Health Financing Progress Matrix assessment

Bangladesh 2021

Summary of findings and recommendations

World Health Organization

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About the Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's health financing system. The assessment builds on an extensive body of conceptual and empirical work and summarizes "what matters in health financing for UHC" into nineteen desirable attributes, which form the basis of the assessment. By identifying areas of strength and weakness in the current health financing system, together with priority policy directions, HFPM assessments complement monitoring of key quantitative indicators on service coverage and financial protection, now enshrined in the Sustainable Development Goals agenda.

HFPM assessments can be implemented within a short time period and provide close-to-real time information for policy makers. Findings support the development of health financing strategies, technical alignment across government and external technical assistance agencies, and provide the basis for monitoring progress over time. The HFPM is the first instrument which allows the systematic tracking of the development and implementation of health financing policies which matter for UHC.

In summary, HFPM country assessments consists of two stages:

- Stage 1: a mapping of the health financing landscape consisting of a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.
- Stage 2: a detailed assessment of thirty-three areas of health financing policy. Each question builds on one or more desirable attribute of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Further details about the HFPM are available here:

https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix

About this report

This Health Financing Progress Matrix high-level summary report provides a concise summary, based on the response and rating for each assessment question, of the key strengths and weaknesses in a country's health financing system.

Using the structure of assessment areas and the desirable attributes of health financing system, the report identifies key areas of health financing policy which need to be addressed to drive progress towards UHC. Looking both at the current situation, and what needs to happen in the future, helps to identify the priority areas for further analytical work, technical support, and implementation.

Also included in this report is the latest information on how the country is performing on key UHC indicators (SDG 3.8.1 and 3.8.2), together with key health expenditure indicators.

Detailed responses for each question are available in a separate annex and can also be found on the HFPM Country Assessment database.

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Abbreviations

BR	Benefits and conditions of access
CBHI	Community-Based Health Insurance
CHE	Current Health Expenditure
COVID-19	Coronavirus disease
DRGs	Diagnosis Related Groups
DTP3	Diphtheria, Tetanus toxoid and Pertussis -3 Doses
ESP	Essential Services Package
EXT	External
GDP	Gross Domestic Product
GGE	General Government Expenditure
GGHE	General Government Health Expenditure
GGHE-D	General Government Health Expenditure Domestic
GHO	Global Heath Observatory
GV	Health Financing Policy, Process and Governance
HEU	Health Economics Unit
HFPM	Health Financing Progress Matrix
HIV/AIDS	Human Immunodeficiency Virus/Acquired immunodeficiency syndrome
HSD	Health Services Division
HSS	Health System Strengthening
IHR	International Health Regulation

LMICs	Lower-middle income countries
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government and Rural Development Co-operatives
NGOs	Non-Governmental Organizations
NHA	National Health Accounts = country HA
OOPs	Out-of-pocket payments
PFM	Public finance management
PHC	Primary health care
PPP	Purchasing power parity
PR	Pooling revenues
PS	Purchasing and provider payment
RR	Revenue raising
SDG	Sustainable Development Goals
SMART	Specific, Measurable, Achievable, Relevant and Time-bound
SSK	Shastho Surokhsma Karmasuchi, Health Protection Scheme
TB	Tuberculosis
UHC	Universal health coverage
UNICEF	United Nations International Children's Emergency Fund
USD	United States Dollar
WHO	World Health Organization

Methodology and timeline

WHO Bangladesh Country Office in collaboration with the Health Economics Unit (HEU), Health Services Division (HSD) of the Ministry of Health and Family Welfare (MOHFW) initiated the assessment of the Health Financing Progress Matrix. For this purpose WHO commissioned this assignment to an independent consultant who has wide working experience in health financing in Bangladesh.

The assessment was originally conducted using the first version comprising forty-eight questions, and subsequently restructured using the structure of version 2.0, released in December 2020. Completion of the assessment was based primarily on a desk review of relevant studies, report, and documents. However, the consultant also informally discussed some issues with knowledgeable persons when clarification was necessary.

The preliminary draft was shared with three knowledgeable persons working in the health sector. Their comments were incorporated in the first draft. The first draft was then shared in a validation workshop with key stakeholders in Bangladesh including representatives from the MOHFW and its directorates, academia and development partners.

Comments received from the validation workshop, as well as from WHO Regional Office for South-East Asia and the Bangladesh Country Office were incorporated into the assessment . The assessment was then subject to review by the HFPM Technical Committee.

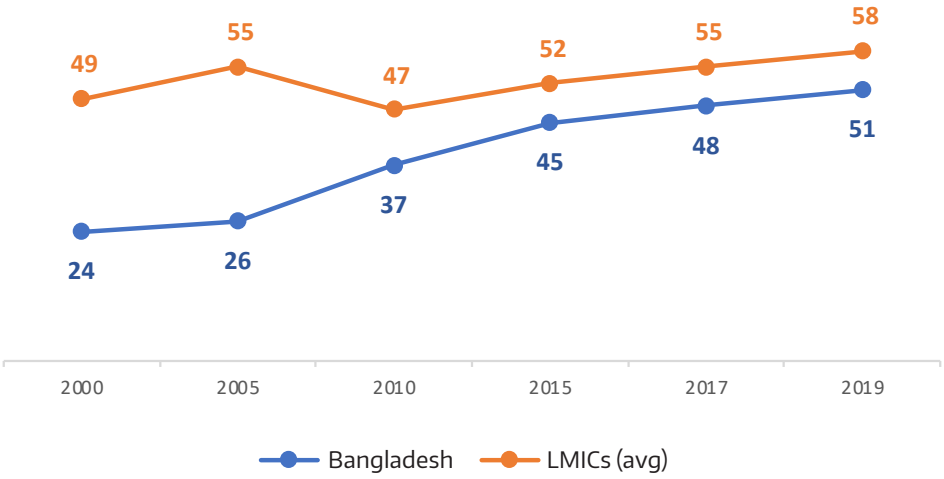
Further details are listed in the table below.

