transfer of financial and/ or administrative authority from central to local levels
Health systems and finance architecture	The organization financing and health policy mechanisms that support UHC
Benefits package	The set of healthcare services provided, to whom and for how much
External resources for health	Financial resources for health received through official development assistance channels

DESCRIPTIVE AREAS	
Structure	Foundational elements that describe how each process is organized
Other descriptors	Breadth of what each process covers
Legal, regulatory and policy environment	Enshrined legal or policy foundations of a process
Fragmentation within process	Unification or separation of the key components of a particular process
Costing and other tools and data	Describes the costing and/or other analysis, tools and evidence that inform prioritization

A set of benchmarks were then established for each question and response, allowing users to compare the various dimensions of resource allocation and priority-setting across countries and over time.

The revised HePRA Tool was then piloted in Philippines and Nigeria, using country responses to the original Nairobi questionnaire, desk review, and consultation with country members as inputs. The tool and database was further reviewed by subject matter experts within the JLN network. The HePRA Tool underwent an internal World Bank review process as well as external review by subject matter experts. Based on feedback from the pilot processand review, the HePRA Tool was refined, and further outreach to 10 participating countries was conducted to populate and validate the HePRA Database. Accordingly, country data captured in the HePRA Database, which informs this 10 country overview, is correct as of year 2019.

The final HePRA suite has two major components:

01. **The HePRA Tool** is in two parts namely prioritization and resource allocation and comprises of 36 questions with benchmarks, a template for a visual depiction of the flow of funds from budget allocation to provider; and a visualization tool for capturing the benchmark responses. The tool also has guidance on how it can be populated independently.

02. **The HePRA Database** compiles 10 country responses to the HePRA Tool in 2019. These responses have been showcased in a simplified overview with a cross-country summary, supported by a visualization of benchmarks.

Disclaimer. The benchmark selections indicated within the HePRA Database represent a subjective categorization based on a more detailed narrative response to questions within the HePRA Tool. All responses have been self-reported by a set of JLN country representatives and validated by other in country experts who are listed in the contribution section of this report. While this is in line with the intended objectives of this tool being used for self-assessment and peer learning, some response bias may be reflected.

ACRONYMS

BP	benefits package
CHE	Current Health Expenditure
DFAT	Department of Foreign Affairs and Trade
DG	Director General
FY	Financial Year
GDP	Gross Domestic Product
GGHE-D	General Government Health Expenditure – Domestic
GHED	Global Health Expenditure Database
HePRA	Health Priority Setting and Resource Allocation Benchmarking Tool and Database
HE	Health Expenditure
HTA	Health Technology Assessment
LMIC	Low-and Middle Income countries
MOF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
N/A	Not applicable
NCD	Noncommunicable diseases
NGO	Non Governmental organization
NHA	National Health Accounts
NHIA	National Health Insurance Agency
NHIF	National Health Insurance Fund
OOP	Out-of-pocket
PBB	Program-based Budgeting
PHC	Primary Health Care
SDG	Sustainable Development Goals
SHI	Social Health Insurance
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

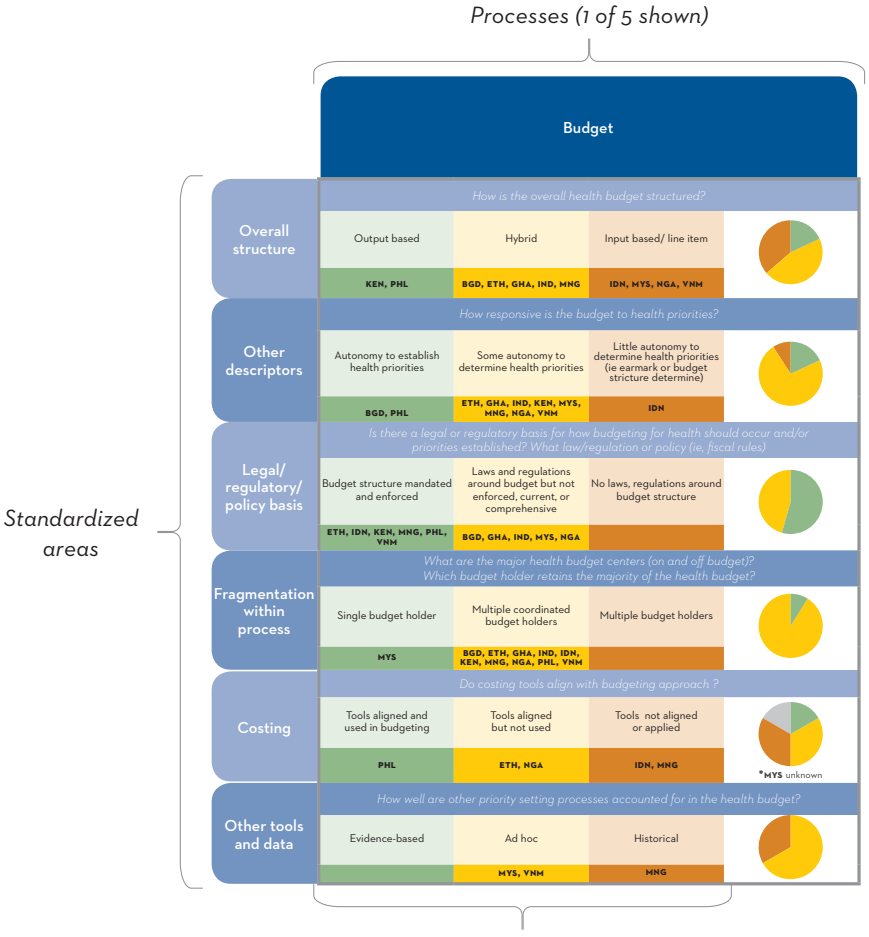
KEY TERMS

TECHNICAL TERMS	
Area	A HePRA-specific term that describes cross-cutting components that help to categorize and describe the identified HePRA processes. These are: overall structure, scope, legal/regulatory/policy, fragmentation, and costing/other tools and data. Each area under an HePRA process is associated with a question and benchmark to synthesize the narrative response.
Assessment (monitoring/ evaluation)	Examination of whether spending has occurred against priorities to meet policy and fiscal objectives, which is made transparent and available for purposes of accountability and use in future planning and prioritization processes.
Benefits package	The defined list of healthcare services covered by public funds and the financial terms of such coverage (such as cost-sharing). Some countries use health benefits packages (HBPs) to meet basic health needs for the entire population; others use HBPs to meet the health needs of specific populations, such as pregnant women, children, the elderly, or the poor; for specific levels of services, such as for inpatient, outpatient or primary care, or for specific programs, such as maternal and child health.
Budgeting	The process of assigning resources to priorities, units, or individuals within a given resource envelope.
Budget cycle	The process through which budgets are formulated, allocated, spent and monitored according to public financial management rules.
Cost-benefit analysis	A systematic process to compares costs and benefits, both of which are quantified in common monetary units.
Cost-effectiveness analysis	A comparison of costs in monetary units with outcomes in quantitative non-monetary units such as quality-adjusted life-years (QALYs) and disability-adjusted life years (DALYs) or in natural units (such as cholesterol level, mortality or case detection).
Country income status	For the 2017 fiscal year, low-income economies are defined as those with a gross national income (GNI) per capita of $1,025 or less in 2015; lower middle-income economies are those with a GNI per capita between $1,206 and $4,035; upper middle-income economies are those with a GNI per capita between $4,036 and $12,475.
Decentralization	The redistribution of some financial and/or administrative authority from central to local levels, which can occur in differing degrees. Deconcentration and devolution, defined below, are ways to describe decentralization.
Deconcentration	The partial transfer of authorities from central to local levels (i.e., administrative but not financial).
Devolution	The full transfer of financial and administrative authorities to local levels.
External Resources	Financial resources for health received through official development assistance channels.
Health Technology Assessment	The systematic evaluation of properties, effects and impacts of health technologies.
Payment (implementation/ execution)	Financing and spending against planned priorities through various budget centers and ideally using strategic purchasing, including autonomy and flexibility to re-allocate funds according to emerging priorities.
Prioritization (agenda setting)	Evidence-based identification and prioritization of policy issues against a given forecast, budget ceiling or resource envelope, and occurring as a part of processes linked to budgeting, decentralization, health systems and financing, the benefits package and/or donor resources for health.
Health Technology Assessment	The systematic evaluation of properties, effects and impacts of health technologies.
Payment (implementation/ execution)	Financing and spending against planned priorities through various budget centers and ideally using strategic purchasing, including autonomy and flexibility to re-allocate funds according to emerging priorities.
Prioritisation (agenda setting)	Evidence-based identification and prioritization of policy issues against a given forecast, budget ceiling or resource envelope, and occurring as a part of processes linked to budgeting, decentralization, health systems and financing, the benefits package and/or donor resources for health.
Priority-setting	Priority-setting can be defined as the assignment of finite health resources, between competing commitments, against an infinite demand for health care. Evidence-based priority-setting uses data and tools to guide decisions about value for money in establishing these priorities as a part of planning processes. Health priorities can be shaped across a number of prioritization processes within a country (see prioritization).
Process	A HePRA-specific term that describes a broad component of a countries decision-making landscape that can impact how health priorities are established. In the HePRA Tool, these are: budget structure, benefits package, health systems and financing, external resources, and decentralization.
Resource Allocation	Adoption of policies and allocation of resources according to budgetary rules as guided by policy priorities and health sector targets and/or other decision-making principles. Although many countries have established priority-setting processes that are aimed to guide financial decision-making, there is no guarantee that these priorities will be used to formulate budgets, or that these priorities will be traceable throughout the budget cycle as resources are then spent, reallocated, or monitored.
Sustainable Development Goals (SDGs)	A set of 17 goals that aim to end extreme poverty and hunger, fight inequality and injustice, combat climate change, and more. On September 25, 2015, the leaders of 193 United Nations member states adopted the goals as part of a new global sustainable development agenda. The 17 goals and their targets for 2030 are described at www.un.org/sustainabledevelopment/sustainable-development-goals/.
Universal Health Coverage (UHC)	According to the World Health Organization, UHC means that "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."

HePRA at a Glance

The HePRA Tool and Database is supported by summary visualizations that synthesize multiple country benchmark responses across Parts 1 (prioritisation processes) and 2 (fund allocation, payment and assessment), both for each country and as a whole across all 10 countries. We have categorized possible responses to questions using benchmarks that fall along a scale from what is most (green), moderate (yellow) to least (red) optimal as a priority-setting/ resource allocation mechanism. While the nature of the benchmarks vary by question, the rationale remains consistent.

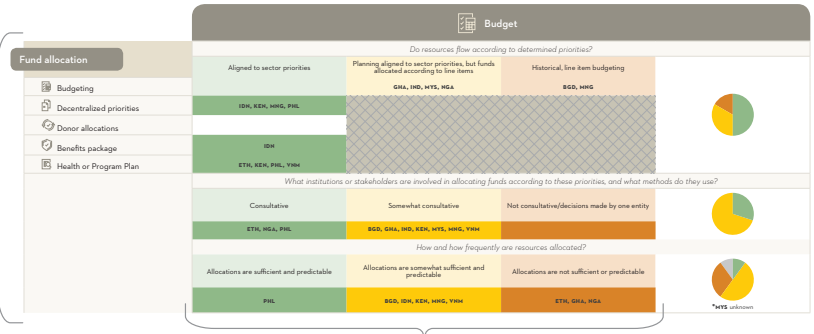
Synthesis visualization for Part 1



Overview of all/selection of country results for standardized benchmarks

Synthesis visualization for Part 2

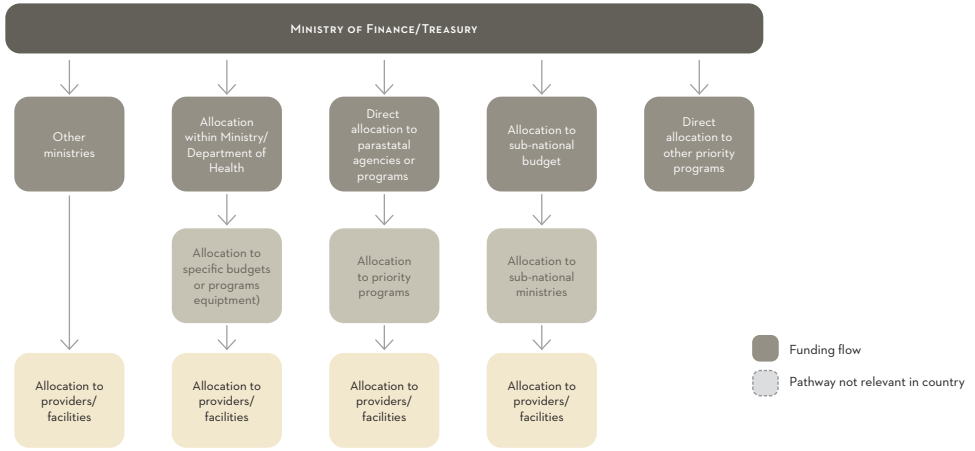
Resource allocation steps (1 of 3 shown)



Overview of all/selection of country results for standardized benchmarks

The tool is supported by a resource allocation visual for each country, which shows how funds flow from the national level through the health system, and where possible, indicates what criteria are used to determine allocations.

Resource allocation/Fund flow visual



HePRA Country Health Expenditure Trends

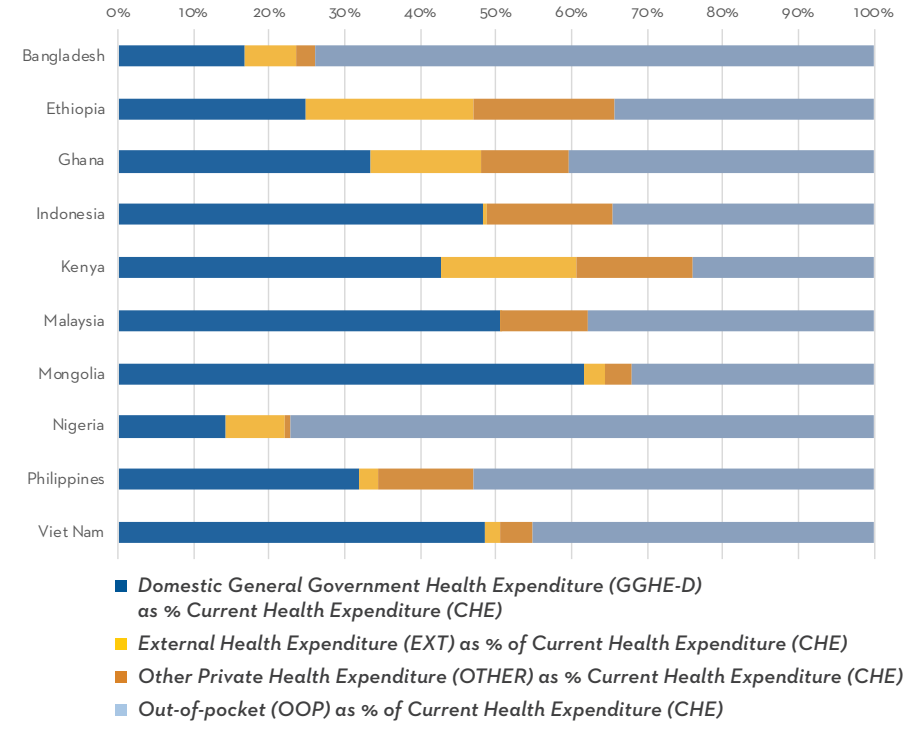
Health expenditure trends in the 10 countries where HePRA has been administered are presented below (Table 1: Health Expenditure for the 10 HePRA Countries). While all 10 HePRA countries are categorized as low-and middle income countries, the resources each of them spend on health (as a percentage of their GDP as well as per capita) varies significantly. There is also variation in how much health spending comes from the government versus from out-of-pocket spending, and from external resources for health (Table 1: Current Health Expenditures).

Table 1. *Health Expenditure for the 10 HePRA Countries*

	Population (mill)	CHE per Capita in US$	CHE as % GDP	GGHE-D as % GDP
Bangladesh • **BGD**	164.67	36.28	2.27	0.38
Ethiopia • **ETH**	104.96	25.26	3.50	0.87
Ghana • **GHA**	28.83	66.75	3.26	1.09
Indonesia • **IDN**	263.99	114.97	2.99	1.45
Kenya • **KEN**	49.70	76.61	4.80	2.05
Malaysia • **MYS**	31.62	384.07	3.86	1.95
Mongolia • **MNG**	3.08	148.78	4.00	2.47
Nigeria • **NGA**	190.89	73.92	3.76	0.53
Philippines • **PHL**	104.92	132.90	4.45	1.42
Vietnam • **VNM**	95.54	129.58	5.53	2.69

WHO Global Health Expenditure Data 2017

Figure 3. *Current Health Expenditure Split*



WHO Global Health Expenditure Data 2017

Part 1: Prioritization

Overall, a majority of the HePRA countries fall under the 'moderate' benchmark indicating a gradual move towards priority-setting practices being somewhat evidence-based and responsive to in country needs.

Budgeting: While several countries still have input, line item budgeting, nearly half of HePRA countries are moving towards allocating resources based on various forms of program budgeting. Two countries, Kenya and the Philippines, already have full program-based budgeting. While most of the countries have a legal framework for establishing priorities during the budgeting process, several of them have reported that the laws are either not comprehensive, current or enforced. Budgeting continues to occur on a historical or ad hoc basis. The use of costing tools aligned with budgeting approach remains very limited. Most countries also report the existence of multiple budget holders pointing in some cases to inefficiencies arising out of fragmentation.

Decentralization: While several countries have fiscal decentralization, more than half have reported limited autonomy to determine health priorities and accordingly allocate resources at sub-national levels. Even though there are laws that set out roles for sub-national bodies or use of citizen consultation setting health sector priorities, several countries report the laws as not comprehensive, current or enforced. Mongolia, for instance, has an explicit regulation to include citizen consultation, but this does not occur in practice. While in most cases sub-national planning is linked in some ways to national planning processes, sub-national planning happens without clear knowledge of or say in the resources that will in fact be allocated. Additionally, use of tools and evidence to guide priorities remains limited.

Health systems and financing: Countries appear to be evenly distributed with about a third of them being primarily public financed, and with a majority of their population accessing services through publicly funded schemes. Some countries that are primarily publicly financed countries have a majority of their population access services through regulated private sector providers, while others, in spite of there being public financing for health, have a majority of their population access services through unregulated private sector providers.

Benefits package: All countries have at least one defined public benefits package. Some countries have benefits split between the Ministry of Health and an autonomous parastatal National Health Insurance Agency (NHIA), which for the most part, receives dedicated allocations directly from the Ministry of Finance. For instance, Nigeria has packages issued by both the Ministry of Health as well as the National Health Insurance Authority. Split benefits between the MOH and NHIAs in various countries causes coordination challenges. Malaysia is an exception with publicly funded health services but no social health insurance agency. While most countries have laws that set out how resources should be allocated against the benefits package, the laws are not enforced, current or comprehensive. Most countries do use some tools and evidence to guide priorities for the benefits package. Use of cost estimates for the benefits packages remains limited even for countries that rely on other evidence and tools for setting priorities for their benefit packages.

External Resources: Donor funding accounts for less than 10% of the national health budget in most HePRA countries, and most of this external financing is on budget. The use of donor funding for health sector priorities is not well mandated, though coordination mechanisms do exist to improve alignment of donor priorities with national priorities, with increased reliance on tools and evidence for the same.

Part 2: Resource Allocation

Overall, resources are allocated according to priorities and a majority of the HePRA countries score fall under the 'moderate' benchmark in resource allocation, indicating a somewhat systematic fund allocation arrangement.

Fund Allocation: Over half the countries report that fund allocations take place in alignment with sector priorities (as set out in the health or program plan and at the decentralized level). Most countries have a somewhat consultative and responsive fund allocation mechanism allowing a certain amount of flexibility in the hands of those who receive the funds. Vietnam is a country that has completely flexible fund flows recipient authority to reallocate funds according to need. Bangladesh on the other hand has little to no flexibility to re-allocate funds once they have been received.

Payment and Assessment: Even though over half the countries report that fund allocations take place in alignment with sector priorities they also say that funds allocated are only somewhat sufficient and predictable. In many countries, funded priorities continue to be paid for based on inputs, and expenditure is also tracked against input line items only, instead of against priorities. This occurs even in cases where output-based payment mechanisms may be used to direct revenue flows, such as in Mongolia. Philippines is an example of a country where facilities are paid based on outputs and aligned to priorities, and where spending is also tracked against priorities. In the Philippines, payments to operating units is done by output, and performance indicators are published annually with the General Appropriations Act, which sets out the national budget. In most countries, providers and facilities are paid based on inputs and expenditure is tracked against line items only. In some other instances spending is tracked to informed priorities. For instance, in Indonesia, capitation can be linked with payment for health priorities due to a clear set of indicators in place and in Ethiopia a health system account assessment is conducted every two years to track the flow of funds with findings used to inform budgeting priorities.

Budget

Overall structure

How is the overall health budget structured?

Program based	Hybrid	Input based/ line item
KEN, PHL	BGD, ETH, GHA, MNG	IDN, MYS, NGA, VNM

Other descriptors

How responsive is the budget to health priorities?

Autonomy to establish health priorities	Some autonomy to determine health priorities	Little autonomy to determine health priorities (ie earmark or budget structure determine)
BGD, KEN	ETH, GHA, IDN, MYS, MNG, NGA, PHL, VNM	

Legal/ regulatory/ policy basis

Is there a legal or regulatory basis for how budgeting for health should occur and/or priorities established?

Budget structure mandated and enforced	Laws and regulations around budget but not enforced, current, or comprehensive	No laws, regulations around budget structure
ETH, IDN, KEN, MNG, PHL, VNM	BGD, GHA, MYS, NGA	

Fragmentation within process

What are the major health budget centers (on and off budget)?

Single budget holder	Multiple coordinated budget holders	Multiple budget holders
MYS	BGD, ETH, GHA, IDN, KEN, MNG, NGA, PHL, VNM	

Costing

Do costing tools align with budgeting approach ?

Tools aligned and used in budgeting	Tools aligned but not used	Tools not aligned or applied
PHL	ETH, IDN, KEN, NGA	BGD, MNG, MYS

*GHA unknown
**VNM N/A

Other tools and data

How well are other priority-setting processes accounted for in the health budget?

Evidence-based	Ad hoc	Historical
IDN, KEN, PHL	ETH, VNM	BGD, MNG, MYS, NGA

*GHA unknown

Decentralization

What is the jurisdiction of local government in administering health budgets?

Complete sub-national authority, providers/ facilities consulted	Some sub-national authority, providers not consulted	No fiscal decentralization
ETH, KEN, PHL, VNM	IDN, MNG, NGA	BGD, GHA, MYS

How flexible are sub-national budgets in terms of what can be included?

Autonomy to establish health priorities	Some autonomy to determine health priorities	Little autonomy to determine health priorities (ie earmark or budget structure determine)
GHA, KEN, PHL, VNM	ETH, IDN, MYS, NGA	BGD, MNG

Is there a legal or regulatory basis that dicates the role of lower administrative levels in setting health sector priorities?

Role of decentralized structures legally mandated and enforced	Laws and regulations around decentralized role but not enforced, current or comprehensive	No laws, regulations around role of decentralized structure
IDN, KEN, MNG, NGA, PHL, VNM	BGD, ETH, GHA	MYS

Are there multiple plans or strategies at the sub-national level that drive resource allocation?

Sub-national plan is unified with national plan	Sub-national planning is linked in some way to national processes	Sub-national planning is fragmented
ETH, KEN, MNG, NGA	BGD, GHA, IDN, MYS, PHL, VNM	

Are these plans costed?

Sub-national plans costed and costs applied	Sub-national plans costed, but costs not used	Sub-national plans uncosted
IDN, MNG, PHL	BGD, ETH, GHA, KEN, NGA	

*VNM unknown
**MYS N/A

What other tools and evidence are used to guide priorities?

Evidence-based	Some	None
	BGD, ETH, GHA, IDN, KEN, MNG, PHL, NGA	

*VNM unknown
**MYS N/A

Health systems and financing

How would you categorize the domestic health system financing structure?

Primarily public finance	Mixed/transitional	Out-of-pocket payments and private sector financing
GHA, PHL, VNM	ETH, IDN, KEN, MYS, MNG	BGD, NGA

How does the majority of the population access services?