August–October 2019	First version of assessment conducted by Principal Investigator
30 September 2019	Workshop to discuss assessment findings held at the Ministry of Health and Family Welfare, chaired by Director General of Health Economics Unit of MOHFW. Representative form World Bank, UNICEF, SIDA were present at the meeting.
30 October 2019	Key assessment findings presented at high-level policy dialogue on health financing organized by MOHFW.
early April 2020	Review process conducted and recommendations drafted. Further refinement of assessment following discussion between two reviewers and the Principal Investigator
end-April 2020	Assessment submitted to MoHFW for comments, factual corrections
2020-2021	Mapping of assessment into HFPM v2.0 and preparation of high level summary report

Bangladesh UHC performance

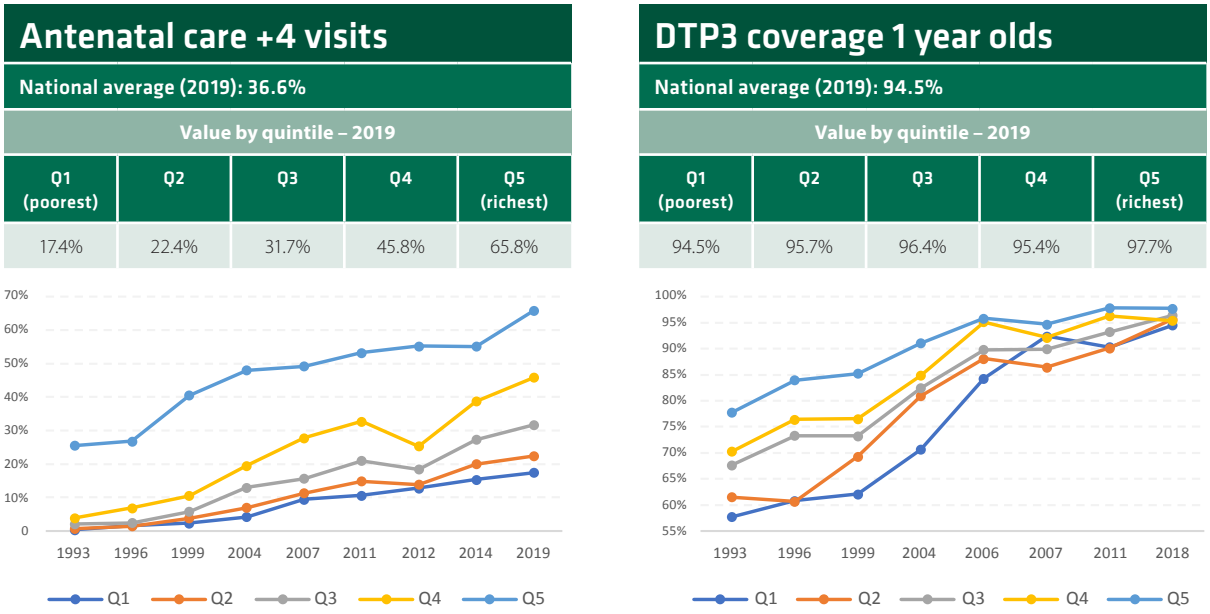
SDG indicator 3.8.1 relates to the coverage of essential services and is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access (World Health Organization, 2021). The service coverage index is a score between 0 and 100, which in Bangladesh more than doubled between 2000 and 2019, although remains below the average for lower middle income countries.

Figure 1: Service coverage index trend in Bangladesh 2000–2019



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

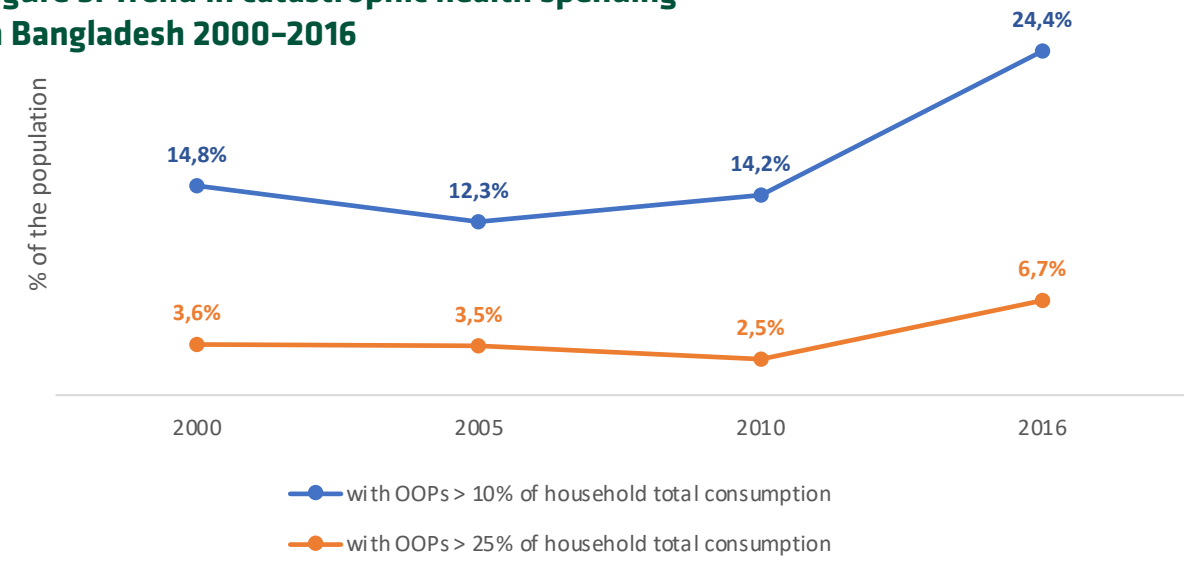
Figure 2: Antenatal care and DTP3 coverage by quintile in 2019



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

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending and defined as the "Proportion of the population with large household expenditure on health as a share of total household expenditure or income". Large is defined using two thresholds first greater than 10% of the household budget and secondly greater than 25% of the household budget. The incidence of catastrophic spending increased in Bangladesh between 2010 and 2016, the latest year for which estimates are available.

Figure 3: Trend in catastrophic health spending in Bangladesh 2000–2016

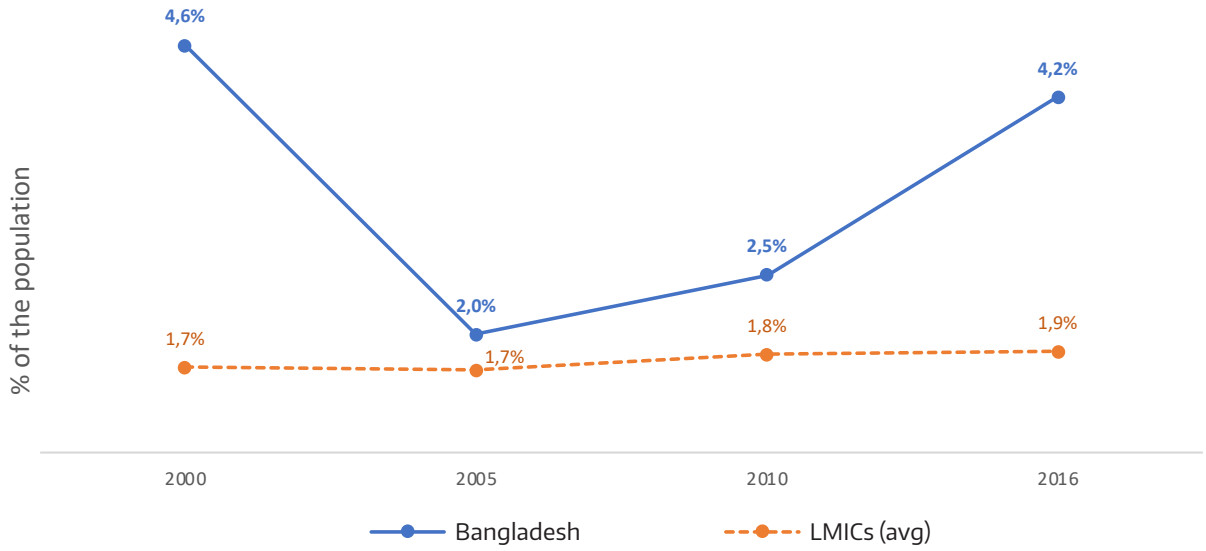


Source: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-with-household-expenditures-on-health-greater-than-10-of-total-household-expenditure-or-income-(sdg-3-8-2)-(-)

While not an official SDG indicator, an additional measure of financial protection looks at health spending which leads to impoverishment.

Some people (the poor and the near poor in particular) are not able to spend more than 10% of their household budget on health. Indicators of impoverishing health spending are defined as the proportion of the population pushed and further pushed into extreme poverty (living with less than PPP$1.90 a day person) by out-of-pocket health spending. The figure below only shows the proportion of the population pushed into extreme poverty. As with catastrophic spending, the incidence has also increased since 2010.

Figure 4: Incidence of impoverishment due to health spending in Bangladesh 2000–2016



Source: https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4892

Bangladesh

Summary of findings and recommendations

Assessment area	Summary findings	Status
Policy process & governance	Bangladesh has developed a comprehensive health financing strategy for 2012-32 following a highly consultative process; however, implementation has been noted as slow. Developing a plan which prioritizes actions in the short to medium term, together with a clear sequencing of these actions, would help to improve implementation.	Established ●●●○
Revenue raising	Bangladesh recognises the importance of public funding to address a historically high reliance on OOP payments. However, current targets to increase the priority given to health in the government budget need to be more realistic. Pro-health taxes have been introduced in Bangladesh with a 1% health development surcharge on tobacco products in 2015 but greater clarity is needed regarding their design and implementation, and their impact on revenues for the health should be closely monitored.	Emerging ●○○○
Pooling revenues	While strategies have been outlined to expand population coverage, these risk creating greater fragmentation and inequity in the health system. Reviewing these strategies and developing a system-wide plan to scale-up coverage, based on global experience of what works, is recommended. Incremental steps to reduce inequities in benefits and conditions of access across schemes and rendering patient information systems more interoperable are a priority.	Progressing ●●○○
Purchasing health services	The present basis for resource allocation to providers is driven by historical trends and structured around input-based line items with no adjustments for population health needs nor provider performance. Important analytical work for a new approach to resource allocation has been conducted and piloting/scaleup could help to better direct public funds to priority services. Examining the mix of payment methods across the health system would help to ensure coherent incentives for providers, to increase quality and efficiency in service delivery.	Emerging ●○○○
Benefits & condititons of access	Bangladesh has an established Essential Services Package (ESP) for the entire population with nominal or no user fees. Information campaigns are needed to increase population awareness of entitlements, and to ensure vulnerable groups access health services. The ESP reflects population health needs but regular revision. Unfortunately, no cost-effectiveness or budget impact analyses were used to inform the ESP; such evidence would help to ensure the best use of public resources, not least to facilitate expansions in coverage.	Progressing ●●○○
Public financial management	Processes to improve public financial management (PFM) have been established in Bangladesh, notably the development of a Medium-Term Budget Framework which covers the health sector. Better links to annual budgets and plans is critical to improve predictability (noted as low). Formulating budgets based on programmes outputs would further improve effectiveness. Findings of a diagnostic analysis of PFM barriers in health should be reviewed, particularly causes of low budget execution, and an implementation plan developed. Gradually introducing elements of flexibility in the use of funds should be considered as these would increase efficiency and effectiveness of service delivery.	Progressing ●●○○
Public health functions & programme	From a preparedness perspective, after a 2016 Joint External Evaluation found weaknesses in Bangladesh's financing and budgeting of the International Health Regulations (IHR) Core Capacities, efforts have been made to review and develop plans to address identified issues. In particular additional budgets have been allocated to IHR-related activities and personnel are in place to take forward this agenda. Despite this, many of the activities remain funded by external agencies and have not yet been mainstreamed into government systems. In terms of financing the response, the Government of Bangladesh has been able to allocate and disperse funds as an emergency measure to respond to the challenges of COVID-19. This response has included exceptional spending measures for frontline workers, building of temporary hospitals, procurement of supplies, recruitment, a lump sum allocation, among other areas, over and above the current health sector budget. Despite this multi-faceted response, a recent World Bank review of Bangladesh's public procurement system has found that it has not allowed for timely enough decision-making in the face of the pandemic, which points for areas for improvement.	Progressing ●●○○

Summary of findings by desirable attributes of health financing

Policy process and governance

Desirable attribute GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritise and sequence strategies for both individual and population-based services
Key areas of strength and weakness in bangladesh	**Bangladesh developed a comprehensive health care financing strategy for the period 2012-2032 using an inclusive process** with key stakeholders involving the Ministry of Health and Family Welfare (MoHFW), other ministries, development partners, academia, professional associations, and non-governmental organizations. The strategy was accompanied by a costed implementation plan to understand resource needs and to help ensure alignment across the system; **however**, development of related legal documentation has been limited and the **prioritisation and necessary sequencing of actions are not well defined**, and implementation is noted to be slow.
Recommended priority actions	Global guidance on developing a national health strategy highlights the importance of ensuring a clear vision or roadmap towards UHC together with a clear reasoning of how proposed policies will address current challenges and drive progress towards UHC. Furthermore, **prioritising interventions in the strategy, including actions to be enacted in the short term (through to long term),** can improve the implementation success, as can clarity on how different interventions complement and reinforce each other.
Desirable attribute GV2	**There is transparent, financial, and non-financial accountability, in relation to public spending on health**
Key areas of strength and weakness in bangladesh	**Attention to transparency and accountability in Bangladesh is supported by a Parliamentary Standing Committee, although administrative and technical has been noted to be insufficient, impacting its ability to operate effectively.** Although health spending targets had been set and policies were developed, implementation is stalled due to a noted lack of legal instruments to make policy recommendations binding. Partners were brought together to develop the health financing strategy, but health financing policy dialogue is not held on a regular basis.
Recommended priority actions	**Strengthening administrative and technical support** to the Parliamentary Standing Committee would improve its role in monitoring health system performance. Institutionalizing dialogue, by moving from ad-hoc to systematically organized meetings between the MoHFW and the Ministry of Finance (and other relevant ministries) on health financing policy issues would help to ensure more effective use and accountability of public spending on health. Similarly, ensuring the health financing strategy and related implementation plans include SMART relevant indicators will aid in regular monitoring and evaluation of health financing and spending.
Desirable attribute GV3	**International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments**
Key areas of strength and weakness in bangladesh	Although **data from** national health accounts, public expenditure reviews and household **spending are regularly produced**, shared online and disseminated (+GV3), data for **other health financing functions (eg. regarding pooling, benefits and purchasing of health services) are less regularly monitored**, and not used to inform policy development.
Recommended priority actions	**Evidence and information on key health financing policy areas (i.e. pooling, benefits and purchasing)** can support the development of interventions to effectively address system weaknesses regarding fragmentation in pooling arrangements, inequities in benefits, and inefficiencies in purchasing arrangements. In addition, the comprehensiveness and reliability of provider activity data should continue to be improved to inform policy decisions on strategic purchasing. Further clarity on how evidence is feeding into policy change, and institutionalizing platforms for dialogue on data, would help to foster the development of decisions to form evidence-based policies.