Compulsory or non compulsory tax or contributory scheme	Regulated private for profit or not-for-profit	Unregulated private for profit or not-for-profit
GHA, IDN, KEN, MNG, VNM	MYS, NGA, PHL	BGD, ETH

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Financing of health policies and priorities mandated and enforced	Laws and regulations around priroties but not enforced, current or comprehensive	No laws, regulations around priorities
IDN, KEN, PHL	BGD, GHA, MNG, NGA	ETH, MYS, VNM

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Program plans fully unified in overall plan	Multiple aligned program plans	Fragmented program and sector wide plans
ETH, GHA, MNG, PHL, VNM	IDN, KEN, MYS, NGA	BGD

Are these plans costed and/or linked to a health financing strategy?

Plans costed and costs applied	Plans costed, but costs not used	Programs and/or sector plan uncosted
BGD, ETH, PHL	GHA, IDN, KEN, NGA	MYS, MNG

**VNM N/A

What other tools and evidence are used to guide priorities?

Evidence-based	Some	None
IDN, KEN	BGD, ETH, GHA, MYS, MNG, NGA, PHL	

**VNM N/A

Benefits package

How is/are the public Benefits package(s) structured?

Centrally established positive or negative list	Multiple or partial lists for various populations, services, or system levels	No unified list
ETH, GHA, PHL, VNM	BGD, IDN, KEN, MNG, NGA	MYS

What is included in the Benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist	One/more of tertiary, specialist and PHC, but not all	Package not defined
ETH, IDN, KEN, MNG, PHL, VNM	BGD, GHA, NGA	MYS

Is there a legal or regulatory basis that dictates how resources should be allocated against the Benefits package?

Benefits packages mandated and enforced	Laws and regulations around benefits packages but not enforced, current or comprehensive	No laws, regulations around benefits packages
	BGD, GHA, IDN, KEN, MNG, NGA, PHL, VNM	ETH

**MYS N/A

Outside of the main package, are there other packages specified for specific programs?

Fully unified in overall package	Fragmented benefits packages, but linked to overall package	Fragmented benefits packages
ETH, GHA, IDN, PHL, VNM	KEN, MYS	BGD, MNG, NGA

How is/are the benefits package(s) costed?

Benefits packages costed and costs applied	Benefits packages costed, but costs not used	Benefits packages uncosted
BGD, PHL	GHA, IDN, KEN, NGA	ETH, MNG, VNM

**MYS N/A

What other tools and evidence are used to guide priorities?

Evidence-based	Some	None
ETH, IDN, KEN, PHL	BGD, GHA, NGA, VNM	MNG

**MYS N/A

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Most donor funding on budget	Mix	Most donor funding off budget
PHL, VNM	BGD, ETH, GHA, IDN, NGA	KEN, MNG

**MYS N/A

What is the % of CHE that comes from external resources?

< 10%	10% < x < 50%	50% < x < 90%
BGD, IDN, MYS, MNG, NGA, PHL, VNM	ETH, GHA, KEN	

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Donor funding of priorities mandated and enforced	Laws and regulations around priorities but not enforced, current or comprehensive	No laws, regulations around donor funding of priorities
IDN, MYS, MNG, PHL, VNM	BGD, ETH, GHA, KEN, NGA	

Are external resources aligned to priorities of the major budget holder?

External resources fully aligned to sector priorities	Coordinaton exists, but poor alignment	Donor priorities are not linked to country priorities
IDN, MYS, PHL, VNM	BGD, ETH, GHA, KEN, MNG, NGA	

Are the costs of donor programs transparent and available to the government?

Costs are fully available to government	There is some knowledge of costs	Costs of donor programs are not known
BGD, ETH, MYS, PHL, VNM	GHA, IDN, KEN, MNG, NGA	

What other tools and evidence are used to guide priorities?

Evidence-based	Some	None
VNM	BGD, ETH, NGA, PHL	IDN, MNG

*GHA unknown
**KEN, MYS N/A

Budget

Fund allocation

- Budgeting
- Decentralized priorities
- External resources
- Benefits package
- Health or Program Plan

*Do resources flow according to determined priorities?**

Aligned to sector priorities	Planning aligned to sector priorities, but funds allocated according to line items	Historical, line item budgeting
	GHA, MYS, NGA, VNM	BGD, MNG
IDN, KEN, MNG, PHL		
ETH, IDN, KEN, PHL, VNM		

What institutions or stakeholders are involved in allocating funds according to these priorities?

Consultative	Somewhat consultative	Not consultative/decisions made by one entity
ETH, NGA, PHL	BGD, GHA, IDN, KEN, MYS, MNG, VNM	

How and how frequently are resources allocated?

Allocations are sufficient and predictable	Allocations are somewhat sufficient and predictable	Allocations are not sufficient or predictable
PHL	BGD, IDN, KEN, MYS, MNG, VNM	ETH, GHA, NGA

Payment

Who receives funds: Do they have flexiblity to reallocate funds according to need?

Fund flows are flexible	Fund flows are somewhat flexible	Fund flows are not flexible
VNM	ETH, GHA, IDN, KEN, MYS, MNG, NGA, PHL	BGD

How are funded priorities paid for?

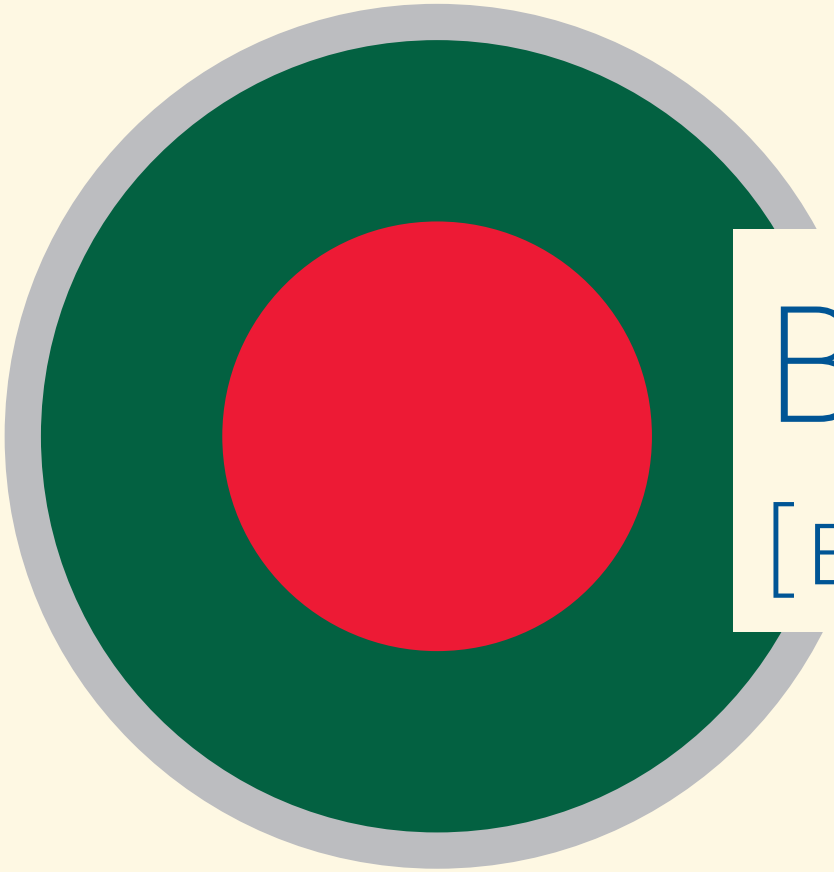
Providers and facilities paid based on output and aligned to priorities	Providers and facilities paid based on outputs, but no link to priorities	Providers and facilities paid based on inputs
PHL	GHA, IDN	BGD, ETH, KEN, MYS, MNG, NGA, VNM

Assessment

How are funding flows tracked against priorities?

Clear indicators are in place to track spending against priorities	Expenditure is tracked against line items only	Funding flows are not transparent
ETH, IDN, PHL	BGD, GHA, KEN, MYS, MNG, NGA, VNM	

* *If planning is aligned to sector priorities but funds are allocated according to line items, funds will not be able to flow on the basis of decentralized priorities, external resources, benefits package or health or program plan. Accordingly those options have been greyed out.*



Bangladesh

[BGD]

BGD	ETH	GHA	IDN	KEN	MYS	MNG	NGA	PHL	VNM
Bangladesh	Ethiopia	Ghana	Indonesia	Kenya	Malaysia	Mongolia	Nigeria	Philippines	Vietnam

Central and sub-national budgeting process

Bangladesh has a fiscally centralized government. The government prepares two types of budgets and the Ministry of Health and Family Welfare is funded through both of them – the revenue (non-development) budget is larger and financed solely by the Government of Bangladesh, and the development budget is financed by Government of Bangladesh and development partners. The revenue budget is meant to meet regular expenditure needs while the development budget includes allocations for development spending. The revenue budget follows a line item based incremental approach while the development budget is made using program budgeting approach. The Bangladesh public health system is highly centralized with planning undertaken by the Ministry of Health and Family Welfare and little authority delegated to local levels. Budget estimation is bottom up; however, once budgets are approved, district and lower levels have little flexibility over the use of funds. Virement between line items is only possible within rules set by the Ministry of Finance. Lower levels of administration have no formal role in determining supplies, finance, or even monitoring the performance of the local level service providers.

Health financing landscape and other priority-setting processes

Domestic general government health expenditure constitutes 23% of Current Health Expenditure (CHE). Health care services are provided by the public sector, private sector and non-governmental organizations. Ministry of Local Government, Rural Development and Cooperatives manages the provision of urban PHC services however quality is often an issue due to insufficient allocation of resources, institutional limitations, absenteeism or negligence of providers. In 2015, financing for health that came from sources other than the government accounted for 77% of CHE (OOP 67% while donor, NGO, private insurance & others 10%). Private services are poorly regulated. While public funds for health are the main prepayment mechanism for risk-pooling, there are no major public benefits packages other than one defined through a pilot conducted for individuals below the poverty line (BPL) in one out of 64 districts from 2014 to 2018, known as the Health Protection Scheme – Shasthyo Surokhsha Karmasuchi (SSK).

At the national level, health priorities are informed by key strategic documents namely the National Health Policy the 4th Sector Wide Program (SWaP), the 7th Five Year Plan along with the Health Care Financing Strategy developed by the Health Economics Unit under supervision of the Ministry of Health and Family Welfare. Under the latest five-year program, the Health, Population and Nutrition Sector Development Program, health sector activities have been grouped into 29 operational plans implemented by 29 line directors. 7.6% of CHE comes from external sources and this support comes both on and off budget. Donor funding tends to be on the basis of donor priorities. However, the Ministry functions closely with external donor agencies in preparing its plans and programs. The Government has made continuous efforts to harmonize donor support and align it with national priorities.

PART 2

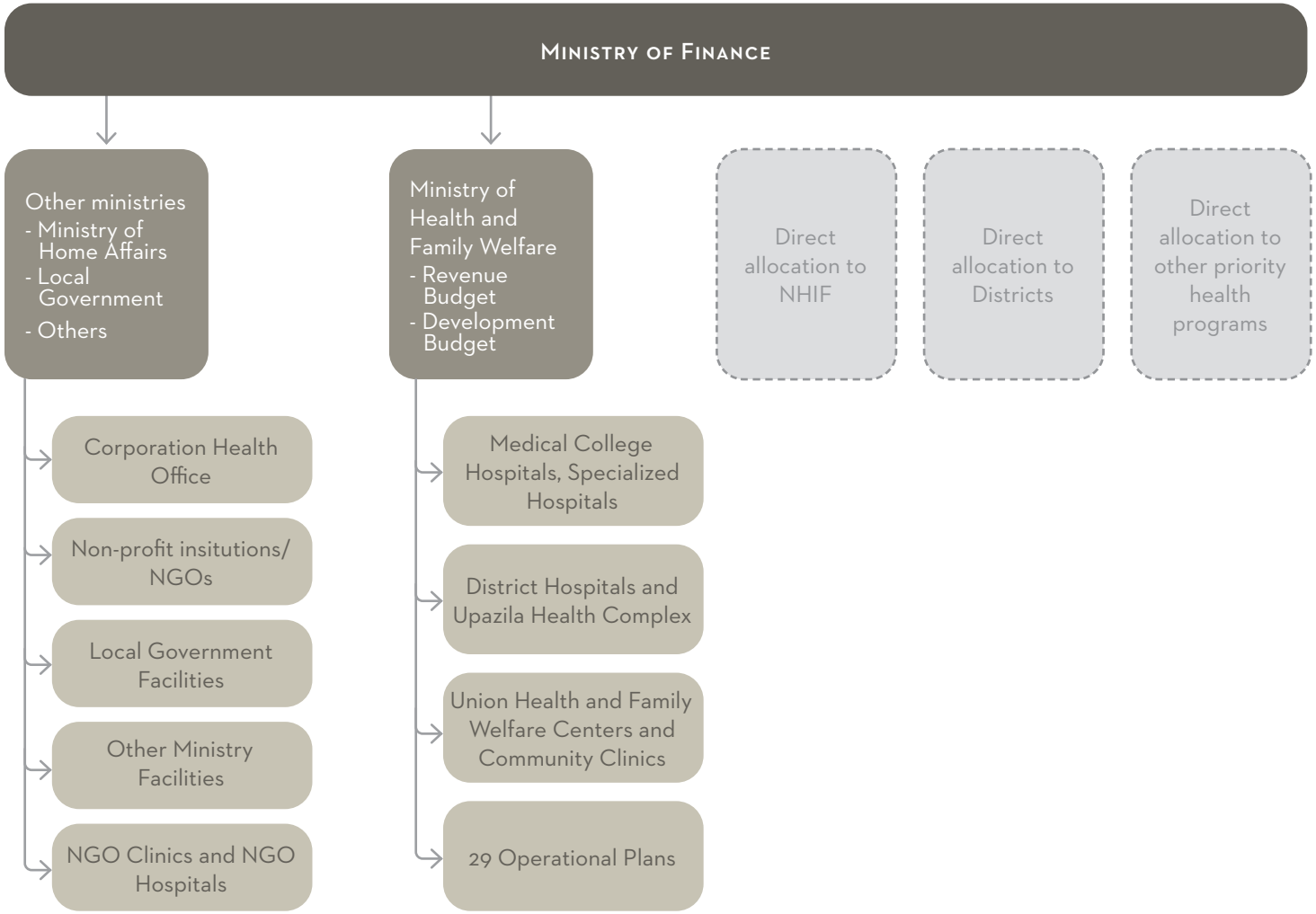
Resource allocation according to health priorities

The MOHFW determines most of the allocation and funds on the basis of the budget proposed from sub-national level. Certain participatory techniques are used for securing broad participation by stakeholder groups including professional and civil society groups and experts deployed by development partners and donors in the preparation of both the health sector plan and programs. MOHFW however has the final authority to make the ultimate decision. Funds are transferred to the Ministry of Health and Family Welfare which makes earmarked grants to 29 Operational Plans, Medical College Hospitals, Specialized Hospitals, District Hospitals and Union Health and Family Welfare Centers. District and sub-district level allocations for health are determined by norms that relate to the number of beds (for food and drugs) and staff in facilities (for salaries) rather than the population size and other demographic and epidemiological measures reflecting health needs. Once funds are transferred, implementing agencies are required to follow strict regulations for budget implementation as laid down by the Ministry of Health and Family Welfare.

Expenditure and monitoring against health priorities

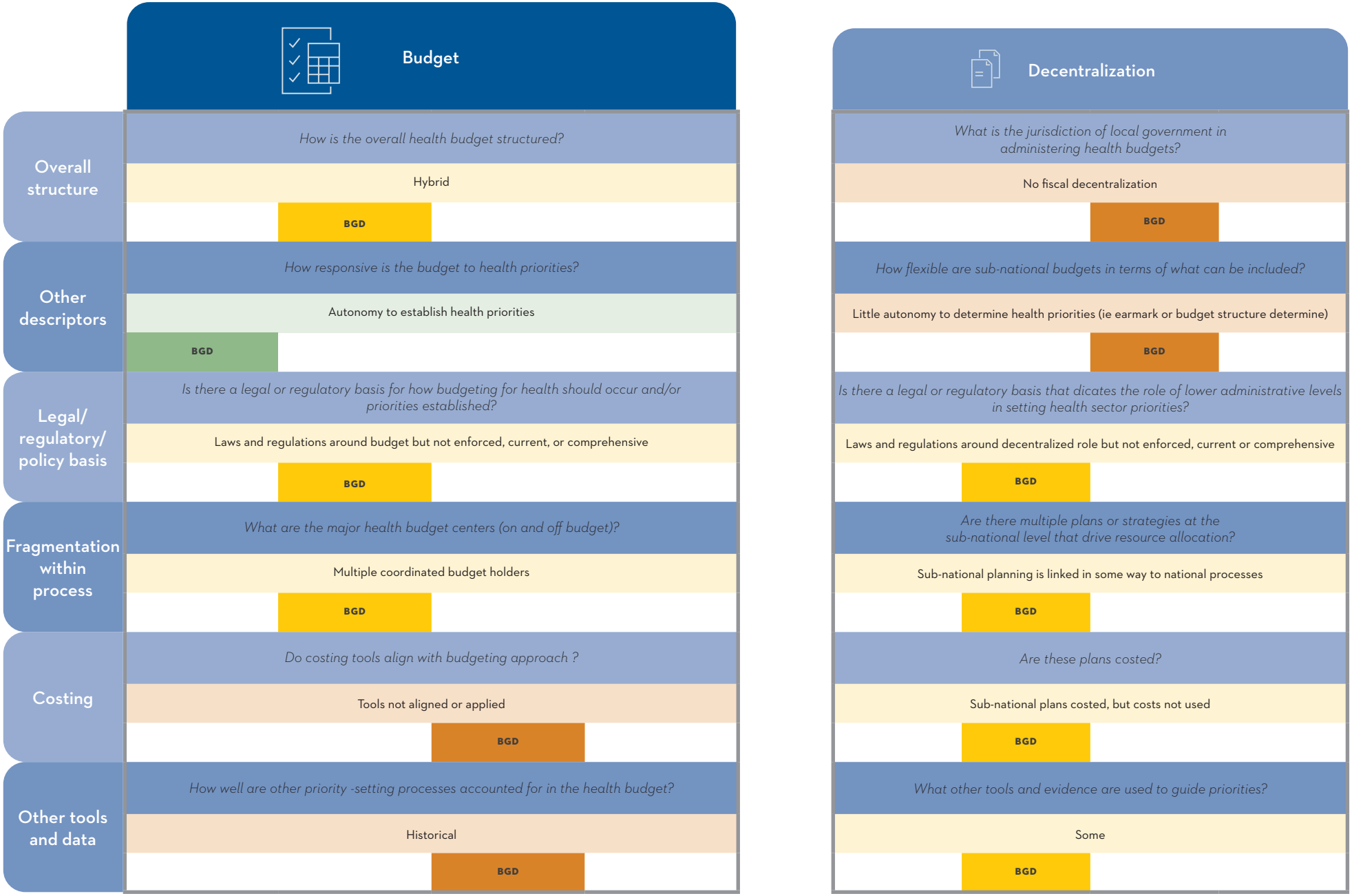
Resources for most implementing agencies are allocated on a quarterly basis. Once the annual budget for an implementing agency is approved, it is required to provide a break down for the quarter (in line with the approved annual budget) in advance in order to receive allocations. Owing to the recently implemented integrated budgetary accounting system implementing agencies are required to report on expenditure in real time on a monthly basis and subsequent quarter allocations are made on the basis of spending so far. Each health sector program undergoes mid-term reviews as well as annual reviews by external teams comprised of national and international experts.

FUND FLOW DIAGRAM



Funding flow

Pathway not relevant in country



Part 1: *The prioritization processes in Bangladesh is highly centralized but somewhat consultative using certain participatory techniques to engage stakeholders in the preparation of sector plans and programs. Health sector priorities are established in long-term strategic documents. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Out-of-pocket payments and private sector financing

BGD

How does the majority of the population access services?

Unregulated private for profit

BGD

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Laws and regulations around piroties but not enforced, current or comprehensive

BGD

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Fragmented program and sector wide plans

BGD

Are these plans costed and/or linked to a health financing strategy?

Plans costed and costs applied

BGD

What other tools and evidence are used to guide priorities?

Some

BGD

Benefits package

How is/are the public benefits package(s) structured?

Multiple or partial lists for various populations, services, or system levels

BGD

What is included in the benefits p ackage? How often is it reviewed?

One/more of tertiary, specialist and PHC, but not all

BGD

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits packages but not enforced, current or comprehensive

BGD

Outside of the main package, are there other packages specified for specific programs?

Fragmented benefits packages

BGD

How is/are the benefits package(s) costed?

Benefits packages costed and costs applied

BGD

What other tools and evidence are used to guide priorities?

Some

BGD

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Mix

BGD

What is the % of CHE that comes from external resources?

10% < x < 50%

BGD

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Laws and regulations around priorities but not enforced, current or comprehensive

BGD

Are external resources aligned to priorities of the major budget holder?

Coordinaton exists, but poor alignment

BGD

Are the costs of donor programs transparent and available to the government?

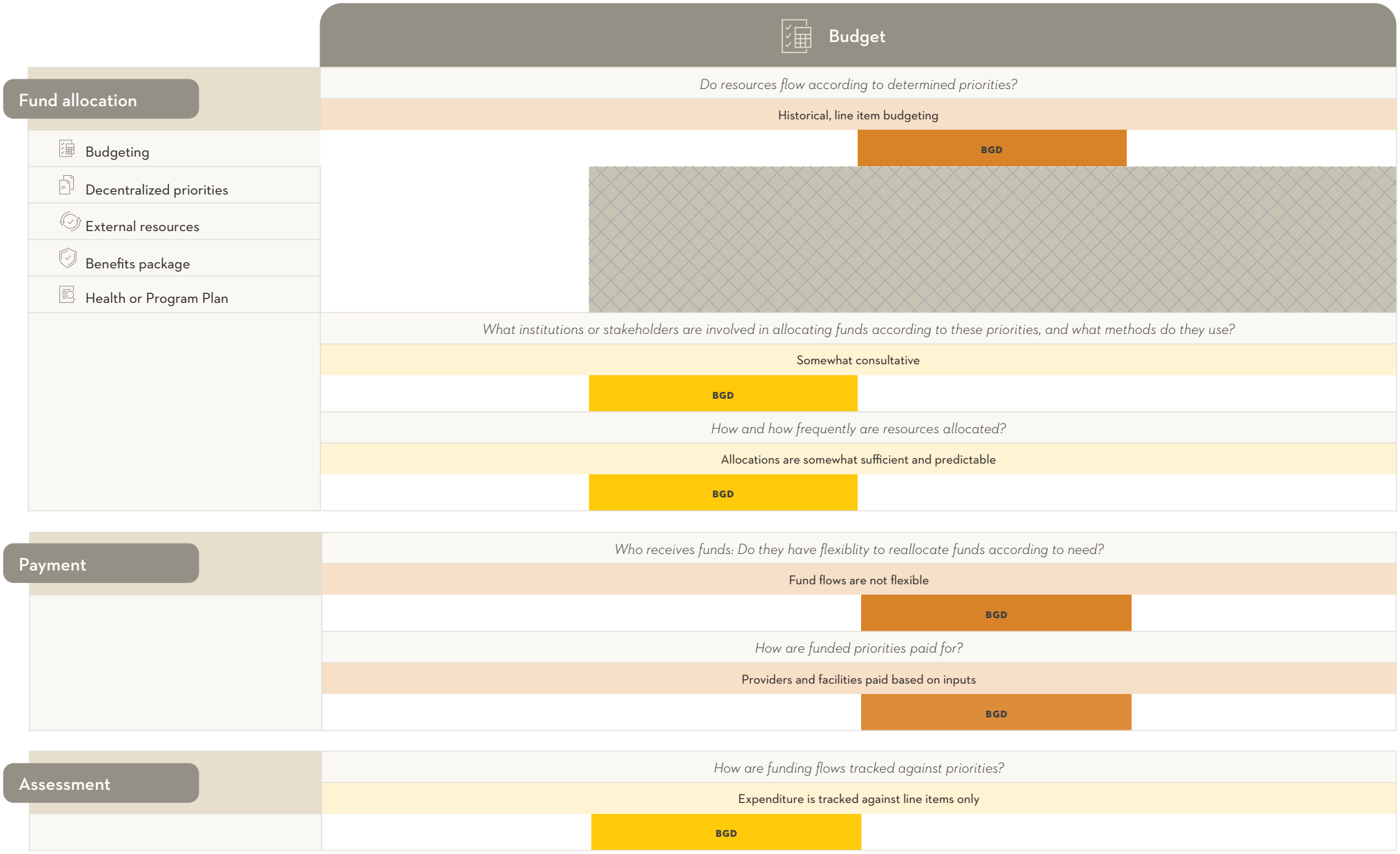
Costs are fully available to government

BGD

What other tools and evidence are used to guide priorities?