Revenue raising

Desirable attribute RR1	Health expenditure is based predominantly on public/compulsory funding sources
Key areas of strength and weakness in bangladesh	**The government of Bangladesh has made clear statements in its health financing strategy regarding the importance of public funding** as the foundation for equitable access to health services and financial protection for its population. These statements were made in response to the i) historically high reliance on out-of-pocket (OOP) payments, accounting for 72% of current health expenditure in 2015, and ii) address the noted lack of priority given to health in the general government budget, which remains low at 5%. Although commitments to public funding sources are laudable, government targets to increase the health share in the total national budget to 15% by 2032 are unrealistic, even in the medium term.
Recommended priority actions	Global evidence has shown that greater reliance on public funding sources is closely associated with better performance on UHC. Shifting the balance away from a predominant reliance on OOP payments, which are highly regressive, would help to mitigate inequities. This transition will not occur overnight, but gradually increasing prioritisation for health within the overall general government budget with more **realistic targets set in light of government fiscal constraints and the macro-economic context is advisable.** Government plans to raise additional revenue through community-based health insurance (CBHI) should be carefully reconsidered, given evidence of the effectiveness of contributory-based schemes in countries with a large informal sector; specifically, resource generation and pooling is limited in most models of CBHI. Countries such as Rwanda take a unique approach to CBHI, which explains its success, and is not automatically successful when transferred to other contexts.

Revenue raising

Desirable attribute RR2	The level of public (and external) funding is predictable over a period of years
Key areas of strength and weakness in bangladesh	**Bangladesh uses a multi-year public sector budgeting process through a Medium-Term Budget Framework** consisting of a three-year rolling budget meant to enhance predictability. **However, projections in the Medium-Term Budget Framework are not realistic** and predictability for the budget of the Ministry of Health and Family Welfare is noted to be poor with annual budget fluctuations ranging from a low of 5% to a high of 29%. Reasons for variations are due to changes in government priorities, shortfalls in revenue, and weak capacity in planning and budgeting.
Recommended priority actions	The use of a Medium-Term Budget Framework follows global good practice, although greater accuracy in budgetary projections would better support planners and implementers to avoid disruptions in service delivery. To ensure forecasts are more realistic, the budgetary process itself could be strengthened by **improving the connection between the three-year rolling budgets with both annual budgets and more regular health policy planning activities. Doing so will improve predictability and accountability of budgets** as these would be based explicitly on clear health priorities, population health needs, and available resources, many of the noted reasons for variations. This in turn would require **building country capacity in planning and budgeting as well as improving the quality and timely collection of financial data.**
Desirable attribute RR3	**The flow of public (and external) funds is stable and budget execution is high**
Key areas of strength and weakness in bangladesh	In Bangladesh, **budget execution has been noted to be low** and a persistent problem. This is due to unrealistic plans, revisions of operational plans, delays in procurement, delays in fund approval and release, a cumbersome and not well understood fund release process, and non-compliance of rules and regulations. Together, these factors lead to both instability and underspending of available revenues for health.
Recommended priority actions	**Formulating the budget based on robust plans and available resources would improve execution** by bringing estimations more in line with fiscal realities. Furthermore, the budget execution rate, or the ratio of funds spent to funds budgeted, **could be improved by addressing public financial management bottlenecks specific to Bangladesh.** Measures which would help to make the release of funds more timely include understanding and rectifying reasons for delays in approval of operational plans, reviewing rules for procurement to reduce delays, and streamlining approval procedures (i.e. Statement of Expenditure). Such actions would also help to limit disruptions in service delivery, by minimizing delays in salary payments, and stockouts of essential supplies. Improving budget execution can also strengthen the case for greater budget allocations to the health sector.
Desirable attribute RR4	**Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms**
Key areas of strength and weakness in bangladesh	**The extent to which the government uses taxes and subsidies as instruments to affect health behaviours is relatively new in Bangladesh.** Since **2015, a 1% 'health development surcharge' has been imposed on all imported and domestically produced tobacco products** and where funds would be earmarked primarily for the prevention of non-communicable diseases, particularly tobacco related diseases. Revenues are currently directed to a government account **but have yet to be fully reflected in the health budget**.
Recommended priority actions	The use of fiscal measures in the health sector can be a powerful mechanism to reduce harmful consumption of unhealthy products, and at the same time raise precious revenues, although a trade-off between the two usually exists. In Bangladesh, **more clarity is needed regarding the design and implementation** of pro health taxes (i.e. type of tax, structure of tax, tax basis, tax rate, tax application) to ensure they follow best global practices and are aligned with regional and global benchmarks (WHO 2021 technical manual, WHO 2019 primer on health taxes). Further, given the recency of their introduction in Bangladesh, it is important to **monitor how these are being implemented, the impact on consumption of tobacco, as well as impact on revenues**, to inform any necessary adjustments in design and implementation.

Pooling revenues

Desirable attribute PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
Key areas of strength and weakness in bangladesh	**While there are plans to increase population coverage in Bangladesh through the introduction of health insurance schemes** (i.e. for the below poverty line population, civil servants, informal sector, and garment workers), **the approach of introducing a scheme for each** sub-population groups runs the serious **risk of creating more fragmentation in the health system and generating greater inequities**. While some transfers of public funds is targeted to the below-poverty fund to help increase access for the poor, this has not been scaled up. At present, there is no clear health financing strategy to increase the redistribution of risk across different population groups and schemes. Additionally, multiple small schemes and fund pools can be financially unstable and require subsidy to remain sustainable.
Recommended priority actions	**Developing a comprehensive and integrated plan to scale-up coverage in way that does not exacerbate fragmentation but rather ensures greater pooling and risk sharing, will support greater protection against financial hardship and greater equity** in the distribution of resources, as well as reduce inefficiencies for example by removing duplication of functional responsibilities of different insurance schemes. A fragmented landscape is likely to compromise equity goals due to the different capacities of individual schemes to raise revenue and the different risk profiles of members in each scheme. If such a landscape is the starting point, mechanisms to promote risk equalisation or cross-subsidisation across the funds, for example through risk equalization mechanisms, government allocation formulae, and subsidies to support both enrolment for the poor and address non-financial barriers, can help to mitigate the downsides.

Pooling revenues

Desirable attribute PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Key areas of strength and weakness in bangladesh	**In Bangladesh, there are multiple schemes or fund pools** and, at present, there is limited coordination between the MoHFW and other ministries responsible for these schemes. As a result, duplication exists in terms of overlapping populations e.g. members of the government employee welfare fund are also entitled to use free services from MoHFW hospitals. Additionally, **it is not clear the extent to which the benefit entitlements of different schemes and the specific obligations or conditions of members' access to them are currently harmonized**. Provider payment mechanisms are coherent across ministries as line-item budgets, with some schemes in the public sector using different payment mechanisms. Regarding a unified (or interoperable) health information system across schemes, this is not yet in place.
Recommended priority actions	Examining the **mapping of coverage schemes (see Stage 1 of the HFPM)** can shed light on the extent to which entitlements and obligations are harmonized across schemes. **Bangladesh can take incremental steps to reduce inequities in benefits across schemes** (e.g. services covered, and conditions of access such as co-payment rates). **Initial steps can also be taken towards unifying or rendering more interoperable patient information systems** e.g. rolling out a standardized patient contact forms establishing unique ID for patients and facilities, and standardising diagnostic and procedure codes.

Purchasing health services

Desirable attribute PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
Key areas of strength and weakness in bangladesh	**The present basis for resource allocation to providers is driven by historical trends and structured around input-based line items (e.g. human resources, bed capacity) with no adjustments for either population health needs or provider performance**. However, technical work has been conducted, proposing options for a new approach, which would reflect different population health needs at sub-national levels (+PS1) but this has not been seriously considered to date. Providers are also paid by other mechanisms varying by scheme and rates also vary depending on whether services are provided in the public or private sector.
Recommended priority actions	The current basis for allocating resources does not promote population health, efficiency, equity or quality of service provision. The **piloting of a revised allocation approach based on indicators of need** (such as population size, mortality rate, poverty rate, etc), is recommended, given its potential to better direct public resource to where they are most needed. Bangladesh can also experiment with the way in which providers are contracted and paid with specific conditions to incentivize both quality and efficiency improvements.
Desirable attribute PS2	**Purchasing arrangements are tailored in support of service delivery objectives**
Key areas of strength and weakness in bangladesh	Under **current purchasing arrangements** in the public sector, providers receive a fixed salary through a line-item budget, with no **explicit incentives to improve efficiency, or quality in service delivery, for example through improved co-ordination across specialties and different levels of care**. Some quality improvement and accreditation processes have been piloted in limited public facilities, and a **Quality Improvement Secretariat was established** to review standards, develop guidelines, and key performance indicators on quality, clinical audits, etc. Nevertheless, the general quality of services is **perceived as poor, both in public and private sectors**. Private facilities need to meet certain infrastructure and human resource requirements to be licenced, but there is no established mechanism to regularly monitor quality of care.
Recommended priority actions	Introducing provider incentives based on achieving priority service-delivery objectives should be considered, for example by establishing contracts with conditions around high quality of care and coordination of care, with supporting performance-based payments. In addition to **an incentive system, the development of accreditation standards for facilities and registration of providers in both the public and private** sector would further ensure purchasing arrangements support service delivery objectives. Last but not least, the establishment of mechanisms to monitoring quality of care on a regular, rather than ad-hoc basis, is critical.
Desirable attribute PS3	**Purchasing arrangements incorporate mechanisms to ensure budgetary control**
Key areas of strength and weakness in bangladesh	There is currently **no strong incentive for providers to increase efficiency** in service delivery given input-based line-item payments and fixed salaries in the public sector. **In the private sector, reliance on fee-for-service** likely results in over-provision of services, without counteracting measures. Certain schemes have **experimented** with payment methods such as simplified DRGs but the effects are not yet evaluated, and hence remain small in scale (–PS3). **Budgetary control for medicines** is reflected through the centralised procurement of medicines, together with a focus on generics. While this has kept publicly procured medicines **at a low price**, 64% of OOP payments (an estimated 43% of total health expenditure) is still spent on medicines which indicates that greater budgetary control is needed.
Recommended priority actions	Global good practice **requires taking a system-wide view of all provider payment methods** e.g. by mapping out the different methods used, the incentives generated, looking at how these play out at the health facility level, and whether the net effect is positive in terms of contribute to health system goals. Given most provider payment systems are mixed, such an assessment could help to establish coherence and alignment in provider payment across the health system. For example, budgetary controls in the form of global budgets or expenditure caps (or ceilings) can be mixed with DRGs or bundled payments, possibly with a variable payment based on performance. Reducing the fragmented way in which funds flow to provides can improve strategic purchasing as well as spending control in Bangladesh. Regarding spending on medicines, **greater price regulation in the wider pharmaceutical market** and monitoring of prescription practices would help to further contain costs and improve financial protection.

Benefits and entitlements

Desirable attribute BR1	Entitlements and obligations are clearly understood by the population
Key areas of strength and weakness in bangladesh	**While there is an established Essential Services Package for the entire population** (+BR1), it is unclear if the population is fully aware of their benefits and entitlements (–BR1), not least as **different schemes cover different additional services with varying conditions** to access them.
Recommended priority actions	Even if benefits are explicitly defined, if the population lacks awareness, they may continue to pay OOP for services that are indeed covered, negatively impacting on financial protection, and creating broad inefficiencies from the perspective of using limited resources to progress towards UHC. Informational leaflets, **publicity campaigns**, and household visits are various approaches to **ensuring the population understand their entitlements and obligations.**
Desirable attribute BR2	**A set of priority health service benefits within a unified framework is implemented for the entire population**
Key areas of strength and weakness in bangladesh	Bangladesh is ahead of many countries as it **established a universal essential service package in 1997**. **The package reflects population health needs** and covers maternal, neonatal, child and adolescent health care, family planning, nutrition, communicable diseases and non-communicable diseases. **Burden of disease** data for Bangladesh shows that in 2017 the top four diseases that cause most deaths are non-communicable diseases. Similarly, among the top ten diseases causing premature death, four relate to communicable, maternal, neonatal, and nutritional diseases while five are non-communicable diseases – thus the package is relevant. **However, various health insurance funds their members additional health services, and thus there are some differences in entitlements in the health system**.
Recommended priority actions	As the Essential Services Package (ESP) was established in 1997 and revised in 2016, more regular **revision of the non-contributory essential package** is advisable to ensure the ESP continue to meet population health needs **as trends in epidemiological patterns evolve.** Bangladesh can also take **incremental steps to reduce any inequities in benefits across schemes** (e.g. regarding differences in service entitlements and both financial and non-financial conditions of access).
Desirable attribute BR3	**Prior to adoption, service benefit changes are subject to cost-effectiveness and budgetary impact assessments**
Key areas of strength and weakness in bangladesh	Although the Essential Services Package was developed and revised based on certain criteria, e.g. existing primary health care services, burden of disease, and the goa of improving financial protection, **no cost-effectiveness or budget impact analyses were conducted**. Benefit packages specific to other funds, e.g. for the below-poverty population, were developed with a consideration of diseases common amongst the poor. Similarly, no budget impact analysis was done at the time of its formulation.
Recommended priority actions	Global guidance on the design of benefit entitlements recognizes that the process is both technical and political, and should be based on data, dialogue and (political) decision. **Specific cost-effectiveness studies, health technology assessments, and budget impact analyses should be conducted and used to inform revisions to benefit packages. Furthermore, such studies would help to assess resources needs and gaps, improving alignment** with budgets and, ultimately, stability in the provision of services.
Desirable attribute BR4	**Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers**
Key areas of strength and weakness in bangladesh	The Essential Services Package is financed through government revenues and external funding through a pooled fund. A recent study estimated that the **total cost for its provision accounts for 57 percent of the Ministry of Health and Family Welfare's budget** for that year – as such **substantial resources will be necessary to further expand population coverage**. Misalignment is also reflected with primary care facilities in the public sector reporting shortages of medicines and non-functioning equipment resulting in patients sometimes having to purchase medicines and diagnostic services from private sector.
Recommended priority actions	During the process of defining benefits, due **consideration to financial implications and budgetary impact needs to be conducted to ensure that defined services are delivered effectively.** While costings are often estimated, **identification of specific revenue sources is often lacking.** Any additional benefit entitlements need to be supported with clarity regarding new additional revenues.
Desirable attribute BR5	**Benefit design includes explicit limits on user charges and protects access for vulnerable groups**
Key areas of strength and weakness in bangladesh	The Essential Service Package is **delivered with nominal or no user fees**, which helps to **ensure access to covered services to vulnerable groups** with financial protection. However, benefits associated with other health insurance schemes sometime require user fees, co-payments or require other obligations that may act as a barrier to access; nevertheless, there are some policies where the poor, ultra-poor and at-risk populations do receive services free of charge (e.g. urban PHC).
Recommended priority actions	**A review of population obligations to access benefits** – both financial (e.g. co-payments) and non-financial (e.g. referrals) – is recommended to identify policy adjustments which could help to further UHC. Evidence from **other countries shows that exemptions for specific priority services** (e.g. reproductive, maternal, new born and child health, certain conditions associated with catastrophic costs, medicines for treating specific and rare diseases) and/or **exemptions for specific vulnerable population groups** (poor or near-poor, mothers, children) can help to ensure effective coverage. More specifically, countries in Europe have shown that **fixed and low co-payments with income-related caps** on total co-payments **were effective in ensuring access.**