Some

BGD



Part 2: *Resources are largely allocated based on historical budgeting with limited flexibility at the lower level for reallocation. Midterm reviews are used to examine funding flows for each health sector program. Note that all benchmarks are based on subjective categorization.*

Ethiopia

[ETH]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

PART 1

Central and sub-national budgeting process

Ethiopia has a fiscally devolved government. At the federal level, Ethiopia has used a program-based budget since 2011/12. However, regions and districts establish local priorities and budgets using line-item budgeting. Regional subsidies from the state are determined by a joint budget allocation formula which is approved by the House of People's Representatives. Regional governments then receive block grants and earmarked grants from the central government, determine budget allocations according to national and local priorities, and make further allocations to regional programs and to districts via another level of block grants.

Health financing landscape and other priority-setting processes

Domestic general government health expenditure represents approximately 32%[1] of Ethiopia's current health expenditure. Most domestic health expenditure comes from the salary of the health professionals, recurrent costs for health facilities and also the Health Extension Program, which offers basic health and medical care for essential health services like HIV, TB, and vaccination services. For coverage of services outside of those in HEP, there are two public health insurance systems: community-based health insurance (CBHI) for the agricultural and informal sectors – which has been progressively scaled-up since 2012 to cover 16% of informal workers – and the not-yet-implemented social health insurance (SHI) for those employed in the formal sector. However, out-of-pocket payments are 31% of current health expenditure.

At the national level, health priorities are informed by key strategic documents – the 20-year envisioning document and the Health Sector Transformation Plan (HSTP) – while the Essential Health Service Package (EHSP) is used to guide service provision. More than 35% of current health expenditure comes from external donors, and this support is largely off-budget. However, many donors pool funds toward the SDG Performance Fund, a mechanism by which available funding from donors is combined and managed by the government via earmarked budgets.

1 Health expenditure data for Ethiopia comes from the 7th round National Health Account which was launched in 2019.

PART 2

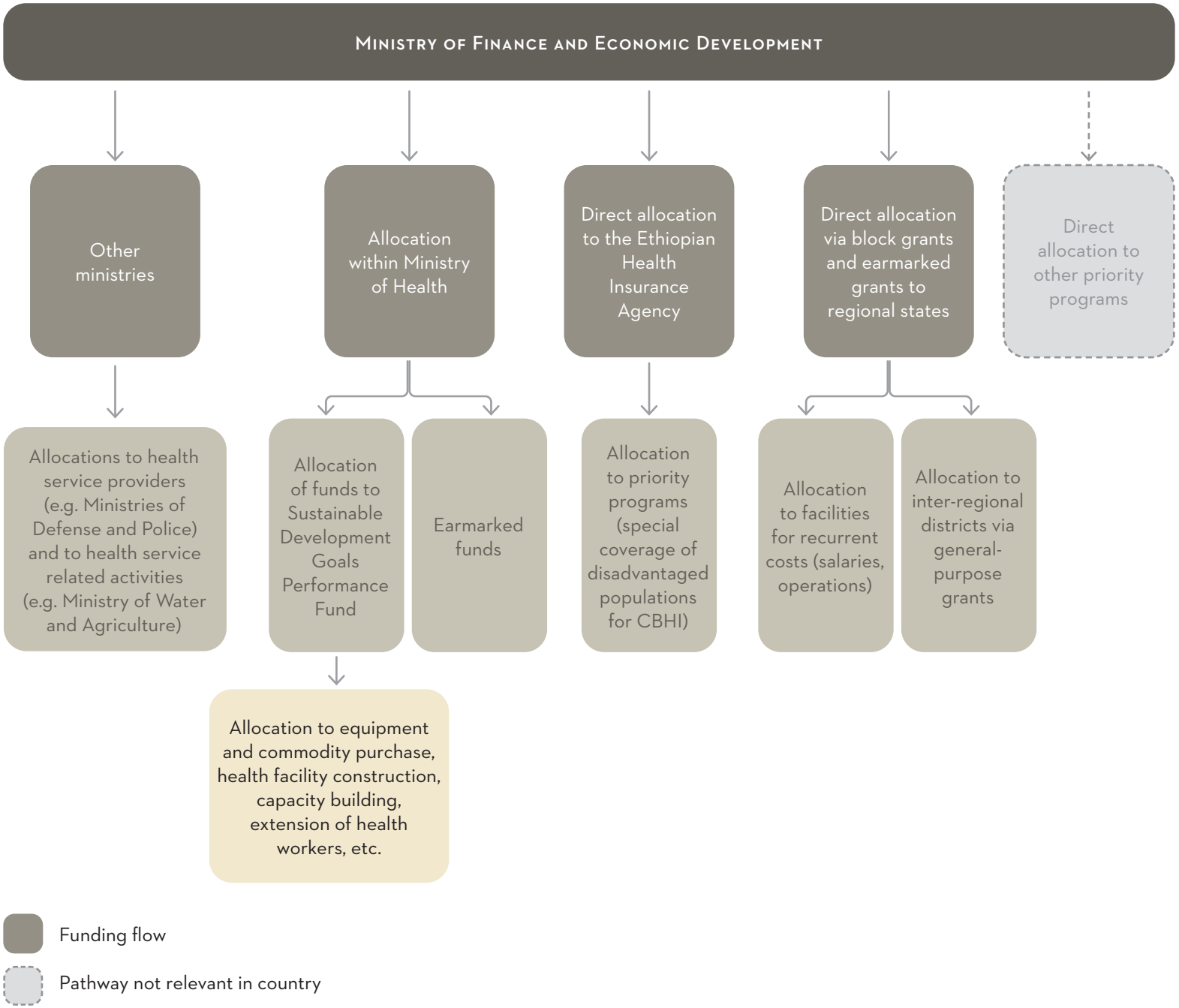
Resource allocation according to health priorities

The priorities set out in the 20-year Envisioning Plan, the Health Sector Transformation Plan, and the Essential Health Services Package are embodied in a budget request developed through a consultative process, which is submitted to Parliament for negotiation and approval. The Joint Core Coordinating Committee, which contains the Ministry of Health and donors, is involved in determining allocations in line with national priorities. Funds are transferred to the Ministry of Health and separately, to regional states via block grants and earmarked grants (according to an allocation formula), and to the Ethiopian Health Insurance Agency. Regions then make block grant allocation to districts and allocate to regional level programs using their own priority-setting process.

Expenditure and monitoring against health priorities

Payments to operating units are done by input and government entities receiving funds may adjust these allocations with approval from the Ministry of Health. Under the CBHI scheme, providers are paid on a fee-for-service basis. Outside of CBHI, service providers are financed through a combination of block grants from general government revenue, in-kind transfers from the FMOH, user fees, and government subsidy for providing waived services to the poor. A health system account assessment is conducted every two years to track the flow of funds and the findings are used to inform budgeting priorities, but there is a gap in considering these findings into the budget annually.

FUND FLOW DIAGRAM



Part 1: *The prioritization processes in Ethiopia are systematic and consultative, with health sector priorities established in long-term strategic documents and decentralized priorities informing a participatory budget process. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Mixed/transitional

ETH

How does the majority of the population access services?

Unregulated private for profit or not-for-profit

ETH

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

No laws, regulations around priorities

ETH

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Program plans fully unified in overall plan

ETH

Are these plans costed and/or linked to a health financing strategy?

Plans costed, and costs applied

ETH

What other tools and evidence are used to guide priorities?

Some

ETH

Benefits package

How is/are the public benefits package(s) structured?

Centrally established positive list

ETH

What is included in the benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist

ETH

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

No laws, regulations around benefits package

ETH

Outside of the main package, are there other packages specified for specific programs?

Fully unified in overall package

ETH

How is/are the benefits package(s) costed?

Benefits package uncosted

ETH

What other tools and evidence are used to guide priorities?

Evidence based

ETH

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Mix

ETH

What is the % of CHE that comes from external resources?

10% < x < 50%

ETH

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Laws and regulations around priorities but not enforced, current or comprehensive

ETH

Are external resources aligned to priorities of the major budget holder?

Coordinaton exists, but poor alignment

ETH

Are the costs of donor programs transparent and available to the government?

Costs are fully available to government

ETH

What other tools and evidence are used to guide priorities?

Some

ETH

Part 2: *Resources are largely allocated based on health sector and decentralized priorities, with somewhat flexible, but often insufficient, funding flows occurring against those priorities. National health accounts are used every two years to examine funding flows, but annually there is not a process to evaluate expenditure against priorities within annual budget cycles. Note that all benchmarks are based on subjective categorization.*

Ghana

[GHA]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

Part 1

Central and sub-national budgeting process

Ghana has a fiscally centralized government. The budget is between input based and hybrid, and in the midst of a transition towards more output-based budgeting. In some instances there is use of program-based budgeting however this is limited. Program-based budgeting was piloted in 2010 and fully introduced countrywide in 2014 by the Ministry of Finance. Local authorities have little control over health budgets/ expenditures, because most of their resources are executed centrally or earmarked from the centre to specific programs or initiatives.

Health financing landscape and other priority-setting processes

Domestic general government health expenditure represents approximately 38.4% of Ghana's current health expenditure. Funds allocated from government revenue are mostly used for compensation and limited capital investment. Internally Generated Funds which include nontax revenues, National Health Insurance claims and reimbursement are increasingly becoming the major sources of funds for service delivery in all health facilities. Funds for the National Health Insurance Scheme are earmarked in the national budget, while donor funds are earmarked for direct implementation at district level.

At the national level there is a National Development Plan (2018-21) that spells out the goals and priorities for the Medium Term. The various Health Implementing Agencies derive their 4-Year Strategic Plans from the National Development Plan. Since 2003, Ghana has implemented a predominantly tax funded (70%) national health insurance scheme for basic health care, now covering 36% of the population. A generous benefits package has meant high pharmaceutical expenditures, and there are genuine concerns about national health insurance scheme affordability and sustainability. As of 2016 12.8% of current health expenditure came from external sources. Donor Basket funding are fully aligned to health sector priorities. However, there are challenges with earmarked funding.

Part 2

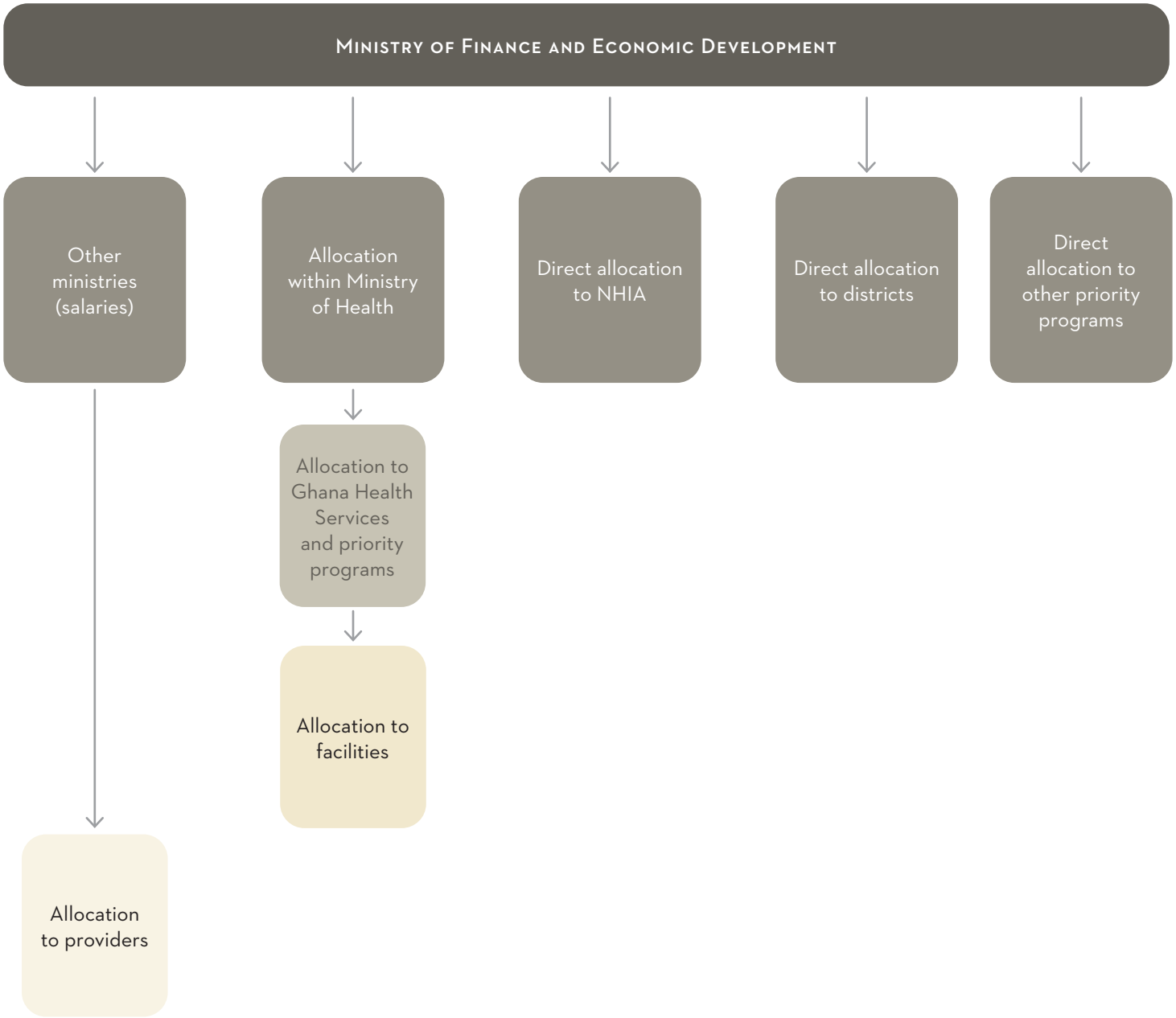
Resource allocation according to health priorities

Following the issuance of budget guidelines by the Ministry of Finance, the Ministry of Health allocates budget to Agencies with stakeholder consultation through the sector Budget Committees. Agencies in turn take over and do their own allocation according to priorities. Budgets are prepared at the lower levels based on what the priorities are and within the broad policy framework of the sector. Overall, planning is done based on priorities, but fund flow tends to be limited. Funds are transferred to the Ministry of Health and separately, to the National Health Insurance Authority, districts and other priority programs via block grants and earmarked grants. Ministry of Health then allocates to Ghana Health Services which further allocates to facilities. Annual health sector reviews, monitoring reports, operational research, cost effectiveness analysis and budget impact assessments have been used to inform allocation decisions.

Expenditure and monitoring against health priorities

Funded priorities in health facilities are output based through multiple provider payment mechanisms including case based payments, fee for service, diagnostic related groups and capitation. Programs and other priorities are input based. There is flexibility to reallocate government funds with limited flexibility for donor and earmarked funds. Annual, periodic and specific audits are carried out to track fund flow to priorities. However, it is mostly limited to funds rather than programs.

FUND FLOW DIAGRAM



Part 1: *The prioritization processes in Ghana are increasingly systematic and consultative, with health sector priorities established in long-term strategic documents and a participatory budget process. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Primarily public finance

GHA

How does the majority of the population access services?

Compulsory tax scheme

GHA

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Laws and regulations around piroties but not enforced, current or comprehensive

GHA

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Program plans fully unified in overall plan

GHA

Are these plans costed and/or linked to a health financing strategy?

Plans costed, but costs not used

GHA

What other tools and evidence are used to guide priorities?

Some

GHA

Benefits package

How is/are the public benefits package(s) structured?

Centrally established positive list

GHA

What is included in the benefits package? How often is it reviewed?

One/more of tertiary, specialist and PHC, but not all

GHA

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits package but not enforced, current or comprehensive

GHA

Outside of the main package, are there other packages specified for specific programs?

Fully unified in overall package

GHA

How is/are the benefits package(s) costed?

Benefits package costed, but costs not used

GHA

What other tools and evidence are used to guide priorities?

Some

GHA

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Mix

GHA

What is the % of CHE that comes from external resources?

10% < x < 50%

GHA

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Laws and regulations around priorities but not enforced, current or comprehensive

GHA

Are external resources aligned to priorities of the major budget holder?

Coordinaton exists, but poor alignment

GHA

Are the costs of donor programs transparent and available to the government?

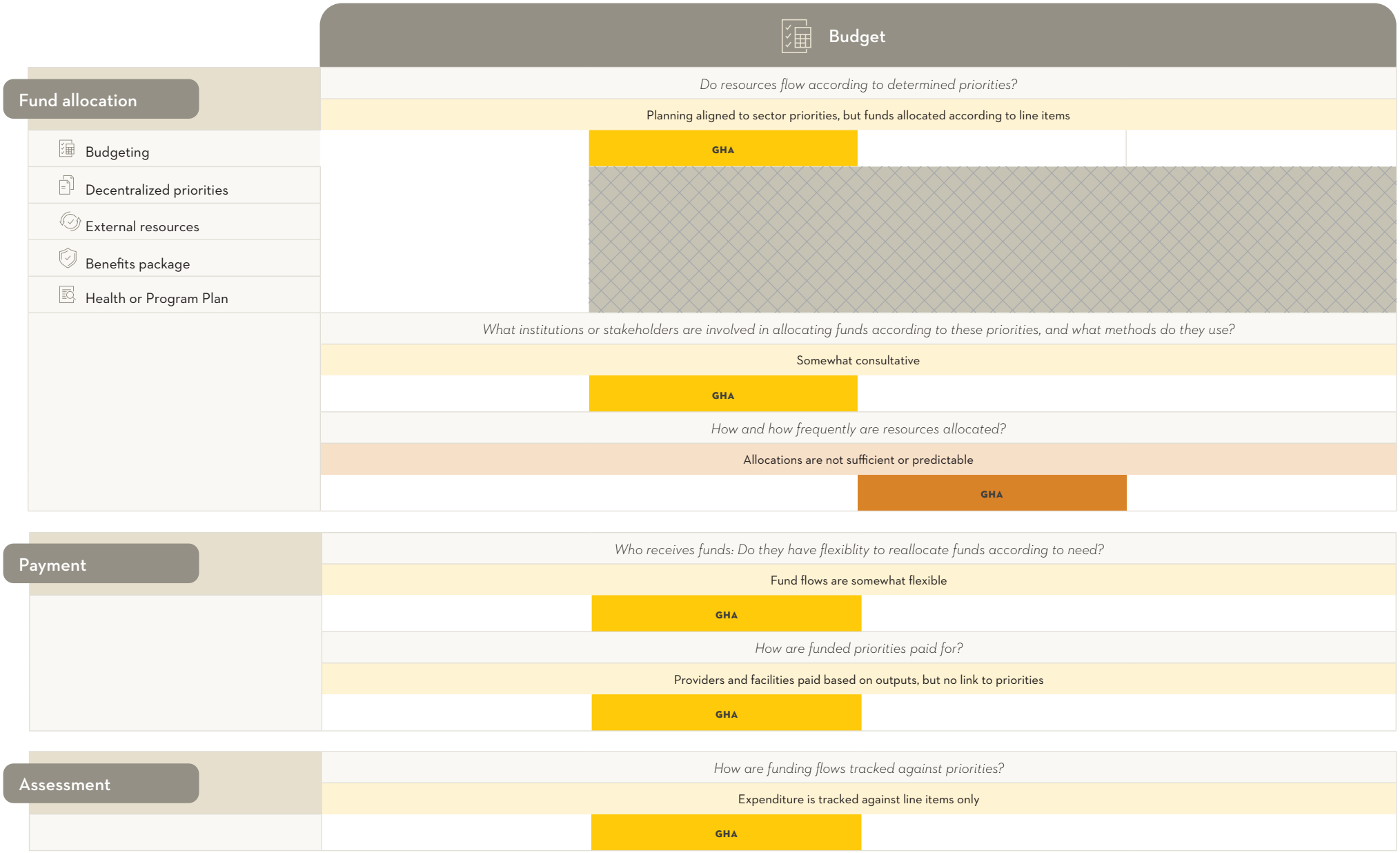
There is some knowledge of costs

GHA

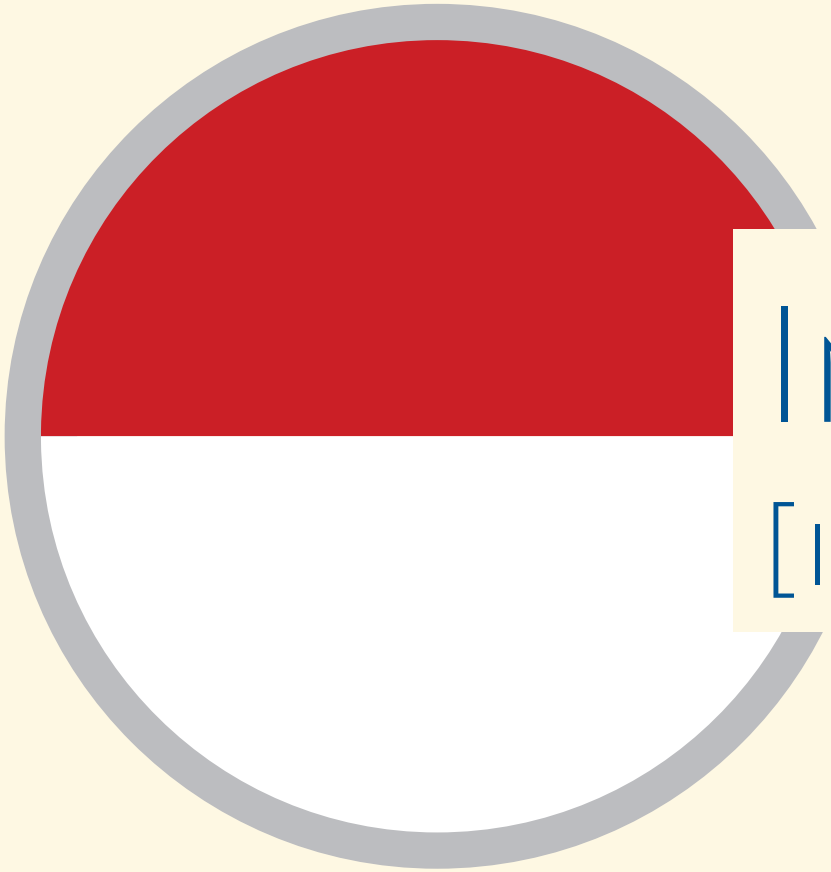
What other tools and evidence are used to guide priorities?

Unknown

GHA



Part 2: *Resources are allocated largely based on historical budgets, with somewhat flexible, but often insufficient, funding flows occurring against priorities. Annual, periodic and specific audit are carried out to track fund flow to priorities. However, it is mostly limited to funds rather than programs. Note that all benchmarks are based on subjective categorization.*



Indonesia

[IDN]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

Part 1

Central and sub-national budgeting process

Indonesia has a line item, input based budget system. While the government has been thinking of shifting to performance-based budgeting (PBB) and is running some PBB pilots, the current budget system is weakly linked to performance. There are a robust set of earmarks that are regulated by law and govern fund flow in Indonesia: Central Government allocates 5% of national budget, and sub-national government earmarks 10% of their local budget allocation (outside of salary). The 5% also includes JKN benefits (JKN is Jaminan Kesehatan Nasional, the Indonesia National Health Insurance for UHC) for the poor and near poor covering 94.1M (35.2%) of population, as well as human resources, infrastructure, health facilities, and other priorities. Benefits for government servants through JKN are covered at 60% by the Central Government and 40% by workers. For private sector, 80% of benefits are covered by the company and 20% by workers. Decentralization was legally mandated in 1999 and included oversight of health spending down to the district level. District governments hold the majority (65%) of the public budget, while provincial and central governments hold roughly equal remaining amounts. Sub-national funding relies heavily on intergovernmental transfers, which make up 90% of their revenue. At the sub-national level, there is some authority to set priorities with a combined "top down bottom up" process that is mandated by law. Regardless, public participation in priority-setting often occurs unevenly. Priorities at the sub-national level must also cover the Minimum Health Service Standards (SPM), which is intended to align national priorities to district priorities. Priorities are outlined in sub-national plans and budgets which are costed and combined with budgets at the provincial level and then included as a part of the central government budget and workplan.