Public financial management

Desirable attribute PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
Key areas of strength and weakness in bangladesh	**Processes to improve overall public financial management have been established in Bangladesh, notably the development of a Medium-Term Budget Framework for the public sector, including for health**. The Framework identifies linkages between strategic objectives and activities with priority spending areas although formulation of annual health specific budgets could be improved to increase predictability and stability. Public financial management capacity specifically in the health sector is noted to be weak. **Regarding flexibility in spending, this is noted to be low as budgets are structured around inputs and fairly rigid**. For the operating budget, only transfers across broad economic categories are currently allowed. For the development budget, only transfers between broad economic groups under recurrent categories are allowed but not between recurrent and capital.
Recommended priority actions	Key findings and recommendations from a recent 2018 World Bank study on public financial management in Bangladesh should be reviewed and discussions held on their application to the health sector. **Adjusting approaches to budget formulation in a way that moves away from budgets based on historical inputs to being structured around programmes outputs would improve effectiveness, accountability, and flexibility in spending.** Training for budgeting and planning in health would further strengthen country capacity in public financial management.
Desirable attribute PF2	**Providers can directly receive revenues, flexibly manage them, and report on spending and outputs**
Key areas of strength and weakness in bangladesh	In Bangladesh, **budget execution is noted to be persistently low** due to identified challenges concerning delays in fund availability, delays in procurement, delays in fund release/lack of operational funds at facility level, cumbersome approval processes to receive funding, etc. There is also **currently little, or no financial or managerial autonomy given to providers** in the public sector. The Ministry of Health and Family Welfare cannot retain and utilize collected user fees, with such revenues directed to the Treasury.
Recommended priority actions	Establishing concrete plans to **build country capacity in overall public financial management in the health sector** would help to ensure resources flow smoothly to frontline services, and that they are spent efficiently. The **2018 World Bank diagnostic and its recommendations should also be carefully reviewed for recommendations to improve budget execution**, e.g. simplification of approval processes while balancing accountability through the tracking of expenditures, centralising procurement processes where efficiency gains are present. In addition, **gradually increasing autonomy to providers** by, for example, allowing facilities which meet certain standards/criteria to retain all or a portion of user fees, and have some authority over the contracting and management of staff, would allow providers to respond to incentives around efficiency or quality of care in service delivery. Such delegation of authority would require supporting legislation.