Health financing landscape and other priority-setting processes

Indonesia has a mixed/transitional health financing landscape, with a high degree of OOP (37.3% of CHE). External resources for health make up a small proportion of the total resource envelope (0.4%), with almost half of those resources being on budget. The health insurance system JKN currently covers 80% of the population. The poor and near poor are financed by a premium subsidy, with the rest being contributory based. The National Health Sector Strategic Plan is legally enforced, and aligned to other specific plans related to human resources, capacity building, nutrition, and tropical diseases. The core document has a costed annual plan that aligns to an overall sectoral medium-term plan, but this is aspirational and not applied. The JKN has a comprehensive benefits package which includes both medical and nonmedical benefits across all three of PHC, tertiary and specialist level care, but is not explicit. Drugs listed in the national formulary are covered by the scheme. There are some excluded services (i.e. cosmetic surgery, infertility) but for the most part services are automatically covered without copayments, balanced billing or caps, except for upgraded accommodation to the higher ward class. There is one overall package for JKN although programs are vertically managed. The JKN package is costed, but costs are not applied. Additionally, there are emerging concerns with alignment between the SPM and the benefits package, with the former emphasizing public health and the latter focusing on individual health.

Part 2

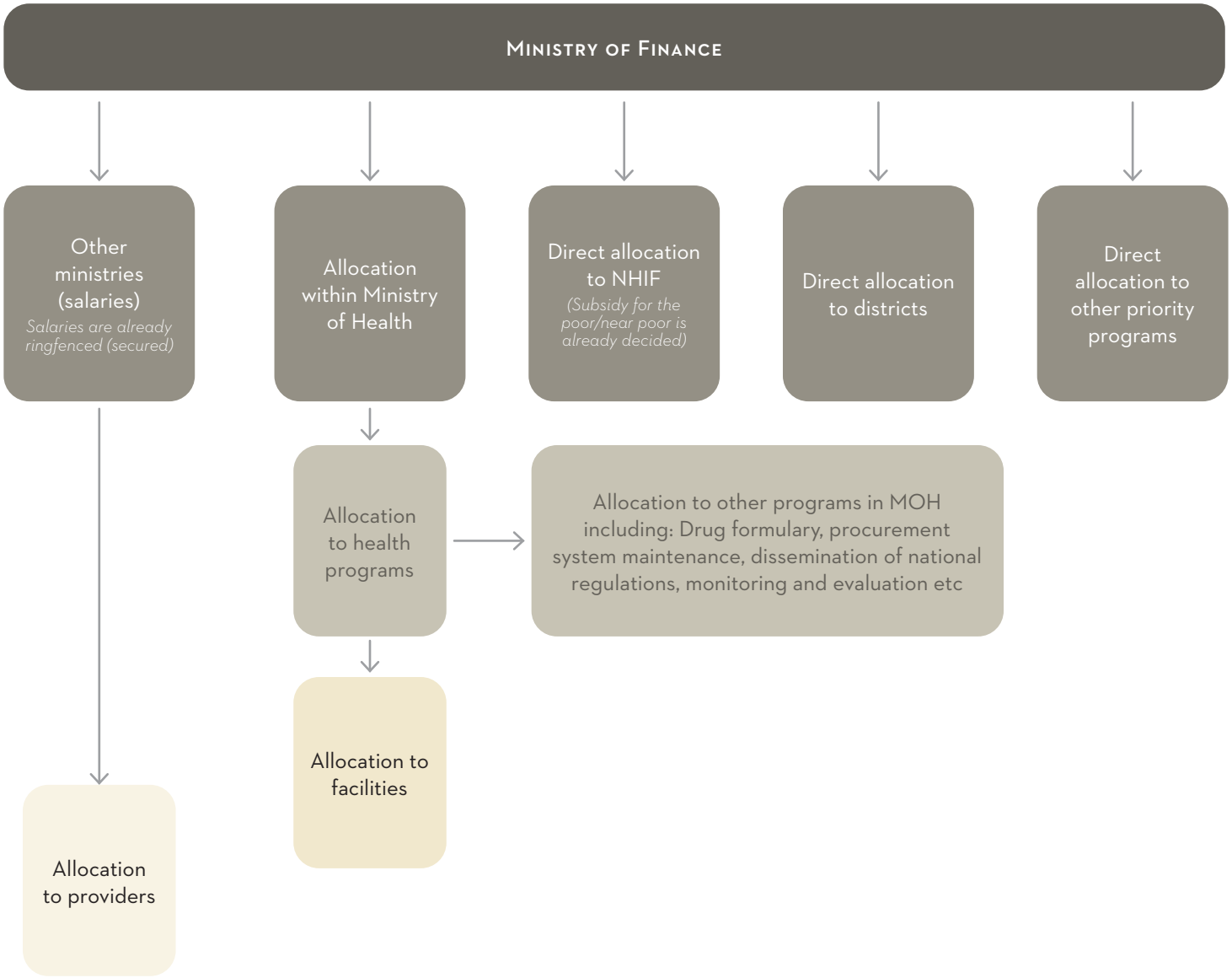
Resource allocation according to health priorities

Resources are allocated by line items with targets linked to sector priorities. There are regulations dictating that funds should flow according to sector priorities. However, aspirational planning documents are not well aligned to annual roll out planning and the health workplan. Fund allocation is somewhat predictable, although there have been deficits due to resource availability and insufficiency constraints. Delays in transfers have recently been minimized.

Expenditure and monitoring against health priorities

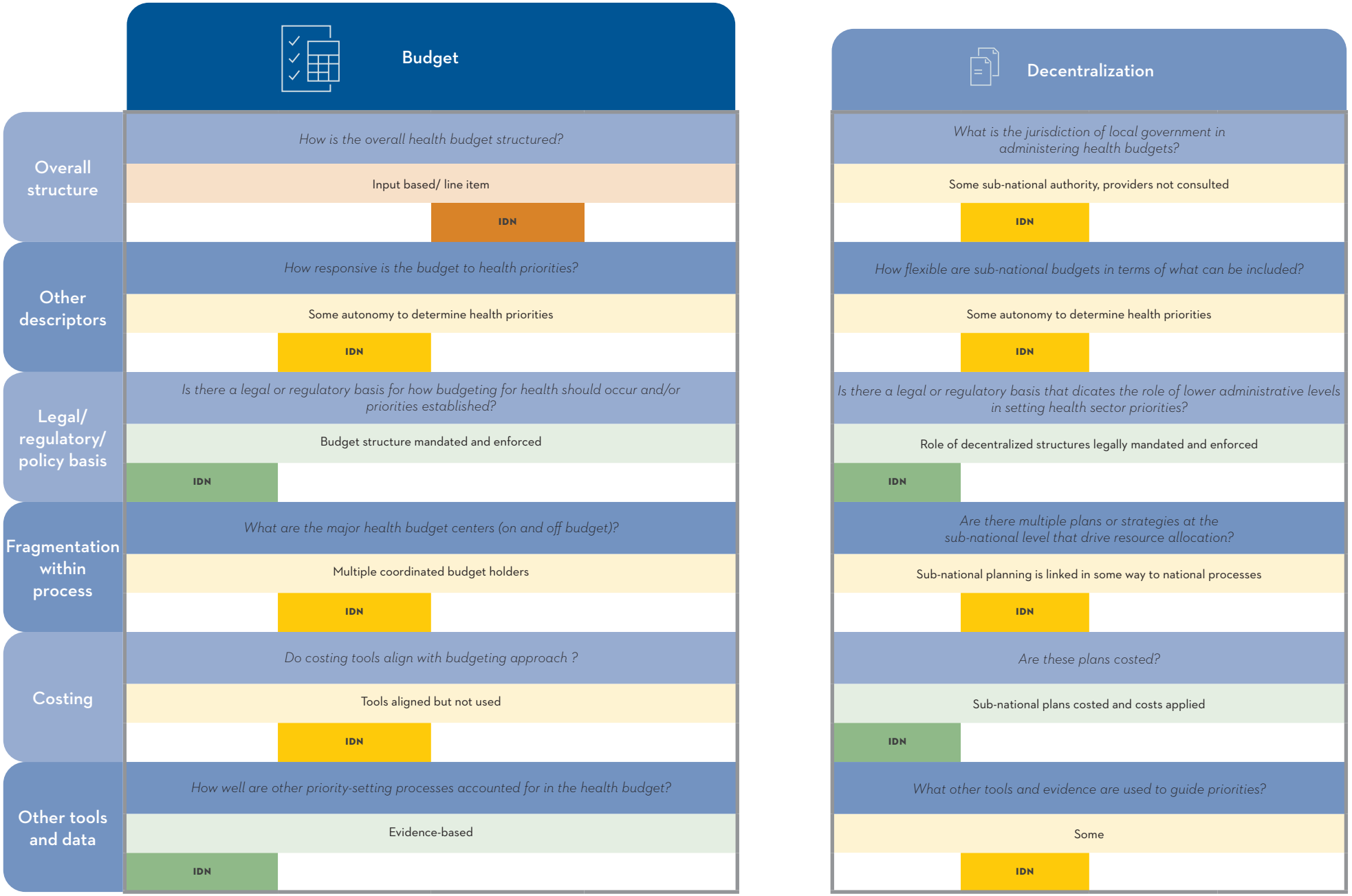
Intergovernmental fiscal transfers from central to district level are pooled and there is some flexibility to reallocate according to emerging priorities. For the most part, funds are paid according to priorities with a mix of input and output based payment mechanisms used. Only capitation can be linked with payment for health priorities due to a clear set of indicators in place. While there are diagnosis-related groups (DRGs) at the hospital level, these have not been adjusted in some time and are not sufficient to control and cover costs. The Government of Indonesia is still improving the right mechanisms to ensure accountability and consistency, especially between national and district strategic documents and the annual budgeting and workplan development. There are quarterly reconciliations and annual accountability reports, but the information is limited to absorptive capacity. BPJS (Badan Penyelenggara Jaminan Sosial the Social Insurance Administration Organization that set up JKN), however, has strictly limited access to data including expenditure data, which makes monitoring difficult. At the district level, there are punitive systems in place to ensure adherence to the SPM.

FUND FLOW DIAGRAM



Funding flow

Pathway not relevant in country



Part 1: *Budgeting and planning at the national and decentralized levels are fairly well aligned in Indonesia, however the system of budgeting remains input based. Sub-national priorities have the greatest impact on shaping budget priorities: while the HSSP and benefits package are both costed, these costs are limitedly used for decision-making. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Mixed/transitional

IDN

How does the majority of the population access services?

Compulsory tax and contributory scheme

IDN

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Financing of health policies and priorities mandated and enforced

IDN

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Multiple aligned program plans

IDN

Are these plans costed and/or linked to a health financing strategy?

Plans costed, but costs not used

IDN

What other tools and evidence are used to guide priorities?

Evidence-based

IDN

Benefits package

How is/are the public benefits package(s) structured?

Multiple or partial lists for various populations, services, or system levels

IDN

What is included in the benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist

IDN

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits package but not enforced, current or comprehensive

IDN

Outside of the main package, are there other packages specified for specific programs?

Fully unified in overall package

IDN

How is/are the benefits package(s) costed?

Benefits package costed, but costs not used

IDN

What other tools and evidence are used to guide priorities?

Evidence-based

IDN

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Mix

IDN

What is the % of CHE that comes from external resources?

< 10%

IDN

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Donor funding of priorities mandated and enforced

IDN

Are external resources aligned to priorities of the major budget holder?

External resources fully aligned to sector priorities

IDN

Are the costs of donor programs transparent and available to the government?

There is some knowledge of costs

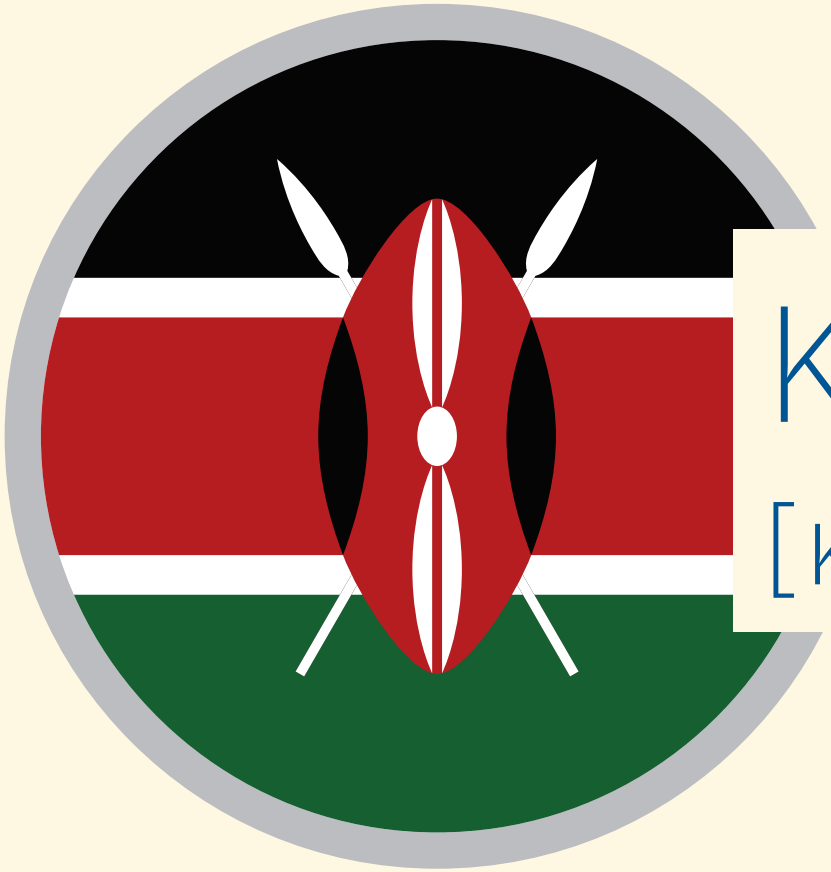
IDN

What other tools and evidence are used to guide priorities?

None

IDN

Part 2: *Fund flow predictability is improving, although there are issues with sufficiency. Capitation at the PHC level helps to link resources to priorities. DRGs at the hospital level use a clinical pathway that allows for cost control, but in implementation, there are many problems in adherence to regulations and fraud on the side of hospital or in payers (BPJS). At district levels there are systems in place to ensure adherence to SPM, but other reconciliation and accountability reports have limited links to priorities. Note that all benchmarks are based on subjective categorization.*



Kenya

[ken]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

Part 1

Central and sub-national budgeting process

Kenya has a devolved government. National and county level governments have been transitioning to program-based budgeting since FY2013/14. Central transfers to counties are made in the form of equitable share allocation (based on a revenue sharing formula and allocated as a block grant), conditional grants, and allocations from a Fuel Levy Fund. County governments also raise own source revenues. County governments, in total, command a similar proportion of the budget as the national Ministry of Health. Though program budgeting is done, in practice, budgeting at county level resources are allocated to outcomes and outputs and implemented through line items. However, program-based budgeting in counties has not been implemented fully as expected. The budgeting process is participatory with stakeholder involvement including the community that is involved in identification of interventions. County governments are responsible for administering their own budget including discretion on how to allocate funds to health, subject to the departmental ceiling set by the County Strategy Fiscal Paper. Budget oversight is through the office of the auditor general, the Controller of Budget and county legislature.

Health financing landscape and other priority-setting processes

Domestic general government health expenditure represents approximately 37% of Kenya's current health expenditure. Most of the population accesses services financed through public funds from general government revenues, and 19.1% of the population have a form of health insurance, with 16% covered by the National Hospital Insurance Fund, a contributory insurance scheme which is mandatory for the formal sector. Out-of-pocket payments (often for medicines and diagnostics) represent nearly 31% of current health expenditure. About a fifth of current health expenditure comes from external donors, and this support is largely off-budget. Donor contributions are included within the MOH budget in key areas (e.g. HIV, reproductive health, immunisation and health system support).

At both the national and county level, health priorities are informed by long-term Government Development plans such as the Kenya Vision 2030, the long term health plans such as the Kenya Health policy; the medium term plans such as the Kenya Medium Term Plan III and the annual development plans in addition to reviews of routine health data, national surveys, and consultation with partners.

Part 2

Resource allocation according to health priorities

Prioritization decisions at national and sub-national level are reflected in the Medium-Term Expenditure Framework driven by national and county-level long-term and annual development plans, participatory planning, and priorities from the legislative arm. These are usually delineated in a budget circular issued by the national or sub-national treasury. National and county level governments are required by law to allocate 70% of the budget to recurrent expenses and 30% to development expenses over the medium term. The budget is also informed by the County Budget Review and Outlook paper which looks at the county budget performance in the previous year and the County Fiscal Strategy Paper which frames the fiscal policy and provides expenditure ceilings.

Conditional grant allocations from donor partners (World Bank and DANIDA) require overall increases in health spending and some requirements /conditions for transfers to certain levels of care but not a particular resource allocation formula. Conditional grants from the national government have criteria based on the kind of fund (e.g. conditional grant for user fee removal reimbursement is based on past utilization), and allocations to semi-autonomous referral hospitals are based on budget requests; while that to regional referral facilities is based on inpatient workload as measured by inpatient bed occupancy.

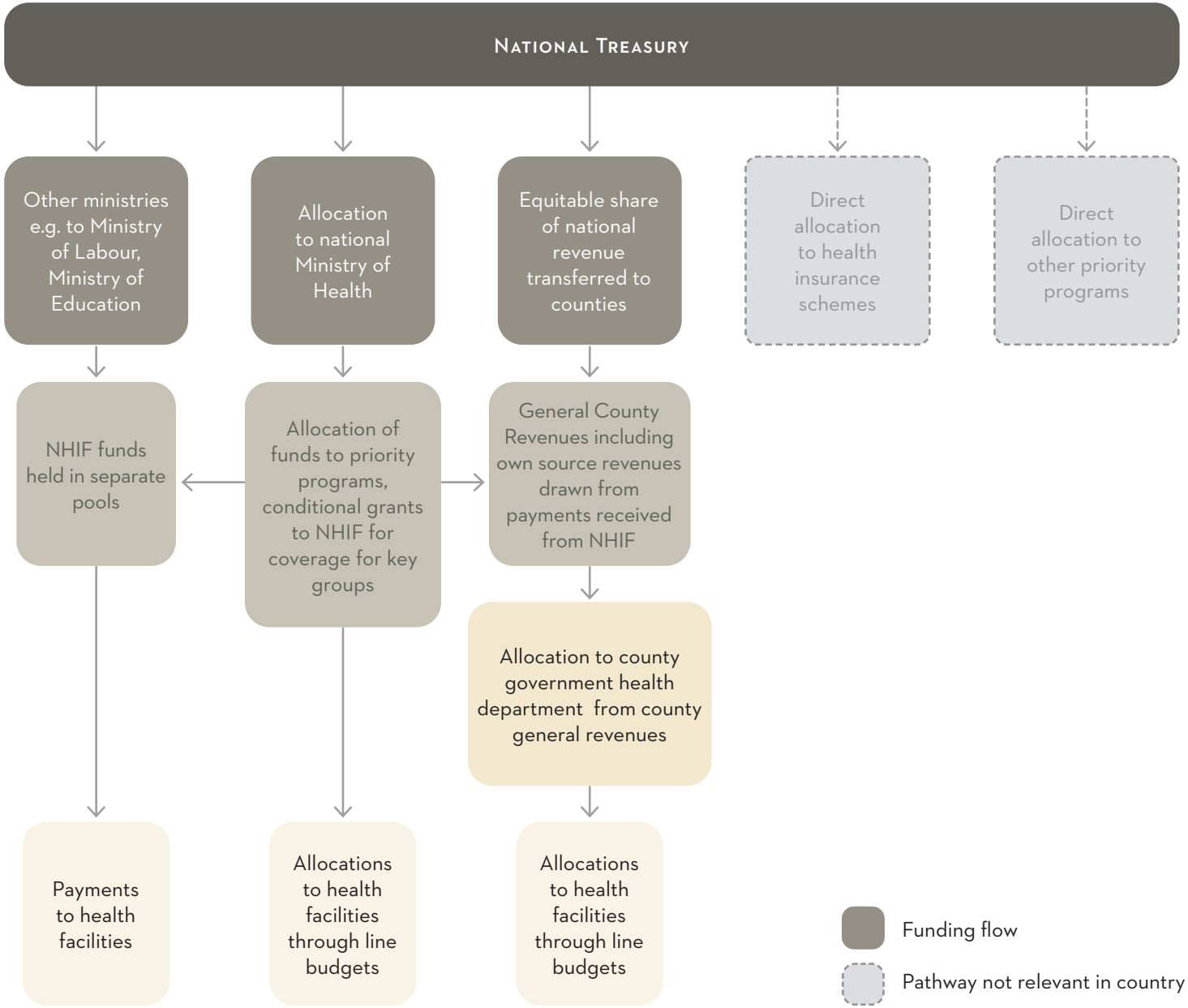
The National Hospital Insurance Fund benefits package development is informed by actuarial analysis and benchmarking, and must be approved by the Board which helps improve its linkages to national health priorities.

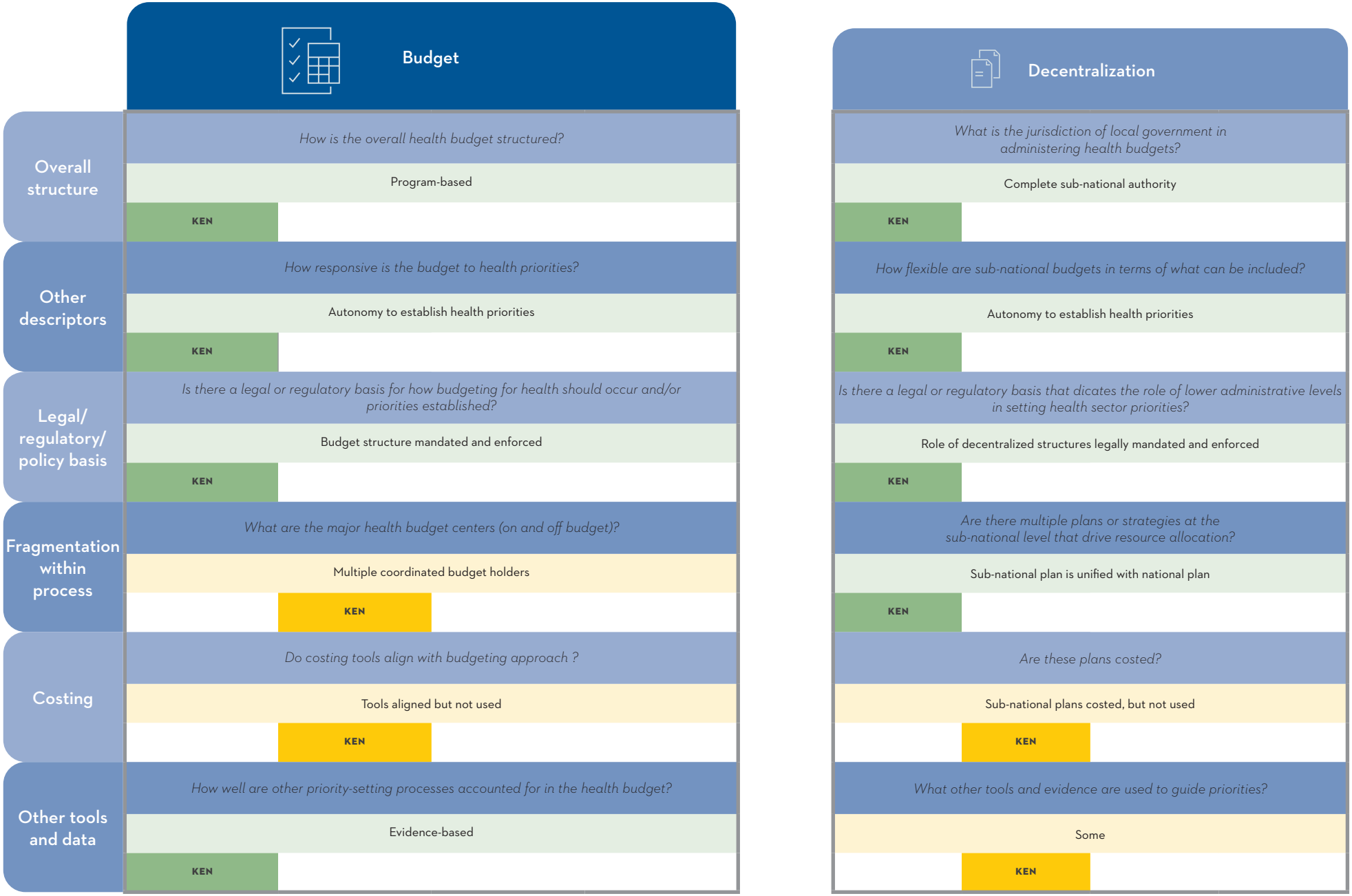
Public health service providers that are semi-autonomous (e.g. referral hospitals or national-level service providers) receive block grants and so have greater flexibility to reallocate funds. Most other service providers (mainly the type managed by county governments) have limited ability to reallocate funding in part given reduced access to funds (PFM rules require funds flow through a centrally held account/fund), reduced managerial responsibility over financial management and over input mix. There are also limits to reallocations across budget lines except as is approved by the People's Representatives within Parliament.