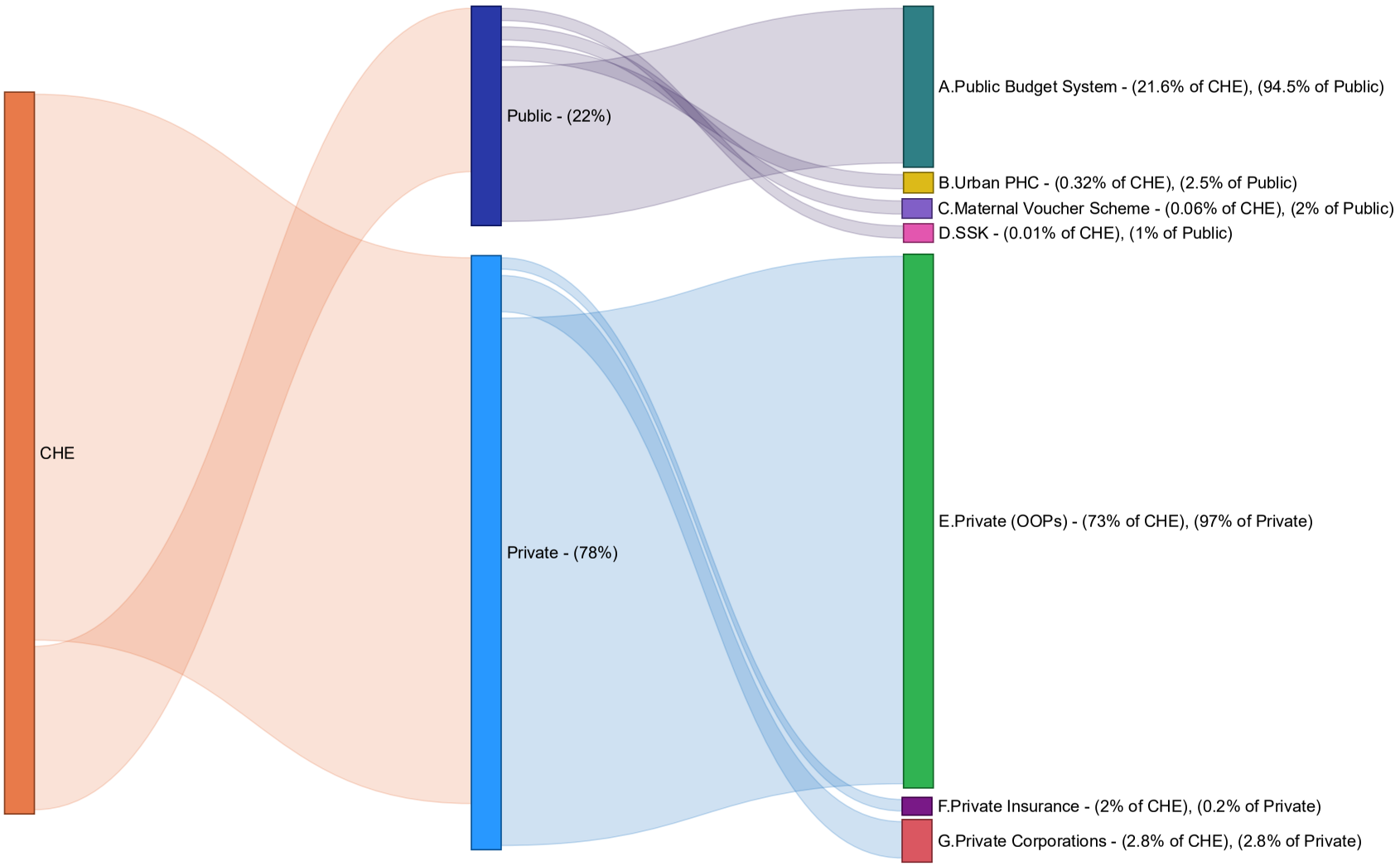
Stage 1 assessment

Stage 1: Health coverage schemes in Bangladesh: health financing arrangements

Criteria	Public system	Urban primary health care	Maternal voucher scheme
Target population **Are all citizens covered, or a specific subgroup e.G. Under 5s, salaried workers?**	All citizens of Bangladesh are entitled to access public health facilities.	Urban citizens of Bangladesh in 11 city corporations and 14 municipalities, particularly targeting the poor, women and children. Source: https://uphcsdp.gov.bd/phase-wise-project-evolvement	Poor (as per defined poverty criteria) pregnant women of 55 sub-districts having no more than two children.
Population covered/enrolled **Actual numbers relative to target pop.**	Around 15.22% of population who need health services, receive those from public system.	17.7 million urban populations in the catchment areas. Source: https://uphcsdp.gov.bd/phase-wise-project-evolvement	201,000 pregnant women.
Basis for coverage/enrolment **E.G. Mandatory, automatic, voluntary**	Automatic	Automatic	Conditional
Benefits / entitlements **Is a list of services, or level of care defined? Do users have to make co-payments?**	An 'Essential Service Package (ESP)(mostly primary health care) comprised of 234 interventions' has been developed and is being delivered through primary and secondary level facilities in both rural and urban areas. Besides, public facilities are delivering other non-ESP services through secondary and tertiary level hospitals. Services are being delivered through nominal user fees.	Essential services focusing maternal, neonatal, child and adolescent health, family planning services, reproductive health care, nutrition services, communicable and non-communicable disease control, behavior change and communication , diagnostic and emergency transportation services. Services are provided through user fees, however, the poor, ultra-poor and at-risk population receive services at free of cost.	Three antenatal visits, one visit for post natal care, safe delivery, treatment of complications including C-section; and blood and urinary laboratory tests at free of cost. Cash transfer for safe delivery, transportation reimbursement and incentives for newborn child.
Revenue sources **Where does the money come from? Budget allocations / transfers; pre-paid contributions.**	• Budget allocations from government revenue (USD 1229 million or 94% of public spending on health went to this scheme in 2015) • External / donor funds	• Government revenue • External/development partners' loans and grants (USD 21.65 million or 1.7% of public spending on health went to this scheme in 2015) • User fees	• Government's development budget •Development Partners' fund.
Pooling arrangements **Is the health budget allocated to regional authorities, is there a single or multiple "insurance" fund(s)?**	• Government budget and external funds are pooled centrally under a sector wide programme. • Procurement and purchasing mostly take place centrally. • Districts receive funds that cover salary-inputs and other inputs that are not procured or purchased centrally.	Single pool managed by the Ministry of Local Government and Rural Development Co-operatives (MOLGRDC).	Single pool managed by MOHFW.
Purchasing arrangements **Describe the management and governance arrangements?**	• There is no purchaser-provider split. • Ministry of Health and Family welfare is responsible for providing primary health services in rural areas and secondary and tertiary level services across the country.	• There is provider purchaser split • A Project Management Unit under MOLGRDC play the role of purchaser. • MOLGRDC contract out NGOs through competitive bidding process to provide services. • The Health Department of the City Corporations and selected municipalities are the implementing agencies in their respective project areas through a Project Implementation Unit (PIU).	• MOHFW plays role of both purchaser and providers. In addition, MOHFW also purchase services from the private sector • National Demand Side Financing (DSF) Committee chaired by Minister of MOHFW is responsible for the policy direction and DSF implementation committee chaired by secretary is responsible for the management of maternal voucher scheme.
Provider payment **E.G. Inputs through budget line items; fee-for service, case payment, capitation, performance-based.**	Input-based line item budgets.	Inputs based line item & fee for services	Inputs based line items for public providers and providers and admin staff receive pre-determined financial incentives per service category.
Service delivery & contracting **Which providers are services purchased from? Public, private? Are contracts / services agreements used?**	• Services are delivered mostly through public facilities. • Non-profit organizations are contracted out to provide services on TB, malaria and AIDS in both rural and urban areas.	MOLGRDC contract out the NGOs to provide primary health care.	• Services are delivered mostly through public facilities. • Beneficiaries as well may receive services from accredited NGOs and private clinics.
Size of the scheme in monetary terms	HF.1.1.1 USD 1978 million or 21.61 % of total health expenditure (93.5% of public spending) (Bangladesh National Health Accounts 1997-2020-unpublished)	HF.1.1.1 USD 29.43million or 0.32% of total health expenditure (1.6% public health spending) (Bangladesh National Health Accounts 1997-2020-unpulished)	HF.1.1.1 USD 3.66 million or 0.06% of total health expenditure (0.27% of public spending) (Administrative data 2015)