Expenditure and monitoring against health priorities

Providers of health services and public health agencies are paid for mainly using global budgets (for MOH payments for services at public tertiary providers) and line item budgets (for services at the county level), within a budget presented along program lines. Kenya continues to transition to a PBB framework. Other payment mechanisms include capitation, fee for service, case-based payments, and per diem payments (mainly from the NHIF). Expenditure at all levels is mostly tracked by line-item only. The legislative arm monitors budget implementation through receipt and review of quarterly budget implementation reports. The budget process also requires annual performance review with stakeholder involvement, though this process is underdeveloped especially at the sub-national level. The country has adopted the Integrated Financial Management Information System (IFMIS) system for tracking financial performance within the national and county government.

FUND FLOW DIAGRAM





Part 1: *Kenya uses a program-based budget, with health sector priorities established in long-term strategic documents. Most of the population access health services through public services and user fees, while those who are formally employed access services through the NHIF.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Mixed/transitional

KEN

How does the majority of the population access services?

Compulsory contributory scheme

KEN

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Financing of health policies and priorities mandated and enforced

KEN

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Fragmented program plans, but linked to overall plan

KEN

Are these plans costed and/or linked to a health financing strategy?

Plans costed, but costs not used

KEN

What other tools and evidence are used to guide priorities?

Evidence-based

KEN

Benefits package

How is/are the public benefits package(s) structured?

Multiple or partial lists for various populations, services, or system levels

KEN

What is included in the benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist

KEN

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits package but not enforced, current or comprehensive

KEN

Outside of the main package, are there other packages specified for specific programs?

Fragmented benefits packages, but linked to overall package

KEN

How is/are the benefits package(s) costed?

Benefits package costed, but costs not used

KEN

What other tools and evidence are used to guide priorities?

Evidence-based

KEN

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Most donor funding off budget

KEN

What is the % of THE that comes from external resources?

10% < x < 50%

KEN

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Laws and regulations around donor funding but not enforced, current or comprehensive

KEN

Are external resources aligned to priorities of the major budget holder?

Coordination exists, but poor alignment

KEN

Are the costs of donor programs transparent and available to the government?

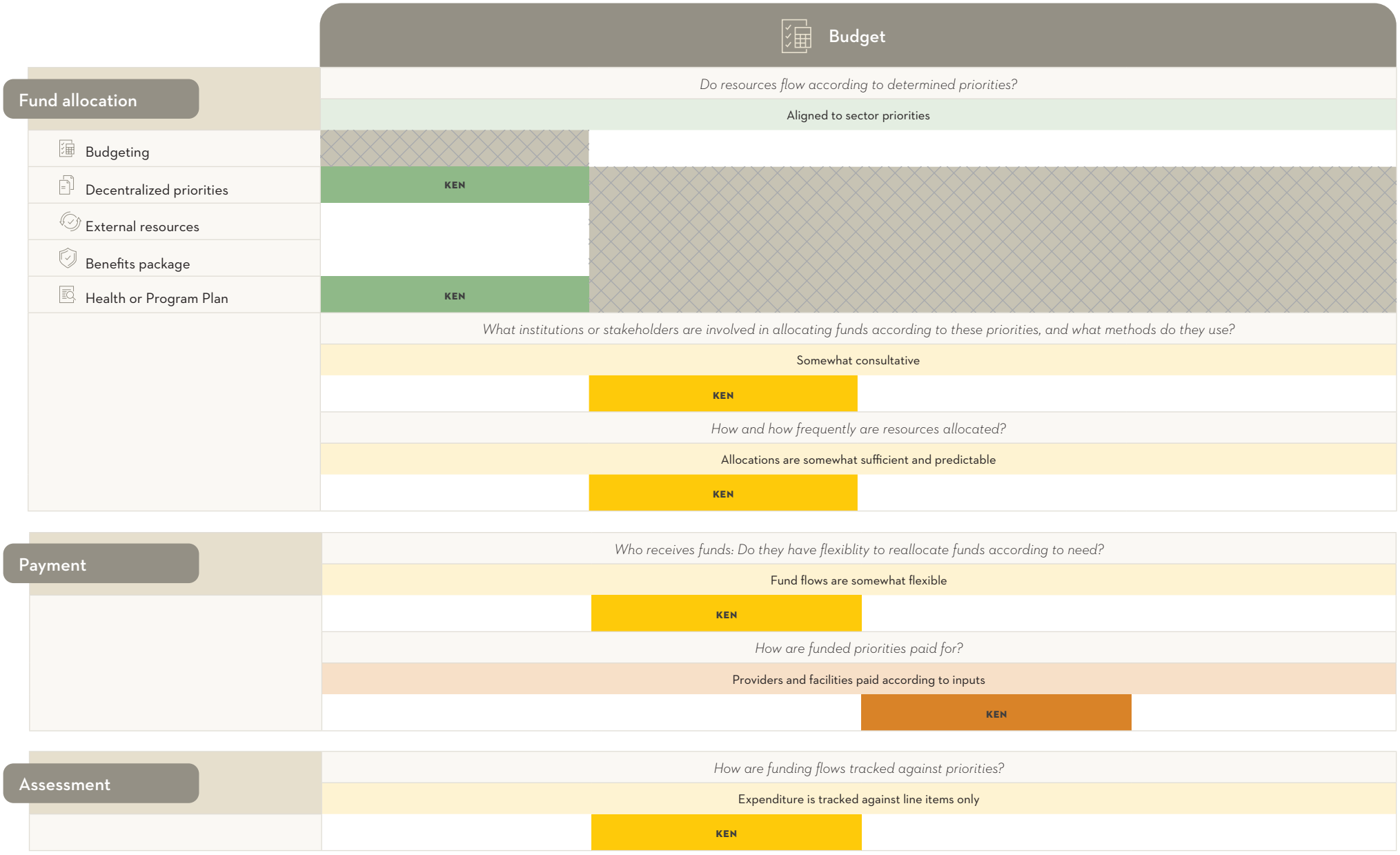
Costed, but costs of programs not available to government

KEN

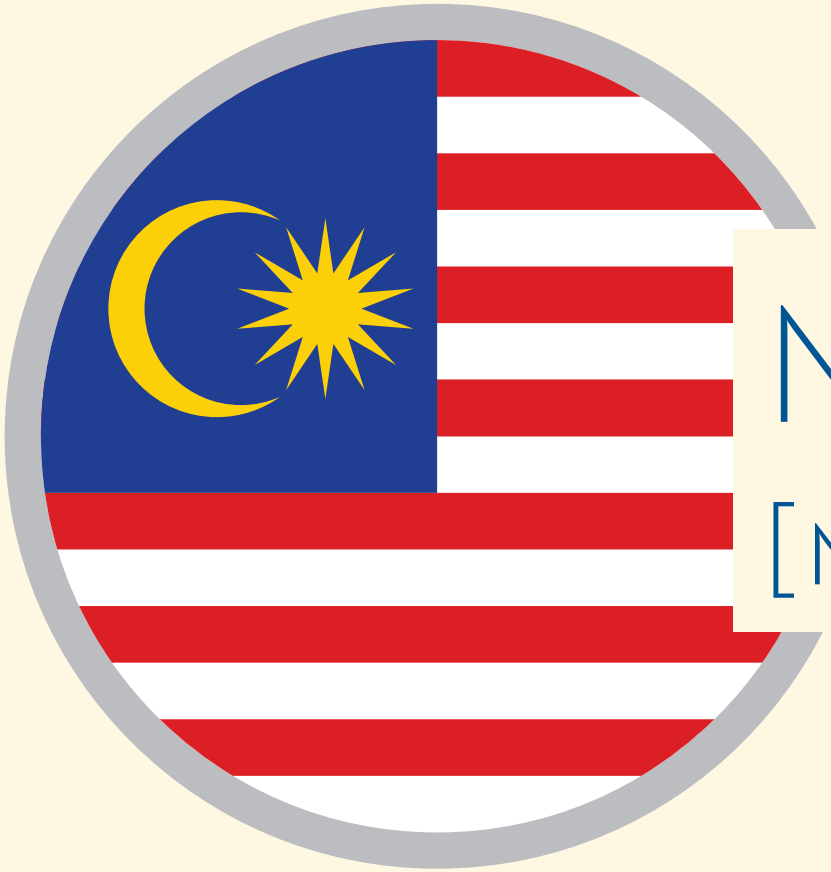
What other tools and evidence are used to guide priorities?

NA

KEN



Part 2: *Resources are largely allocated based on health sector and decentralized priorities through a program-based budget, with somewhat flexible, but often insufficient, funding flows occurring against those priorities. There is budgetary oversight but expenditure is mostly tracked against line-items within annual budget cycles.*



Malaysia

[MYS]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

PART 1

Central and sub-national budgeting process

The Ministry of Finance (MOF) allocates a total budget to the Ministry of Health (MOH) based on review of historical expenditure and new policies approved under the Malaysia Plans. Each year, the MOH, with input from the state health departments, proposes a budget for the subsequent year to the MOF and the Cabinet for review and approval, based on earlier expenditures, budget growth trends, and feedback from lower-level budget holders (state health departments, district health offices, and hospitals).

The decision-making platform in MOH uses the following process: 1) Post-cabinet meeting; 2) MOH Policy Committee Meeting; 3) MOH Planning Steering Committee Meeting; 4) MOH Management Meeting; 5) MOH Special Management Meeting; and 6) Director General of Health Malaysia Special Meeting.

The MOH budget is divided among the various programs — Medical, Public Health, Management, Research and Technical Support, Oral Health, Pharmaceutical Services, Food Safety and Quality. These divisions then allocate the budget to states according to their programs. The state health departments in turn allocate to various 'responsibility centers' – including hospitals, district health offices (which manage public health activities and primary care clinics), district dental offices, and pharmacies – using line-item budgeting.

Health financing landscape and other priority-setting processes

Public health expenditure represents approximately half Malaysia's current health expenditure. There is no social health insurance, though public health services to are offered to all of the population (funded by general revenues/ taxation). However, out-of-pocket health spending represents more than a third of current health expenditure. At the national level, health priorities are informed by strategic plans (5-Year Malaysia Plan, health priorities determined by the Director General of Health and the Minister of Health), SDG and Universal Health Coverage targets, and epidemiologic data, national heath accounts, program monitoring data, and routine health data. Though Malaysia is not fiscally decentralized, state and district/hospital level staff conduct situational analyses to identify priority areas of work to inform short term budgets – these analyses are considered by the MOH to inform national annual budgets. Less than 1% of current health expenditure comes from external donors. Based on a Treasury Circular, a Trust Account was established under Section 9, Act 61 to account for financial contributions from individuals, foreign governments, or international or local bodies which are not entities of the Malaysian government. Such financial contributions are entrusted to government and administered through a Trust Deed for specific purposes. Through this arrangement, financial contributions from external donors are used by the Government in alignment with donors wishes, as long as the funds are subjected to the Trust Deed. All financial contributions for the Trust Account are managed in accordance with the Treasury Circular and for monitoring purposes, a Trust Accounting Committee meeting is held twice a year to report the latest expenses, approve new expenses, and discuss policy matters.

PART 2

Resource allocation according to health priorities

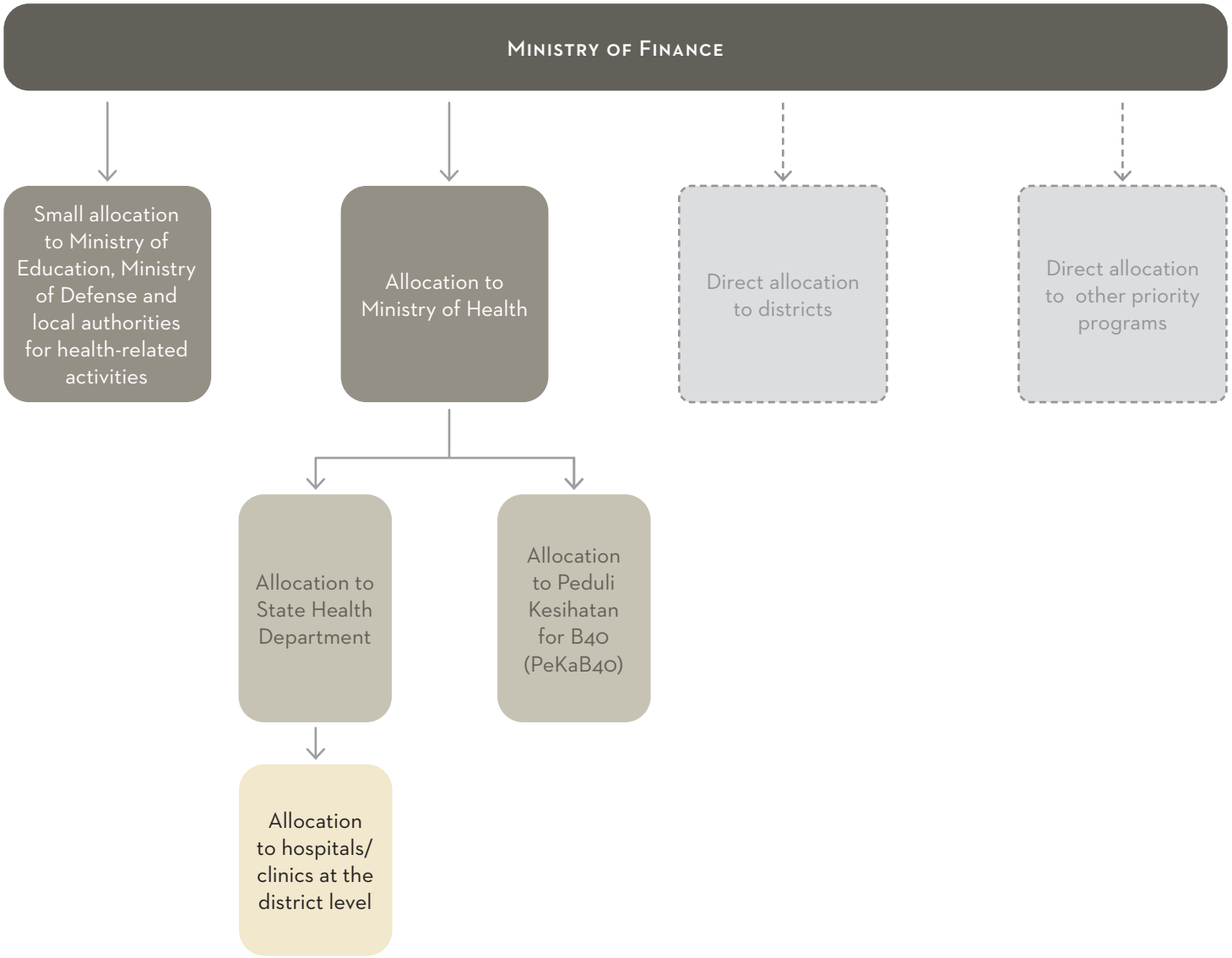
Government health services are almost entirely paid for through a centralized, top-down budget system that allocates funds according to input categories (line items). Budgets cascade downwards from the national Ministry of Health to states, districts, and individual health facilities, such as hospitals. Budgets are programmed according to divisions (programs) within the national ministry, and similar structures are in place at the state level. Public employees are paid salaries at civil service rates.

In 2019, the medical budget accounted for 51% of the total budget. The Ministry of Finance also allocate additional fund through MOH for Peduli Kesihatan for B40 (PeKaB40) which offers non-communicable disease screening for the bottom 40% of population in term of income range.

Expenditure and monitoring against health priorities

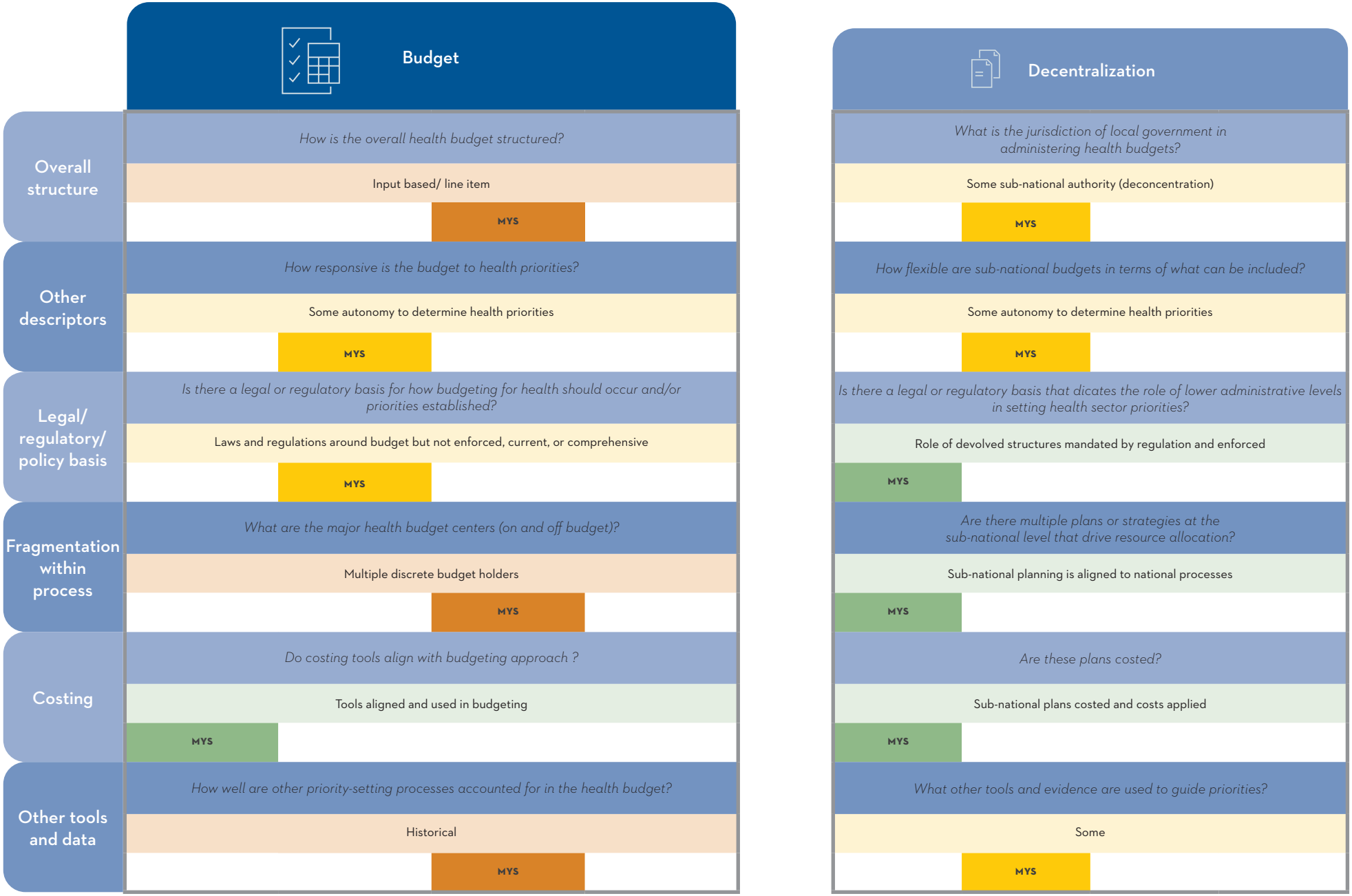
Public health facilities receive a fixed annual budget, organized under standard budget lines and linked to performance indicators and targets which are set based on priorities. Budget reviews are done on a mid-term and annual basis. Audits are conducted regularly at randomly sampled institutions by MOH Internal and External Auditors. Most of the health budget is contained in line-items which cannot be modified. However, hospitals and district health offices have flexibility to reallocate funding within the budget. To do this, they must apply for the Secretary General's approval.

FUND FLOW DIAGRAM



Funding flow

Pathway not relevant in country



Part 1: *Malaysia uses an input-based system. The fiscal system is centralized, with priorities determined by national strategic documents and national steering committee with input from state and district/hospital level consultations on short term budgets. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Mixed/transitional

MYS

How does the majority of the population access services?

Compulsory tax scheme

MYS

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

No laws, regulations around priorities

MYS

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Multiple aligned program plans

MYS

Are these plans costed and/or linked to a health financing strategy?

Plans costed and costs applied

MYS

What other tools and evidence are used to guide priorities?

Some

MYS

Benefits package

How is/are the public benefits package(s) structured?

Single centrally established negative list

MYS

What is included in the benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist

MYS

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

No laws, regulations around benefits packages

MYS

Outside of the main package, are there other packages specified for specific programs?

Fragmented benefits packages, but linked to overall package

MYS

How is/are the benefits package(s) costed?

Benefits packages costed and costs applied

MYS

What other tools and evidence are used to guide priorities?

Some

MYS

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

NA

What is the % of CHE that comes from external resources?

< 10%

MYS

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Donor funding of priorities mandated and enforced

MYS

Are external resources aligned to priorities of the major budget holder?

External resources fully aligned to sector priorities

MYS

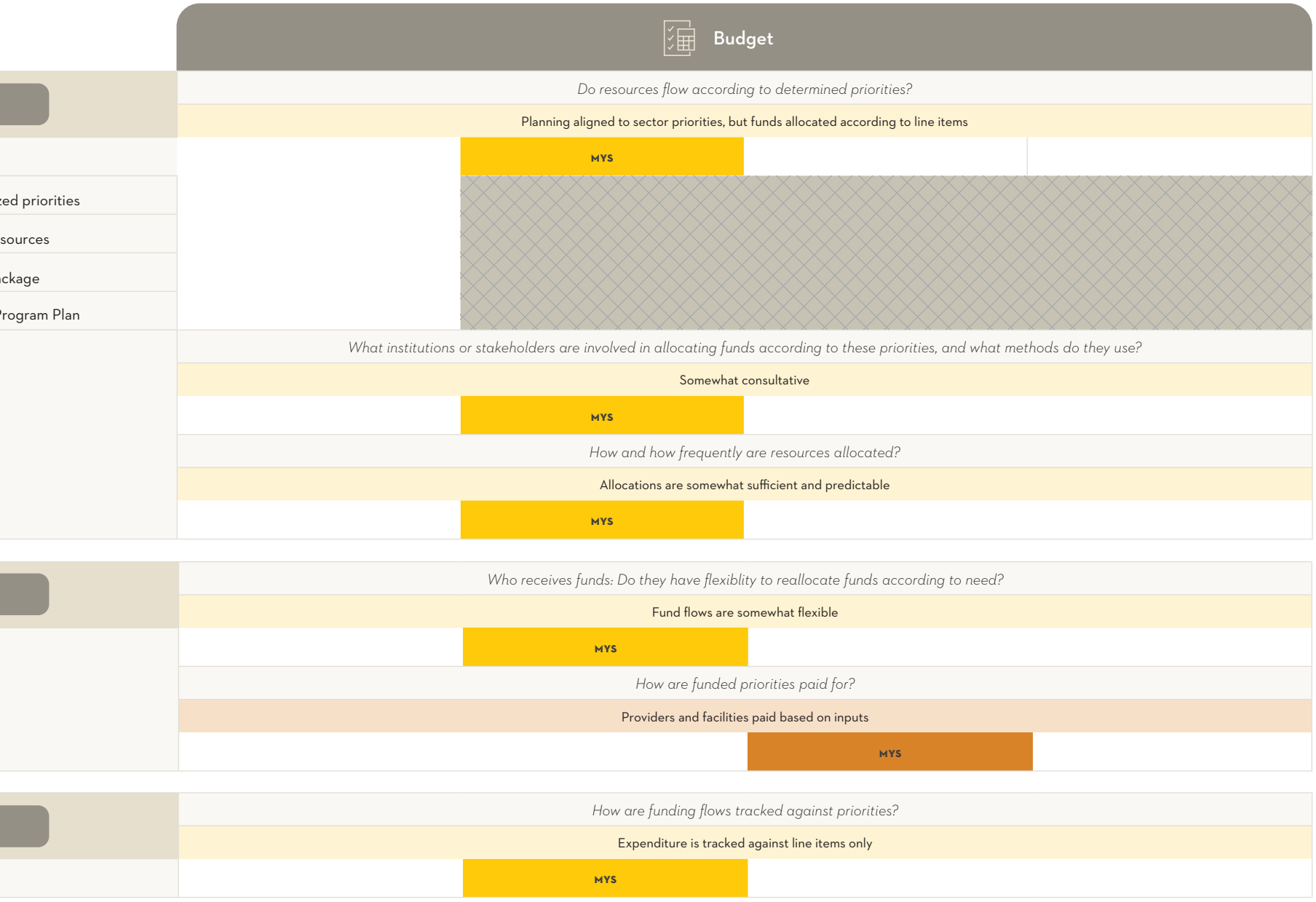
Are the costs of donor programs transparent and available to the government?

Costs are fully available to government

MYS

What other tools and evidence are used to guide priorities?

NA



Part 2: *Malaysia allocates resources according to historical spending data and consultation with districts and hospitals. Allocations are somewhat predictable and sufficient, with mostly inflexible funding flows occurring against those priorities. Expenditure is tracked against line items. Note that all benchmarks are based on subjective categorization.*

Mongolia

[MNG]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

Part 1

Central and sub-national budgeting process

The MOF implements a program-based budgeting approach whereby the health sector uses some form of prioritization to direct resource allocation. However, the linkage between health policies or plans and the budget is seen still weak. Budgeting is incremental based on the previous year's actual execution. Reporting is still on the basis of line items, which limits flexibility and reduces the power of purchasing arrangements. In terms of resource flows, 30-40% of funds go through sub-national governments. The Integrated Budget Law (IBL) mandates the structure of the budget and resource flows. Mongolia is a deconcentrated state with fiscal centralization. However, there is little flexibility or autonomy for budgeting at the sub-national level and the MOH remains the central entity for priority-setting. While there is some legal precedent to include citizen participation, this does not occur. MOH contracts with local provincial governors and district hospital directors, who guide top down decision-making. A separate costed plan is created as a part of this contracting process.

Health financing landscape and other priority-setting processes

Mongolia has a mixed transitional system with OOP as a percentage of CHE at 36%. Donor resources are only 4% of CHE, and do not flow through government channels. There is understaffing and little human resource capacity to monitor donor funding. Currently, two healthcare purchasing mechanisms operate in Mongolia: (1) the tax-funded system and (2) social health insurance. Under the tax-funded system, Ministry of Health (MOH) purchase a defined package of healthcare services from public healthcare providers for the population in Mongolia. under SHI, the Health and Social Insurance General Office (HSIGO) is responsible for collecting contributions from SHI members, managing health insurance funds and purchasing healthcare services from accredited public and private healthcare providers. Social health insurance covers approximately 90% of the population in 2018 and is contributory. While intended to cover out and inpatient care, the SHI program mostly includes curative care at secondary and tertiary level hospitals with some outpatient services. The government covers provision of preventive, public health and maternal and child care, as well as treatment of chronic and infectious diseases such as diabetes and HIV/AIDS. Health and health insurance laws differentiate medical care that is covered by the government vs the insurance program. Benefits covered by SHI will increase and expand as the system gets stronger in order to reduce burden on the state budget. A health sector master plan is currently under development which will be the implementation plan for the state policy. No cost effectiveness analysis or budget impact analysis is used for decision-making.

Part 2

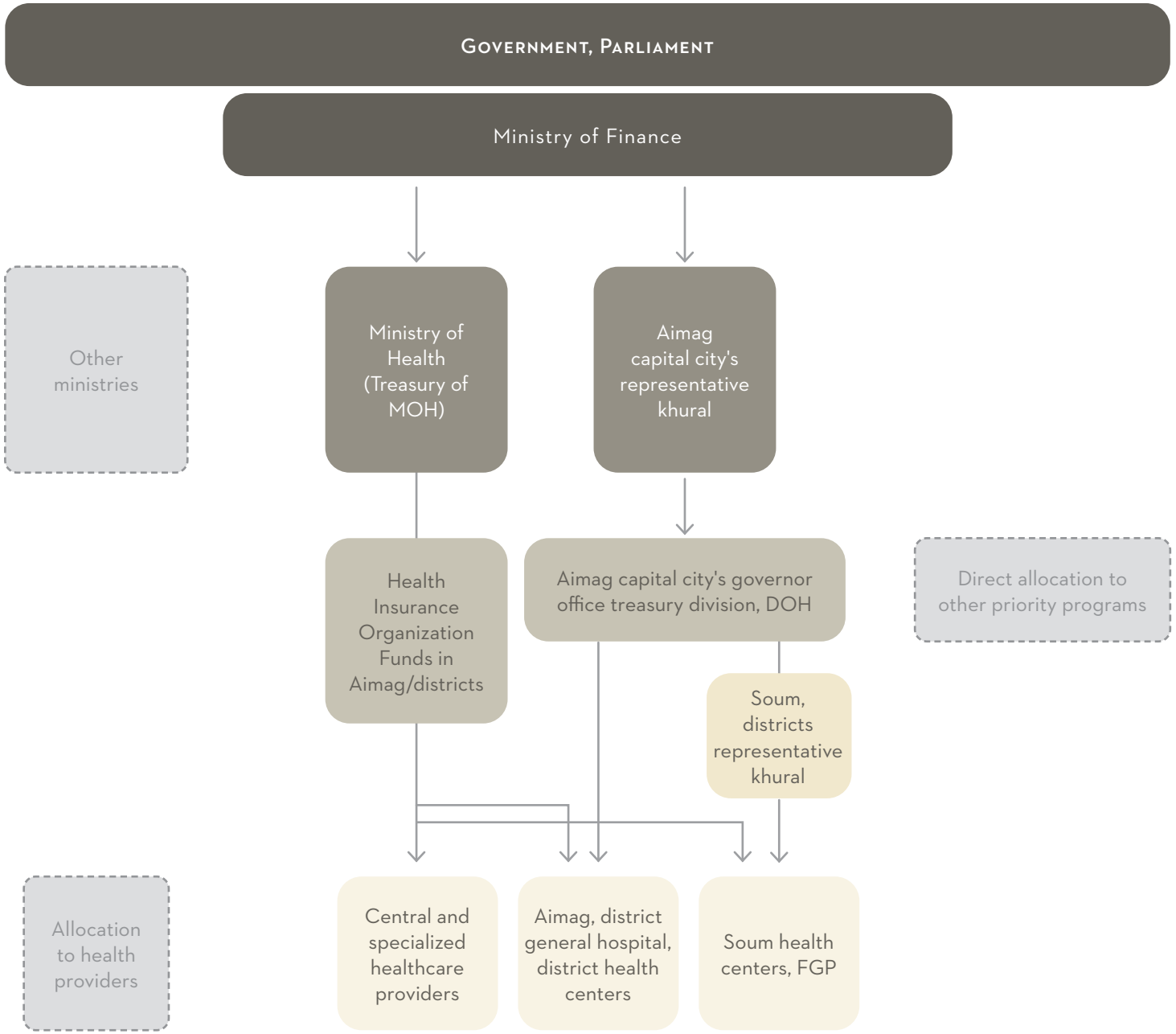
Resource allocation according to health priorities

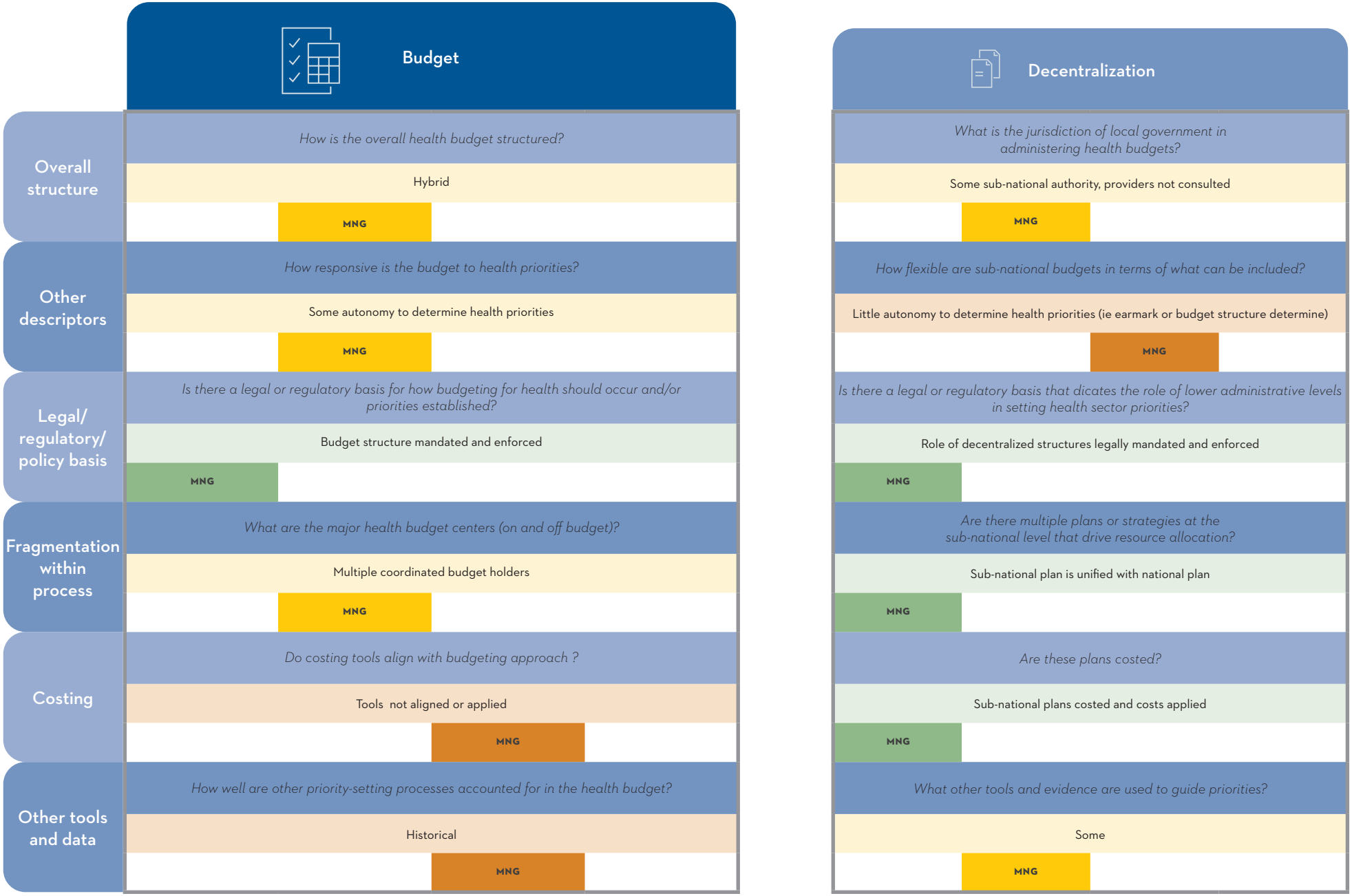
While at the decentralized level some local priorities are taken into account, as a whole planning is still driven by inputs instead of being output-based. There is no clear plan for how to match health service provision with population health needs in Mongolia for either the Health Insurance Organization or general budget revenues. Finance officers in the MOH use some criteria such as population growth, number of beds etc. to make decisions on resource allocation. A capitation formula is used and adjusted based on other needs-based drivers. Inter governmental transfers are not stable, predictable, and transparent. The current system prevents the public purchaser from using output information and needs-based information to allocate resources. Resource allocation is mostly based on historical budgeting,

Expenditure and monitoring against health priorities

While strategic purchasing mechanisms are in place on the revenue side, line item budgets are the main mechanism used to transfer resources to healthcare providers under the tax-funded system. Primary health care providers receive capitation-based resource allocations. The health insurance authority has some autonomy but is not able to act as an active purchaser. There is lack of flexibility to reallocate funds to priorities, although a 2013 law allowed for greater flexibility at the hospital level. Reporting occurs around line items only and there is no mechanism for reviewing and revising resource allocation decisions. Financial budget reports are also ready too late in the year to be used to inform resource allocations.

FUND FLOW DIAGRAM





Part 1: *While some program-based elements are in place, the role of priority-setting in the budget is limited due to reporting against line items. At decentralized levels, contracting defines the parameters of how priorities are set. Benefits are split between the NHI and public sector. The benefits package(s) are not costed. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Mixed/transitional

MNG

How does the majority of the population access services?

Compulsory or non compulsory tax or contributory scheme

MNG

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Laws and regulations around piroties but not enforced, current or comprehensive

MNG

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Program plans fully unified in overall plan

MNG

Are these plans costed and/or linked to a health financing strategy?

Programs and/or sector plan uncosted

MNG

What other tools and evidence are used to guide priorities?

Some

MNG

Benefits package

How is/are the public benefits package(s) structured?

Multiple or partial lists for various populations, services, or system levels

MNG

What is included in the benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist

MNG

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits package but not enforced, current or comprehensive

MNG

Outside of the main package, are there other packages specified for specific programs?

Fragmented benefits packages

MNG

How is/are the benefits package(s) costed?

Benefits package uncosted

MNG

What other tools and evidence are used to guide priorities?

None

MNG

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Most donor funding off budget

MNG

What is the % of CHE that comes from external resources?

< 10%

MNG

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Donor funding of priorities mandated and enforced

MNG

Are external resources aligned to priorities of the major budget holder?

Coordinaton exists, but poor alignment

MNG

Are the costs of donor programs transparent and available to the government?

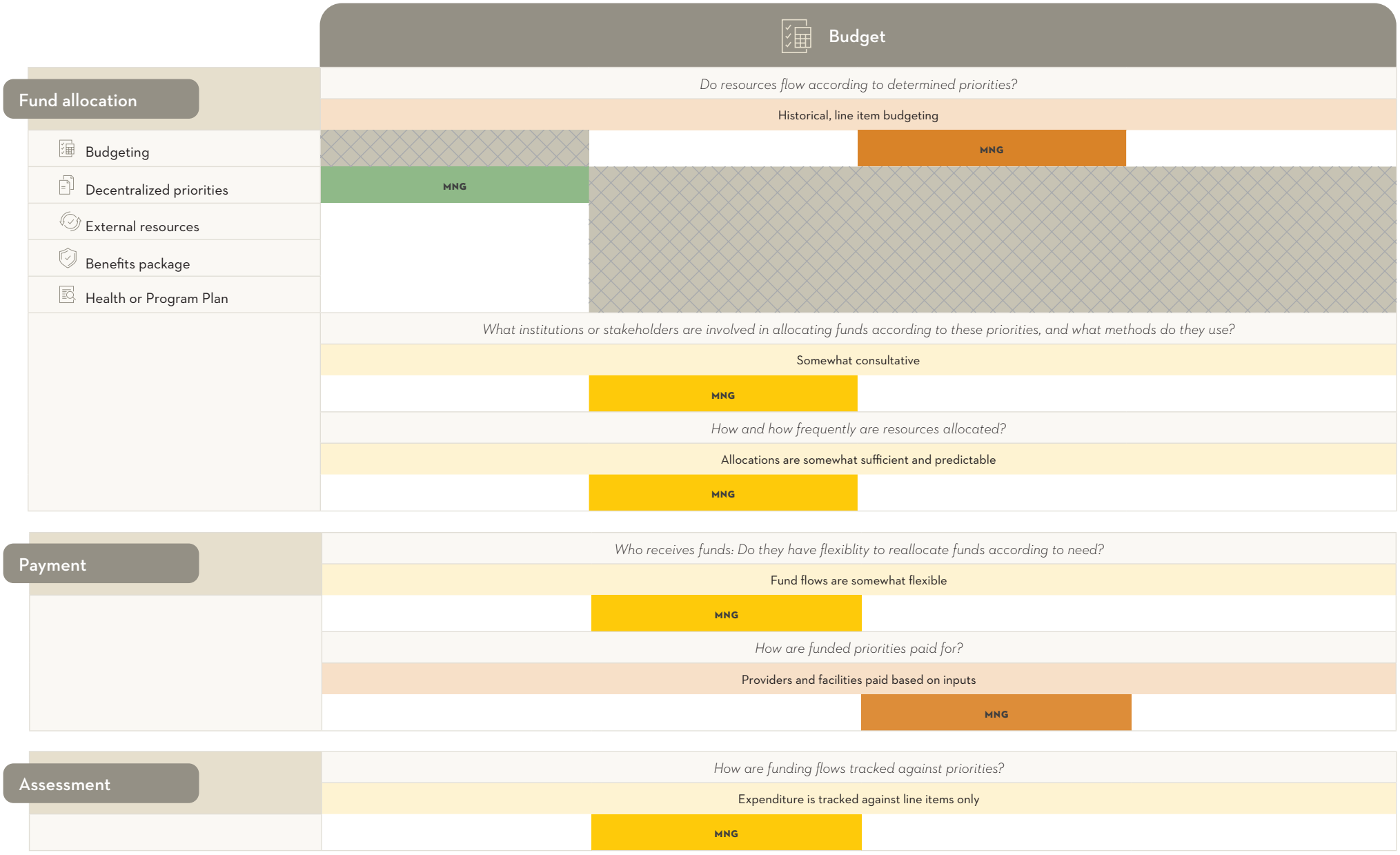
There is some knowledge of costs

MNG

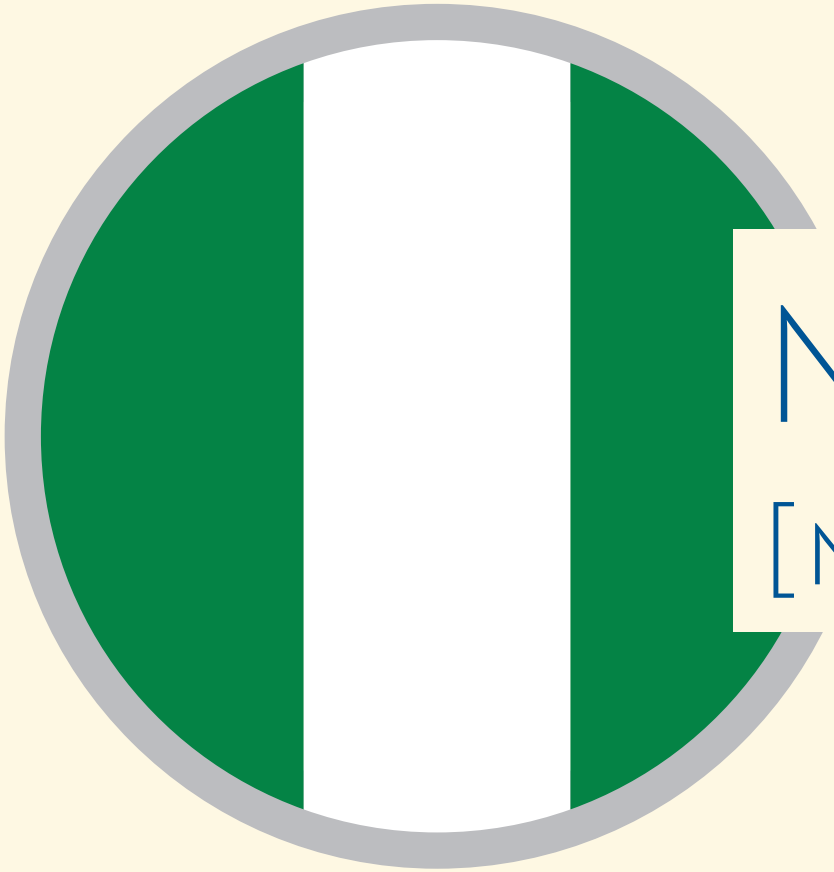
What other tools and evidence are used to guide priorities?

None

MNG



Part 2: *Some prioritization informs resource allocation, but the role for priority-setting is limited. For the most part, historical budgeting informs trends. While strategic purchasing mechanisms are in place on the revenue side, all expenditure reporting is by line item. Note that all benchmarks are based on subjective categorization.*



Nigeria

[NGA]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

PART 1

Central and sub-national budgeting process

Decentralization in Nigeria means that state and local government authorities have jurisdiction to plan and administer health budgets. At the federal level, there is input based line item budgeting with Ministries, Departments and Agencies being allocated funds under personnel, overhead, recurrent and capital expense categories. State governments receive block grants and earmarked grants from the federal government which is then allocated to State Ministries of Health according to national and local priorities. State Ministries of Health make further allocations to regional programs and to districts via another level of block grants.

Health financing landscape and other priority-setting processes

Domestic general government health expenditure represents approximately 13% of Nigeria's current health expenditure. Health care is financed through four mechanisms: public funds (federal, state and local), insurance (private and public), user fees, and donor support. There are two publicly funded benefit packages prescribed by law at the Federal level for which the National Health Insurance Scheme purchases services. States are at liberty to also define their own benefit package depending on their financing capacity and existing epidemiology. However out-of-pocket payment remain very high at over 75%.

At the national level, health priorities are informed by key strategic documents – the National Health Policy and the Health System Development Plan II. Nearly 10% of current health expenditure comes from external donors which comes in a combination of on and off budget resources. Although platforms for partnership coordination exist, ensuring donor alignment to national priorities and programs remains a challenge.

PART 2

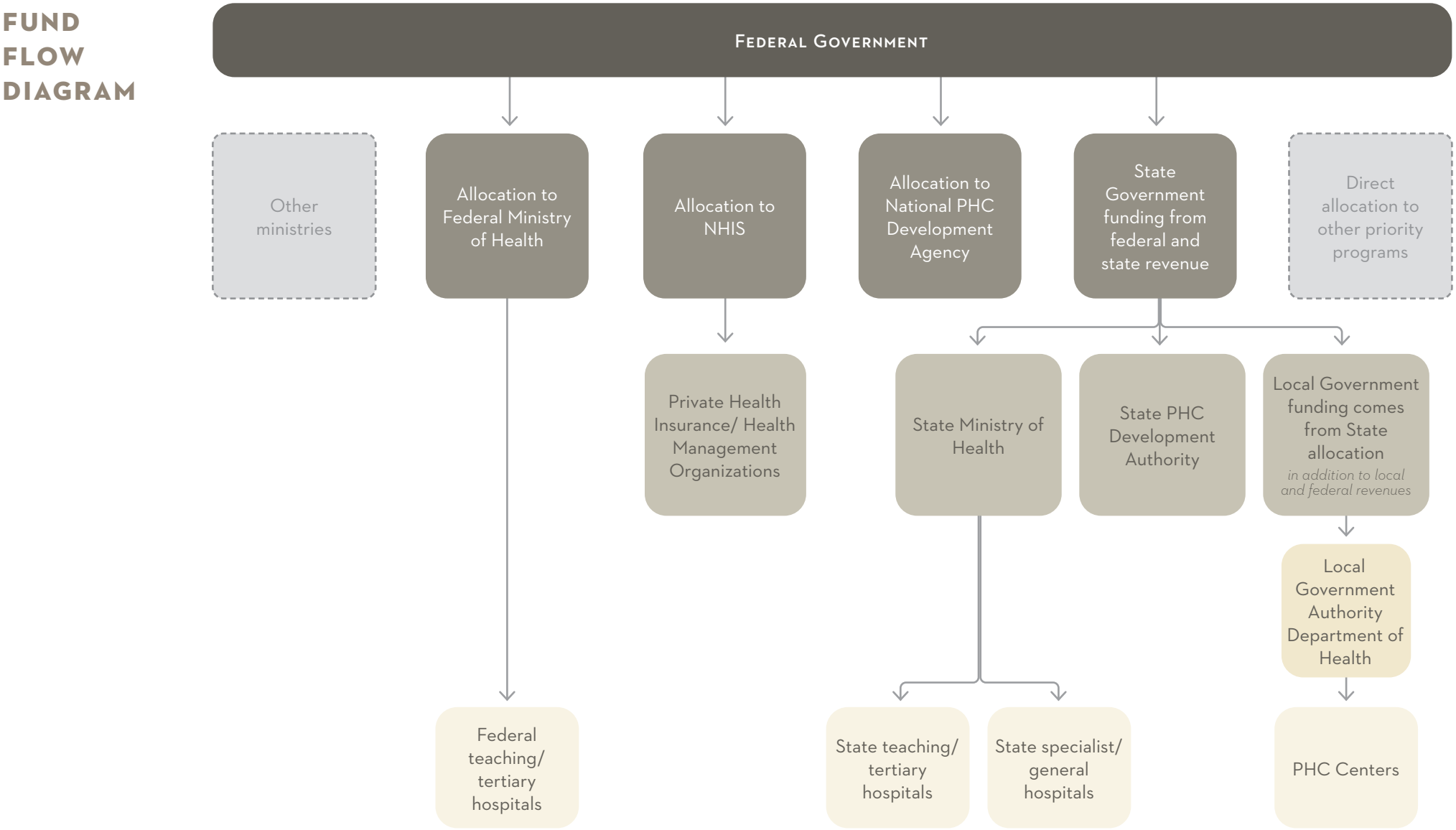
Resource allocation according to health priorities

During the planning stage a 'call circular' is issued by the Ministry of Budget and National Planning to each Ministry to develop their budget aligning with existing national strategy. Unless the circular specifies the envelope for the budget, zero-based budgeting is undertaken. Budget proposals and allocations are consultative but tend to be based on historical budget data. If there are current epidemics or public health emergencies that will require urgent interventions, then decisions are made based on these priorities. Funds are then transferred to the Federal Ministry of Health and separately, to National Health Insurance Scheme, the National PHC Development Agency and State Governments via block grants and earmarked grants. There is a soft earmark wherein some percentage of funds can be reallocated. The remaining allocation remains restricted. Federal Ministry of Health allocates to federal teaching/ tertiary hospitals. State Governments then make allocations to the State Ministries of Health which in turn allocates to State teaching/ tertiary hospitals and State specialist/ general hospitals. Local Government Authorities that receive funding from the State allocation and local and federal revenue fund PHC Centers. Processes for prioritization during budget implementation and operational planning vary but tends to rely on historical trends or political priorities.

Expenditure and monitoring against health priorities

There are different (and often multiple/ fragmented) sources and modalities of paying for funded priorities, overall, they are paid for based on inputs. Monitoring is limited, however there are systematic reporting mechanism. The District Health Information System serves this purpose but the use of existing data for decision-making is poor and not well aligned. Each year at the National Council on Health Meeting, the monitoring and evaluation division of the Department of Health Planning Research and Statistics gives a detailed status report of key performance indicators for the sector that tracks implementation of activities. All States annually publish an audited report of their health budgets and expenditure which includes both capital and expenditure.

FUND FLOW DIAGRAM



Part 1: *The prioritization processes in Nigeria are consultative, with health sector priorities established in long-term strategic documents and decentralized priorities informing a participatory budget process. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Out-of-pocket payments and private sector financing

NGA

How does the majority of the population access services?

Regulated private for profit

NGA

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Laws and regulations around piroties but not enforced, current or comprehensive

NGA

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Multiple aligned program plans

NGA

Are these plans costed and/or linked to a health financing strategy?

Plans costed, but costs not used

NGA

What other tools and evidence are used to guide priorities?

Some

NGA

Benefits package

How is/are the public benefits package(s) structured?

Multiple or partial lists for various populations, services, or system levels

NGA

What is included in the benefits package? How often is it reviewed?

One/more of tertiary, specialist and PHC, but not all

NGA

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits package but not enforced, current or comprehensive

NGA

Outside of the main package, are there other packages specified for specific programs?

Fragmented benefits packages

NGA

How is/are the benefits package(s) costed?

Benefits package costed, but costs not used

NGA

What other tools and evidence are used to guide priorities?

Some

NGA

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Mix

NGA

What is the % of CHE that comes from external resources?

< 10%

NGA

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Laws and regulations around priorities but not enforced, current or comprehensive

NGA

Are external resources aligned to priorities of the major budget holder?

Coordinaton exists, but poor alignment

NGA

Are the costs of donor programs transparent and available to the government?

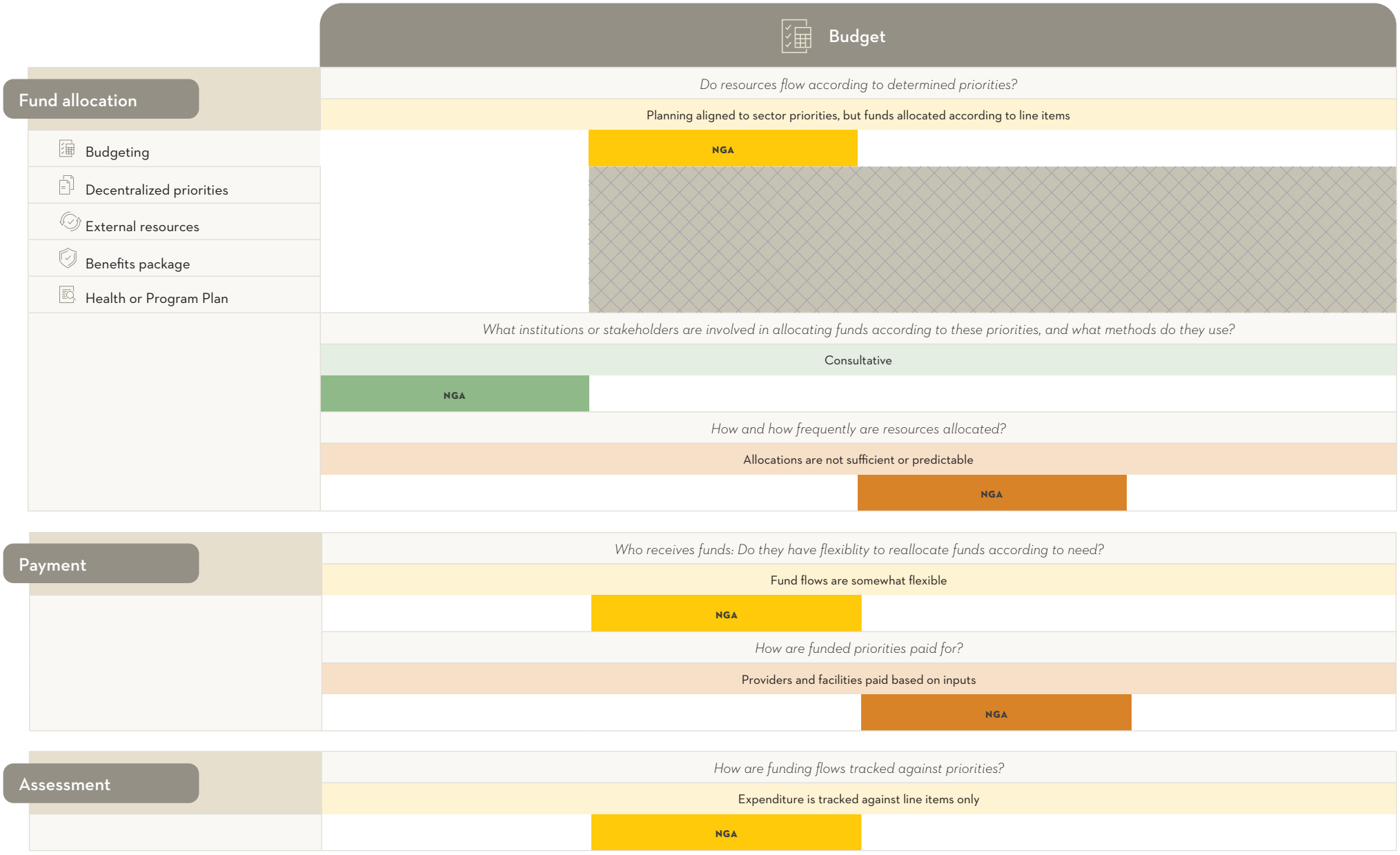
There is some knowledge of costs

NGA

What other tools and evidence are used to guide priorities?

Some

NGA



Part 2: *Resources are largely allocated based on health sector and decentralized priorities, with somewhat flexible, but often insufficient, funding flows occurring against those priorities. There is limited systematic reporting (and where available, reports are mainly not utilized for decision-making). There is no annual process to evaluate expenditure against priorities within annual budget cycles. The National Health Accounts study (which is not conducted every year) is however used to evaluate expenditure against priorities. Note that all benchmarks are based on subjective categorization.*

Philippines

[PHL]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

PART 1

Central and sub-national budgeting process

The Philippines transitioned toward a program-based Budgeting structure in 2018 as part of the Performance Informed Budget initiative by the Department of Budget and Management (DBM). National health priorities strongly inform the budgeting process, in line with the DBM budget priorities framework. Within annual national budget cycles, priorities for spending are established by the Department of Budget and Management and approved by Congress ahead of the annual budget cycle. Sub-national government budget formation follows the national cycle, issuing a Local Budget Memorandum which aligns with national priorities but reflects local priorities and needs.

Health financing landscape and other priority-setting processes

Domestic general government health expenditure represents approximately a third of the Philippines' current health expenditure. Filipinos may access universal health care through the Philippines Health Insurance Corporation, a parastatal institution which offers a costed benefits package to all citizens through a mix of user fees and government subsidies for the poor. However, out-of-pocket payments are high, representing more than half of current health expenditure. At the national level, health priorities are informed by the Department of Health (DOH)-published National Objectives for Health (a medium-term strategic plan) and the Philippine Development Plan. The country is fully devolved, so local government units (LGU) plan, manage and implement local health programs and services using a mix of central financing and local tax revenue. LGUs receive internal allotments from the DBM and exercise discretion on what proportion 80% of the internal grants and all of local revenue are allocated to health, with 20% of the grant allocated in line with a centrally-approved local Comprehensive Development Plans (a medium-term strategic plan) which aligns with Provincial Development Plans. Less than 3% of current health expenditure comes from external donors, and this support is largely off-budget. However, the Philippines requires that all overseas development assistance have government oversight and are aligned with national strategic priorities, and the DOH holds regular coordination meetings with external donors.

PART 2

Resource allocation according to health priorities

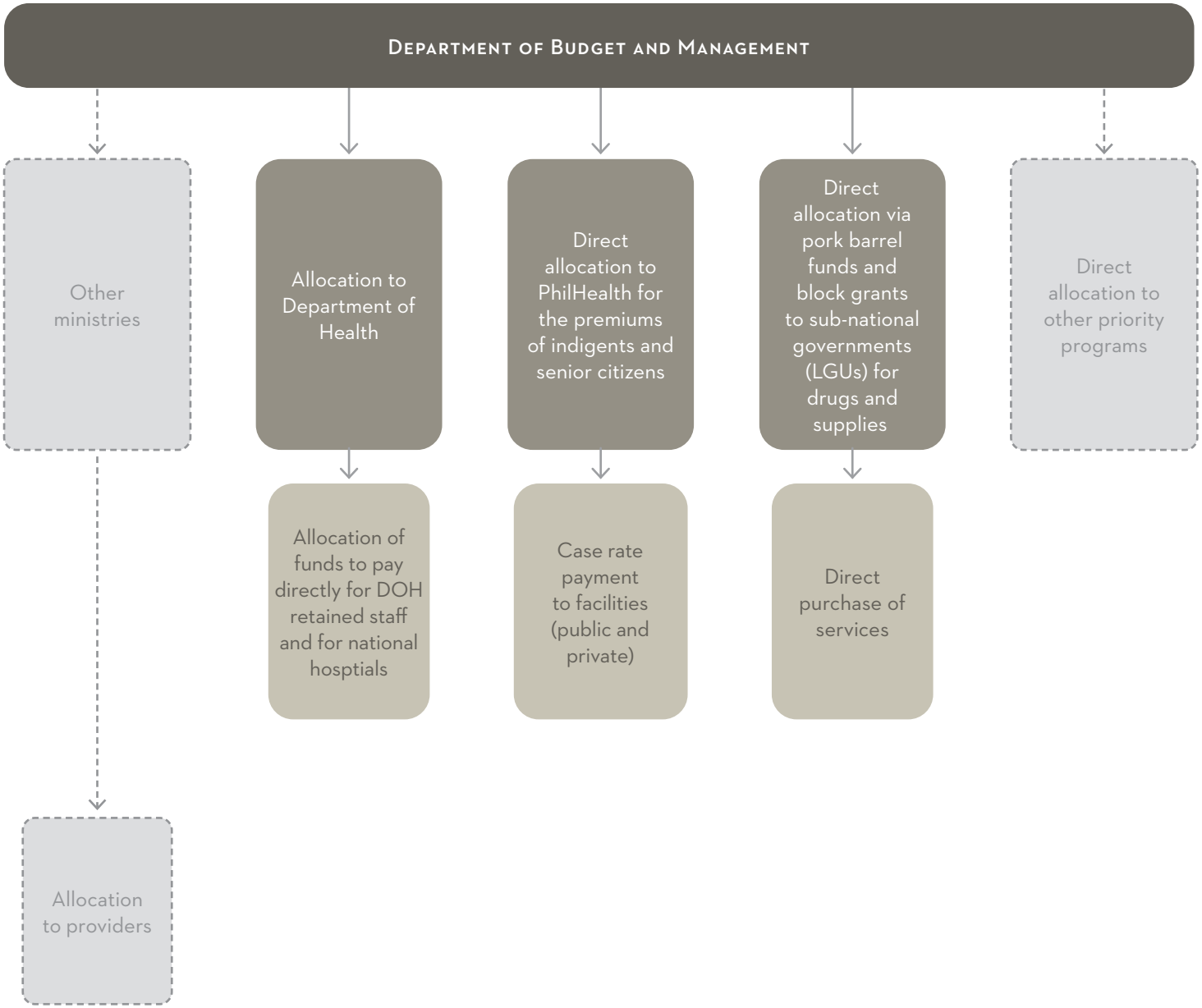
Priorities established in the National Objectives for Health inform the national health budget, Within the health budget set percentages are mandated for allocation to central programs, local governments, Philippine Health Insurance Corporation (PhilHealth), and to attached corporations of the DOH.

Funds are allocated to operating units against established national priorities and according to budget allocations that are made along pre-determined proportions which are shared among multiple budget holders. The DOH allocates most funds to pay directly for DOH-retained staff and National Hospitals, and other centrally-operated institutions. PhilHealth receives an allocation from the DOH budget for a subsidy of premium co-payments for special populations. Local governments receive an allocation of which 20% must be spent on centrally-approved priorities and the rest can be spent at the LGU's discretion.

Expenditure and monitoring against health priorities

Payments to operating units are done by output, and performance indicators are published annually with the General Appropriations Act, which sets out the national budget. These indicators are used to measure spending against performance in audits and accountability reports. Deviations from original allocations by any central operating unit requires an approval process involving the Department of Budget and Management with Executive approval, and local governments must receive approval from the Department of Budget and Management.

FUND FLOW DIAGRAM



Funding flow

Pathway not relevant in country

	Budget	Decentralization
Overall structure	*How is the overall health budget structured?*	*What is the jurisdiction of local government in administering health budgets?*
	Program-based	Complete sub-national authority, providers/facilities consulted
	PHL	PHL
Other descriptors	*How responsive is the budget to health priorities?*	*How flexible are sub-national budgets in terms of what can be included?*
	Some autonomy to determine health priorities	Autonomy to establish health priorities
	PHL	PHL
Legal/ regulatory/ policy basis	*Is there a legal or regulatory basis for how budgeting for health should occur and/or priorities established?*	*Is there a legal or regulatory basis that dicates the role of lower administrative levels in setting health sector priorities?*
	Budget structure mandated and enforced	Role of decentralized structures legally mandated and enforced
	PHL	PHL
Fragmentation within process	*What are the major health budget centers (on and off budget)?*	*Are there multiple plans or strategies at the sub-national level that drive resource allocation?*
	Multiple coordinated budget holders	Sub-national planning is linked in some way to national processes
	PHL	PHL
Costing	*Do costing tools align with budgeting approach ?*	*Are these plans costed?*
	Tools aligned and used in budgeting	Sub-national plans costed and costs applied
	PHL	PHL
Other tools and data	*How well are other priority-setting processes accounted for in the health budget?*	*What other tools and evidence are used to guide priorities?*
	Evidence-based	Some
	PHL	PHL

Part 1: *Budgeting and planning at the national and decentralized levels are fairly well aligned in the Philippines, with health sector reflected in a program-based budgeting structure, and local governments establishing priorities for spending in line with local and national priorities. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Primarily public finance

PHL

How does the majority of the population access services?

Regulated private for profit and not-for-profit

PHL

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

Financing of health policies and priorities mandated and enforced

PHL

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder [eg. TB, HIV etc.]?

Program plans fully unified in overall plan

PHL

Are these plans costed and/or linked to a health financing strategy?

Plans costed and costs applied

PHL

What other tools and evidence are used to guide priorities?

Some

PHL

Benefits package

How is/are the public benefits package(s) structured?

Centrally established positive list

PHL

What is included in the benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist

PHL

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits package but not enforced, current or comprehensive

PHL

Outside of the main package, are there other packages specified for specific programs?

Fully unified in overall package

PHL

How is/are the benefits package(s) costed?

Benefits package costed and costs applied

PHL

What other tools and evidence are used to guide priorities?

Evidence-based

PHL

External resources

How would you categorize the partner landscape in terms of financial contributions to health?

Most donor funding on budget

PHL

What is the % of CHE that comes from external resources?

<10%

PHL

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Donor funding of priorities mandated and enforced

PHL

Are external resources aligned to priorities of the major budget holder?

External resources fully aligned to sector priorities

PHL

Are the costs of donor programs transparent and available to the government?

Costs are fully available to government

PHL

What other tools and evidence are used to guide priorities?

Some

PHL

Budget

Fund allocation

- Budgeting
- Decentralized priorities
- External resources
- Benefits package
- Health or Program Plan

Do resources flow according to determined priorities?

Aligned to sector priorities

PHL

PHL

What institutions or stakeholders are involved in allocating funds according to these priorities, and what methods do they use?

Consultative

PHL

How and how frequently are resources allocated?

Allocations are sufficient and predictable

PHL

Payment

Who receives funds: Do they have flexiblity to reallocate funds according to need?

Fund flows are somewhat flexible

PHL

How are funded priorities paid for?

Providers and facilities paid based on output and aligned to priorities

PHL

Assessment

How are funding flows tracked against priorities?

Clear indicators are in place to track spending against priorities

PHL

Part 2: *Resources are largely allocated based on health sector and decentralized priorities, with flexible and reliable funding flows occurring against those priorities. Performance indicators are used to assess spending in audits conducted within the budget cycle. Note that all benchmarks are based on subjective categorization.*

Vietnam

[vnm]

	BGD		ETH		GHA		IDN		KEN		MYS		MNG		NGA		PHL		VNM
Bangladesh		Ethiopia		Ghana		Indonesia		Kenya		Malaysia		Mongolia		Nigeria		Philippines		Vietnam	

Part 1

Central and sub-national budgeting process

Vietnam has a fiscally decentralized government and uses an input-based system. At the central level, the state budget is granted to the Ministry of Health (MOH), which oversees hospitals and services under MOH control, while the provincial budgets are determined by centrally-determined allocation norms per capita that take into account region and need. Provincial governments determine budget allocations according to national and local priorities. About a third of the state budget for health is held by the MOH, while the rest is held by local governments.

Health financing landscape and other priority-setting processes

Domestic general government health expenditure represents most of Vietnam's current health expenditure. More than two-thirds of the population is enrolled in the Social Health Insurance Scheme, which offers a comprehensive health services package. However, out-of-pocket payments are still more than 40% of current health expenditure. At the central level, there is not a law or regulation on how budget priorities are established, though decisions are guided by the 5-year National Strategy and a Medium-term Expenditure Framework and policy document, which set benchmarks for health spending by the government. These benchmarks emphasize preventative medicine, public health, disadvantaged and poor populations/provinces, amongst other priorities. Funding levels for provinces are determined by centrally-determined allocation norms per capita which considers the regional categorization and level of need. Regional and municipal governments have the autonomy to determine local priorities but are encouraged by the state to adhere to a principle where at least 30% is spent on preventive medicine. Less than 2% current health expenditure comes from external donors, and this support is largely on-budget. Major donor support is directed through general budget support where it is combined with general budgets.

Part 2

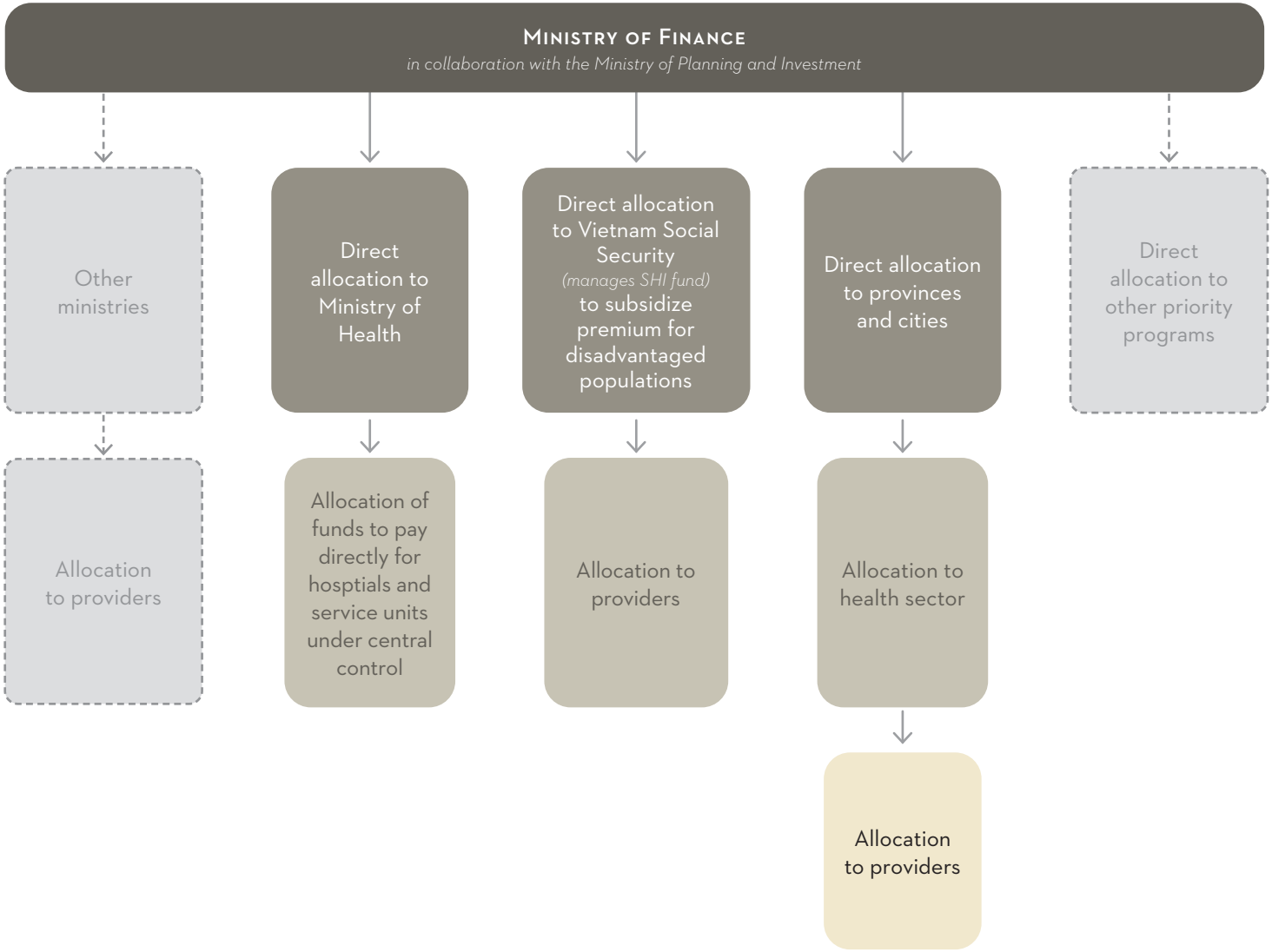
Resource allocation according to health priorities

At the Ministry of Health level, budget allocations are informed by the 5-year National Strategy and a Medium-term Expenditure Framework, but allocations from the MOH to hospitals and services under MOH control are input-based. At the provincial level, the allocation of state budget and financial management is decided by the People's Council and People's Committee, and most allocation for health is based on inputs (i.e., by patient bed, regulated norms). Allocations to health vary by province; often prioritization of competing sector projects reduces the local budget for health.

Expenditure and monitoring against health priorities

The annual health budget is granted directly to the units providing services through the Ministry of Health, including hospitals and units directly under the central government or departments of health/departments of finance for the provinces. Localities with decentralized authorities have the ability to decide on the budget allocation for local health agencies and have flexibility to reallocate. Expenditures are tracked against line items during an audit.

FUND FLOW DIAGRAM



Part 1: *At the central level, Vietnam has an input-based budgeting system, using allocation formulas and budget law to guide priorities. Provinces also use an input-based system, using locally-determined priorities and a national mandate to prioritize primary health care to guide allocations. Note that all benchmarks are based on subjective categorization.*

Health systems and financing

How would you categorize the domestic health system financing structure?

Primarily public finance

VNM

How does the majority of the population access services?

Compulsory or non compulsory contributory scheme

VNM

Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities?

No laws, regulations around priorities

VNM

Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]

Program plans fully unified in overall plan

VNM

Are these plans costed and/or linked to a health financing strategy?

NA

VNM

What other tools and evidence are used to guide priorities?

NA

VNM

Benefits package

How is/are the public benefits package(s) structured?

Centrally established positive list

VNM

What is included in the benefits package? How often is it reviewed?

All 3 of PHC, tertiary and specialist

VNM

Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package?

Laws and regulations around benefits package but not enforced, current or comprehensive

VNM

Outside of the main package, are there other packages specified for specific programs?

Fully unified in overall package

VNM

How is/are the benefits package(s) costed?

Benefits package uncosted

VNM

What other tools and evidence are used to guide priorities?

Some

VNM

External resources

How would you categorize the partner landscape in terms of financial contributions to heatlh?

Most donor funding on budget

VNM

What is the % of CHE that comes from external resources?

<10%

VNM

Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities?

Donor funding of priorities mandated and enforced

VNM

Are external resources aligned to priorities of the major budget holder?

External resources fully aligned to sector priorities

VNM

Are the costs of donor programs transparent and available to the government?

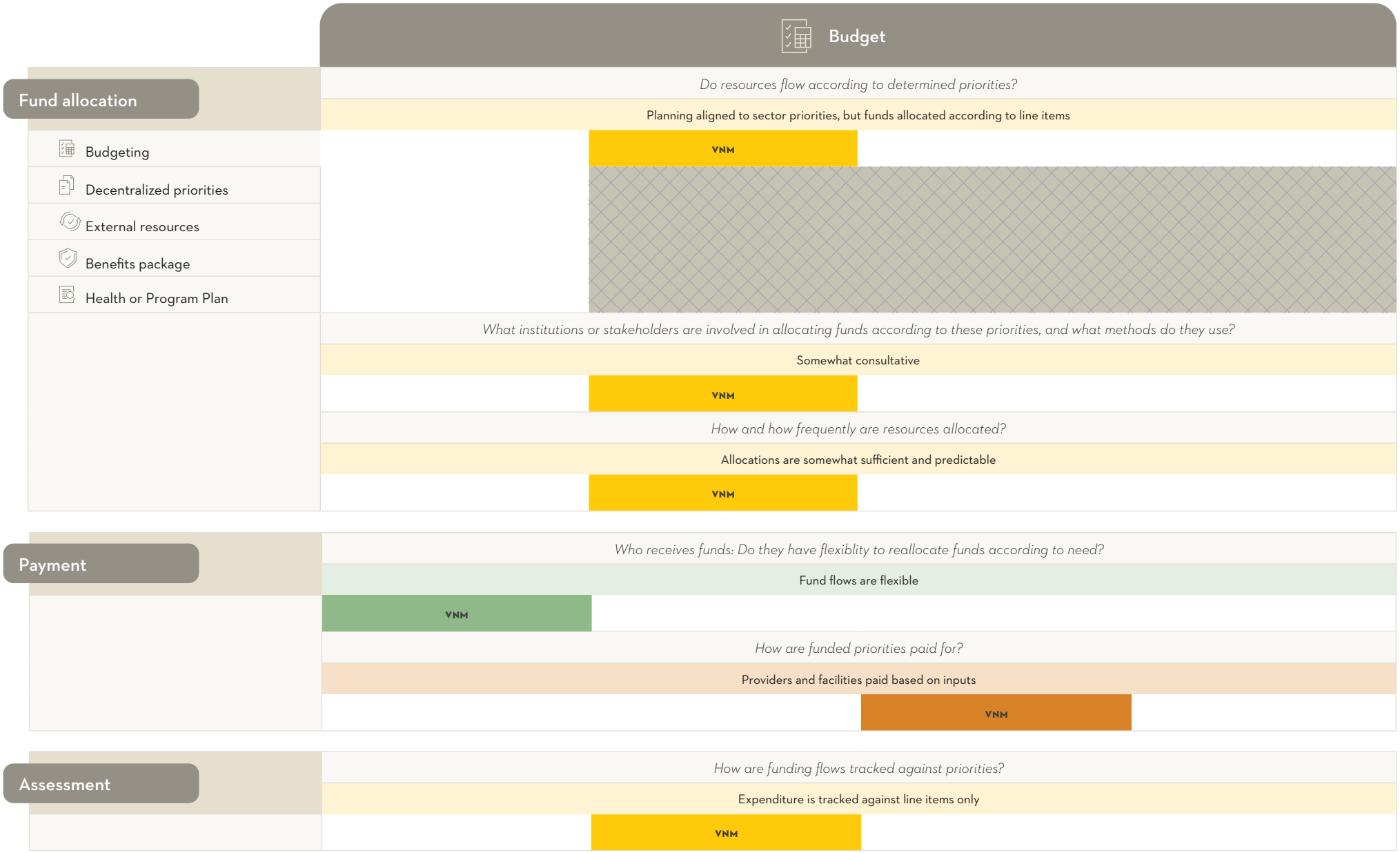
Costs are fully available to government

VNM

What other tools and evidence are used to guide priorities?

Evidence-based

VNM



Part 2: *Resources are largely allocated based according to line item at the national and sub-national level through a somewhat consultative process. Allocations are somewhat sufficient, predictable and flexible. Funding flows occurring against those priorities. Expenditures are tracked against line item. Note that all benchmarks are based on subjective categorization.*

Annexes

Annex A: HePRA Suite at a Glance

HePRA is intended to be independently used by readers who are interested in learning about their countries priority-setting and resource allocation landscape. To support readers in self-populating the tool, which consists of both a questionnaire and visualizations, this Annex will walk through the structure of the HePRA suite in greater detail. A database of detailed country responses that feed into the summary are also included. Readers may also use the rapid response version of the HePRA Tool in Annex B in their own setting.

HePRA Suite

HePRA Database 2019

View the detailed responses from the 10 pilot countries in this Excel document.

www.jointlearningnetwork.org/resources/health-priority-setting-and-resource-allocation-tool/

Blank HePRA Questionnaire

Use this Word document to compile your own detailed responses and determine your benchmarks. You can also build your Funding Flow Diagram from this template.

www.jointlearningnetwork.org/resources/blank-hepra-tool/

Blank HePRA Visualizations

Once you have determined your benchmarks, use this PDF to populate your own visualization.

www.jointlearningnetwork.org/resources/blank-hepra-visualization/

Health Priority Setting and Resource Allocation Benchmarking Tool

This tool includes both a questionnaire and visualization that can be used to create a HePRA Database for your country.

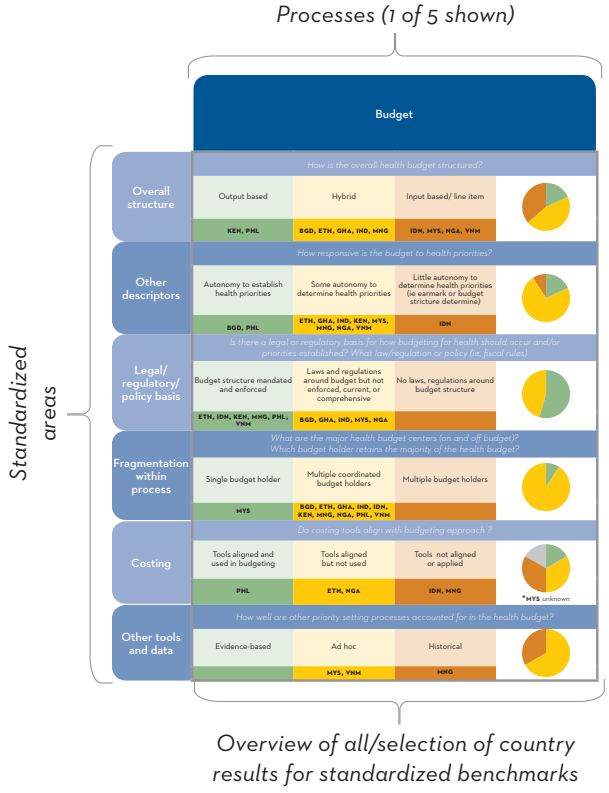
www.jointlearningnetwork.org/resources/health-priority-setting-and-resource-allocation-benchmarking-tool/

HePRA organizes the landscape of priority-setting for health in two parts: **PRIORITY-SETTING** and **RESOURCE ALLOCATION.**

Part 1

In the first part, priority-setting is described across the five major processes that can impact how health priorities are established: budget structure (the backbone of resource allocation), decentralization, health systems and financing structure, benefits package, and external resources for health. These five processes make up the overarching columns within HePRA.

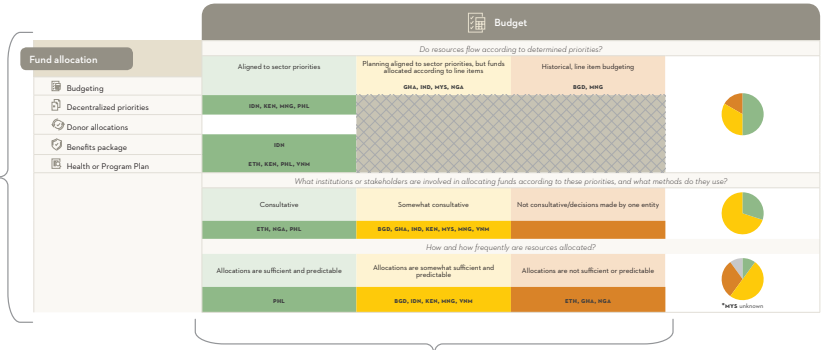
Within each process, the tool lays out six standardized areas which address major components of the processes (overall structure, other descriptors, legal, regulatory, and policy environment, fragmentation, costing, and use of other tools and data to inform prioritization) across rows with accompanying questions. Standardized benchmarks can then be selected to synthesize the narrative response.



Part 2

In the second part, to draw together responses across the five major processes in the tool, HePRA features a high-level set of questions and benchmarks to identify whether funds are allocated according to established priorities, who is involved in allocation decisions, and whether that fund flow is adequate and on time; how funds flow with respect to payment to budget centers and providers, and whether there is flexibility to make changes against emerging priorities; and finally whether there are systems in place to track that funds have indeed been spent according to these identified priorities. Standardized benchmarks can then be selected to capture the nature of each response.

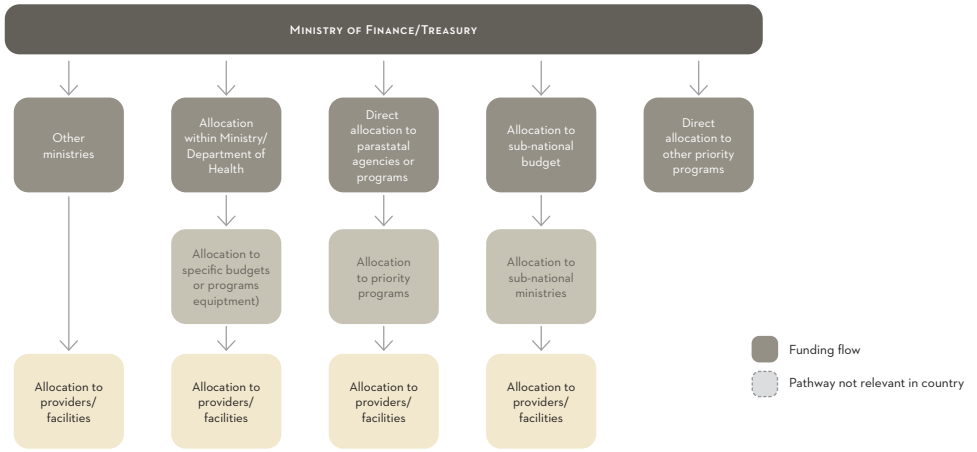
Resource allocation steps (1 of 3 shown)



Overview of all/selection of country results for standardized benchmarks

Funding flow diagram

The funding flow diagram is meant to depict the flow of public funds, from the point of disbursement at the central level, to the Ministry/Department of Health and other entities, through sub-national budget holders and ultimately to providers. The diagram can illustrate where and how decision-making processes drive resource allocation across levels of government and budget holders. The diagram is intended to crystalize which budget holder perspective will be taken when populating the HePRA Tool. We suggest a using the standard template provided in the HePRA Tool.



Annex B: Rapid HePRA Benchmarking Tool

This blank template of the HePRA Tool combines the questions and benchmarks into a single tool for rapid response in order to make answering questions and constructing visualizations easier. More detailed responses can be captured in the word version of the HePRA Questionnaire.

Blank HePRA Questionnaire

Use this Word document to compile your own detailed responses and determine your benchmarks. You can also build your Funding Flow Diagram from this template.

www.jointlearningnetwork.org/resources/blank-hepra-tool/

Health Priority Setting and Resource Allocation Benchmarking Tool

This tool includes both a questionnaire and visualization that can be used to create a HePRA Database for your country.

www.jointlearningnetwork.org/resources/health-priority-setting-and-resource-allocation-benchmarking-tool/

Part 1: Prioritization processes

Questions and benchmarks to describe five major priority-setting elements – please take the perspective of the major budget holder in country where needed and indicate that perspective where relevant. Please indicate the response to the question by placing a "check" in the relevant colored box and adding explanatory notes where needed.

Name of budget holder (please select either major budget holder or chose perspective of a single entity or level where relevant):_____-

Budget

Overall structure

1. *How is the overall health budget structured?*
   - Program based
   - Hybrid
   - Input based/line item

Notes

Other descriptors

2. *How responsive is the budget to health priorities?*
   - Autonomy to establish health priorities
   - Some autonomy to determine health priorities
   - Little autonomy to determine health priorities (i.e. earmark or budget structure determine)

Notes

Legal/ regulatory/ policy basis

3. *Is there a legal or regulatory basis for how budgeting should occur and/or priorities established? What law/regulation or policy (ie, fiscal rules)*
   - Budget structure mandated and enforced
   - Laws and regulations around budget but not enforced/ current/ comprehensive
   - No laws, regulations around budget structure

Notes

Fragmentation within process

4. *What are the major health budget centers (on and off budget)? Which budget holder retains the majority of the health budget?*
   - Single budget holder
   - Multiple coordinated budget holders
   - Multiple budget holders

Notes

Costing

5. *Do costing tools align with budgeting approach?*
   - Tools aligned and used in budgeting
   - Tools aligned but not used
   - Tools not aligned or applied

Notes

Other tools and data

6. *How well are other priority-setting processes accounted for in the health budget?*
   - Evidence-based
   - Ad hoc
   - Historical

Notes

Decentralization

Overall Structure

7. *What is the jurisdiction of local government in administering health budgets?*
   - Complete sub-national authority, providers/ facilities consulted
   - Some sub-national authority, providers not consulted
   - No fiscal decentralization

Notes

Other descriptors

8. *How flexible are sub-national budgets in terms of what can be included?*
   - Autonomy to establish health priorities
   - Some autonomy to determine health priorities
   - Little autonomy to determine health priorities (i.e. hard earmark or budget structure determine priorities)

Notes

Legal/ regulatory/ policy basis

9. *Is there a legal or regulatory basis that dictates the role of lower administrative levels in setting health sector priorities?*
   - Role of decentralized structures legally mandated and enforced
   - Laws and regulations around decentralized role but not enforced/ current/ comprehensive
   - No laws, regulations around role of decentralized structure

Notes

Fragmentation within process

10. *Are there multiple plans or strategies at the sub-national level that drive resource allocation?*
    - Sub-national plan is unified with national plan
    - Sub-national planning is somewhat linked to national processes
    - Sub-national planning is fragmented

Notes

Costing

11. *Are these plans costed?*
    - Sub-national plans costed and costs applied
    - Sub-national plans costed, but costs not used
    - Sub-national plans uncosted

Notes

Other tools and data

12. *What other tools and evidence are used to guide priorities? Please describe who is involved in the process.*
    - Evidence-based
    - Some
    - None

Notes

Health Systems and Financing

Overall Structure

13. *How would you categorize the domestic health system financing structure?*
    - Primarily public finance
    - Mixed/transitional
    - Out-of-pocket payments and private sector financing

Notes

Other descriptors

14. *How does the majority of the population access services? Please describe*
    - Compulsory or non-compulsory tax or contributory scheme (choose one of each)
    - Regulated private for profit or not-for-profit (choose one)
    - Unregulated private for profit or not-for-profit (choose one)

Notes

Legal/ regulatory/ policy basis

15. *Is there a legal or regulatory basis that dictates how resources should be allocated against health sector priorities? What law/regulation or policy?*
    - Financing of health policies and priorities mandated and enforced
    - Laws and regulations around priorities but not enforced/ current/ comprehensive
    - No laws, regulations around priorities

Notes

Fragmentation within process

16. *Are there multiple strategic plans for both the budget holder and different programs funded by that budget holder? [eg. TB, HIV etc.]*
    - Program plans fully unified in overall plan
    - Multiple aligned program plans
    - Fragmented program and sector wide plans

Notes

Costing

17. *Are these plans costed and/or linked to a health financing strategy?*
    - Plans costed and costs applied
    - Plans costed, but costs not used
    - Programs and/ or sector plan uncosted

Notes

Other tools and data

18. *What other tools and evidence are used to guide priorities? Please describe who is involved in the process.*
    - Evidence-based
    - Some
    - None

Notes

Benefits Package(s) covered by major budget holder

Overall Structure

19. How is/ are public benefits package(s) structured?

- Centrally established positive or negative list (choose one)
- Multiple or partial lists for various populations, services, or system levels
- No unified list

Notes

Other descriptors

20. What is included in the benefits package? How often is it reviewed? Please explain how pharmaceuticals are approached.

- All 3 of PHC, tertiary and specialist
- One/ more of tertiary, specialist and PHC, but not all
- Package not defined

Notes

Legal/ regulatory/ policy basis

21. Is there a legal or regulatory basis that dictates how resources should be allocated against the benefits package? What law/regulation or policy?

- BP mandated and enforced
- Laws and regulations around BP but not enforced/ current/ comprehensive
- No laws, regulations around BP

Notes

Fragmentation within process

22. Outside the main package are there other packages specified for specific programs?

- Fully unified in overall package
- Fragmented BPs, but linked to overall package
- Fragmented BPs

Notes

Costing

23. How is/are the benefits package(s) costed? If different programs, please indicate for each

- BP costed and costs applied
- BP costed, but costs not used
- BP uncosted

Notes

Other tools and data

24. What other tools and evidence are used to guide priorities? Please describe who is involved in the process.

- Evidence-based
- Some
- None

Notes

External Resources

Overall Structure

25. How would you categorize the partner landscape in terms of financial contributions to health?

- Most donor funding on budget
- Mix
- Most donor funding off budget

Notes

Other descriptors

26. What is the % of CHE that comes from external resources?

- <10%
- 10% < x < 50%
- 50% < x < 90%

Notes

Legal/ regulatory/ policy basis

27. Is there a legal or regulatory basis that dictates how external resources should be allocated against health sector priorities? What law/regulation or policy?

- Donor funding of priorities mandated and enforced
- Laws and regulations around priorities but not enforced/ current/ comprehensive
- No laws, regulations around donor funding of priorities

Notes

Fragmentation within process

28. Are external resources aligned to priorities of the major budget holder?

- External resources fully aligned to sector priorities
- Coordination exists but poor alignment
- Donor priorities are not linked to country priorities

Notes

Costing

29. Are the costs of donor programs transparent and available to the government?

- Costs are fully available to government
- There is some knowledge of costs
- Costs of donor programs are not known

Notes

Other tools and data

30. What other tools and evidence are used to guide priorities? Please describe who is involved in the process.

- Evidence-based
- Some
- None

Notes

Part 2: Resource allocation

Questions and benchmarks to assess resource allocation in country from the perspective of one budget holder

Fund allocation

31. Do resources flow according to determined priorities?

- Aligned to sector priorities (Please select: Decentralized priorities, external resources, benefits package, health or program plan)
- Planning aligned to sector priorities, but funds allocated based on line items
- Historical line item budgeting

Notes

32. What institutions or stakeholders are involved in allocating funds according to these priorities and what methods do they use?

- Consultative
- Somewhat consultative
- Not consultative/ decisions made by one entity

Notes

33. How and how frequently are resources allocated?

- Allocations are sufficient and predictable
- Allocations are somewhat sufficient and predictable
- Allocations are not sufficient or predictable

Notes

Payment

34. Who receives funds: Do they have flexibility to reallocate funds according to need?

- Fund flows are flexible
- Fund flows are somewhat flexible (ie, can reallocate with approval)
- Fund flows are not flexible (ie, hard earmarks, strict rules on moving items between lines)

Notes

35. How are funded priorities paid for?

- Providers and facilities paid based on output and aligned to priorities
- Providers and facilities paid based on outputs, but no link to priorities
- Providers and facilities paid based on inputs

Notes

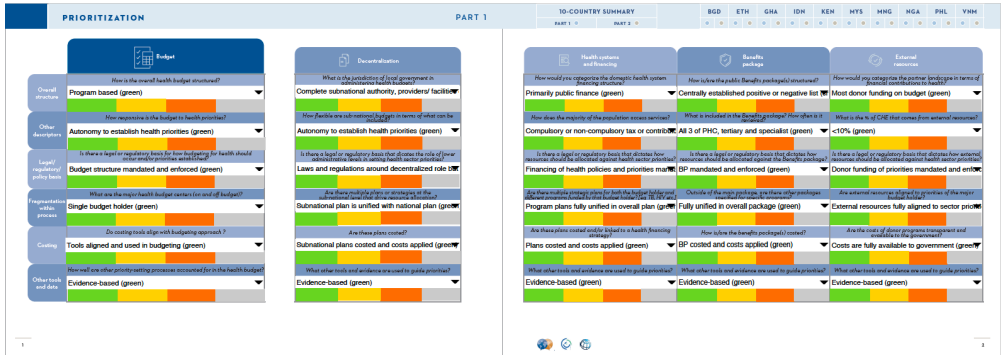
Assessment

36. How are funding flows tracked against priorities?

- Clear indicators are in place to track spending against priorities
- Expenditure is tracked against line items only
- Funding flows are not transparent

Notes

Once the questionnaire has been completed, benchmarks can be separately selected in the visualization tool to describe the narrative response.



Blank HePRA Visualizations

Once you have determined your benchmarks, use this PDF to populate a more detailed visualization.

www.jointlearningnetwork.org/resources/blank-hepra-visualization/

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