Shasthaya surokkha karmoshuchi (SSK)	Private insurance	Corporations, autonomous bodies and private companies	Private sector
Households below poverty line in three sub-districts under a pilot scheme.	Any person can join a private insurance scheme. Sometimes employees join private insurance schemes under group insurance.	Employees of corporations, autonomous bodies and private companies	All citizens of Bangladesh are free to seek care from the private facilities (both for profit and for non-profit organizations).
80,000 households in three sub-districts.	Less than 1% of population.	Less than 1% of population	Around 83.69 % population who need health services, receive those from the private sector.
Automatic	Mostly voluntary. In few cases, employees join mandatory private insurance schemes.	Automatic for employees (voluntary choice of particular enterprise/ corporation)	Voluntary
Inpatient services for 78 diseases including necessary medicines, diagnostics and transport costs. Scheme cover benefits up to BDT 50,000(USD 595) per household per year.	All types of primary, secondary and tertiary level services according to insurance policies. Users sometimes pay co-payment as per insurance policies.	All types of services. Services provided or financed by enterprises.	All type of primary, secondary and tertiary level services.
• Government's budget	Funds for employers contribution and premium.	Funds form employers	Out of pocket payment is the main source of profit organizations. Most non-profit organizations receive external funds to provide subsidized services to service users.
• Government Pays BDT 1000 (USD 12) as premium on behalf of enrolled households. • Single pool managed by the MOHFW.	Separate insurance companies make their own pooling arrangements.	At individual enterprise level	No pooling mechanism.
There is no purchaser provider split. MOHFW is responsible for providing inpatient services through its facilities.	Users choose the providers by themselves. .2.2	Firms are responsible for making purchasing arrangement	Individual private organizations purchase for their organizations. Government regulates the private sector for ensuring quality and controlling prices, as well oversee the compliances of the facilities with the existing regulations.
Simplified DRG to the hospitals for reimbursing investigation and medicine cost and health care providers receive fixed salary through line item budget.	Fee for services.	• fixed salary • Fee for services	Fee for service.
Services are delivered through public facilities.	In most cases, service users have freedom to purchase from any public and private facility and claim to insurance company.	Sometimes firms provide services though their own facilities. In other cases users choose the providers by themselves	Private providers are purchased. However, health personnel, particularly doctors from public system are contracted out to provide private services.
HF.1.1.1 USD 0.32 million or 0.0% of total health expenditure(HEU 2018)	HF. 3.2.3 USD 12.32 million or 0.14% of Total health expenditure (Bangladesh National Health Accounts 1997-2020-unpublished)	HF.2.3 USD 134.45 million or 1.5% of total health expenditure (Bangladesh National Health Accounts 1997-2020-unpublished)	

Figure 5: Health expenditure by stage 1 coverage schemes

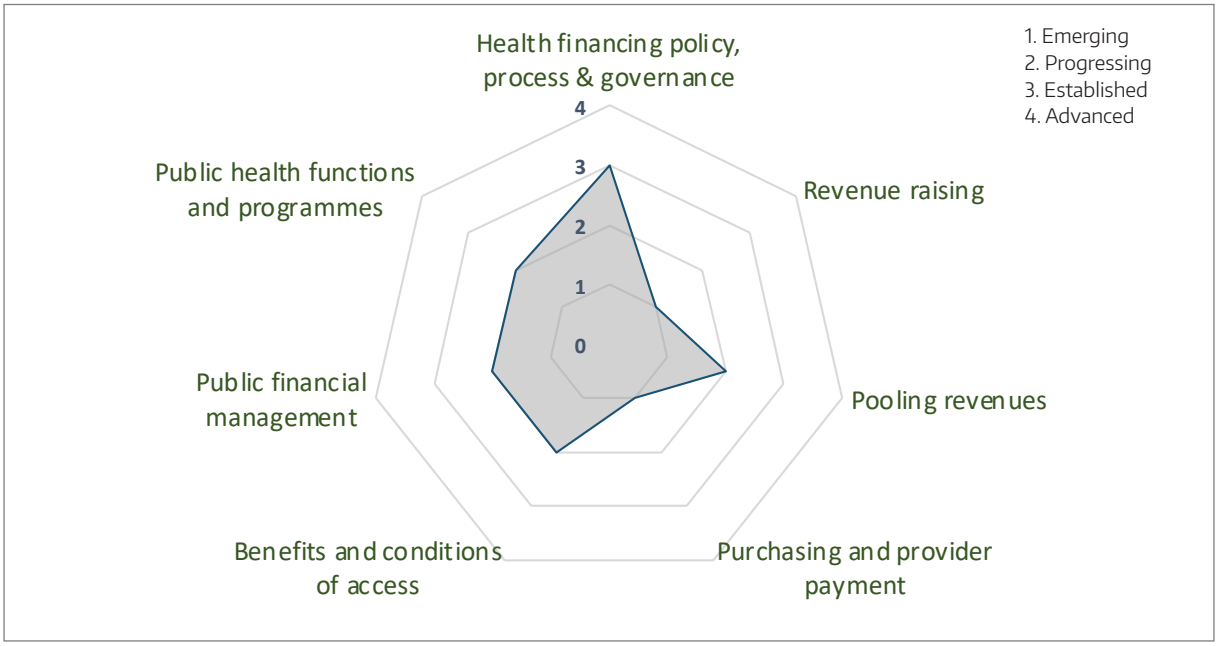


Source: Bangladesh National Health Accounts 2019

Stage 2 assessment

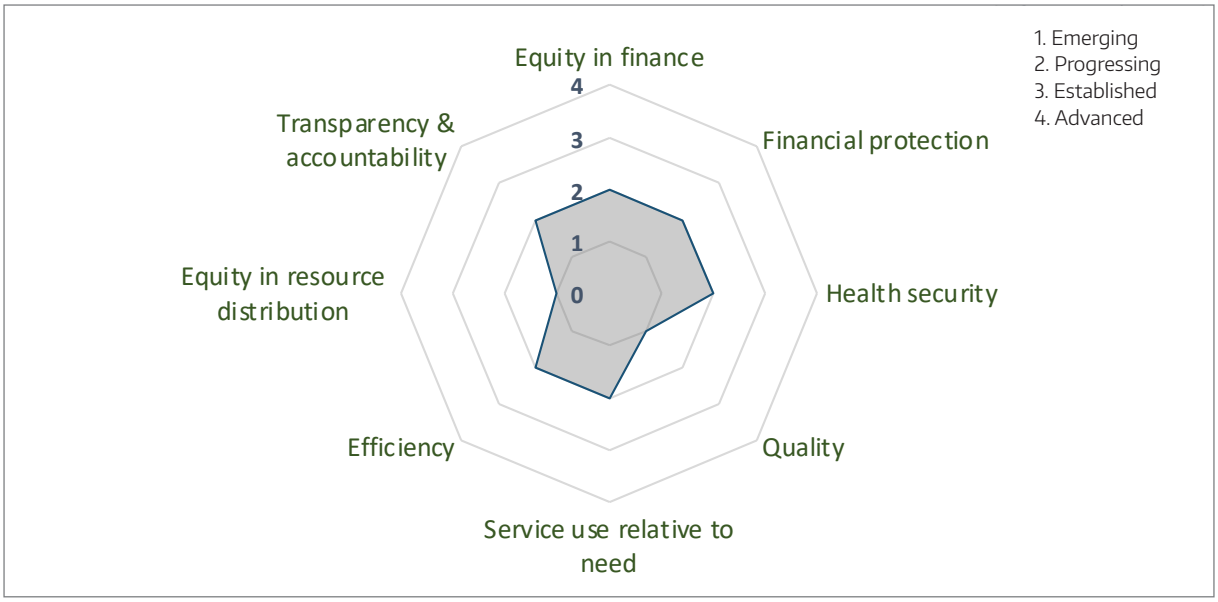
Summary of ratings by assessment area

Figure 6: Average rating by assessment area (spider diagram)



Source: Based on HFPM data collection template v2.0, Bangladesh 2021

Figure 7: Average rating by goals and objectives (spider diagram)

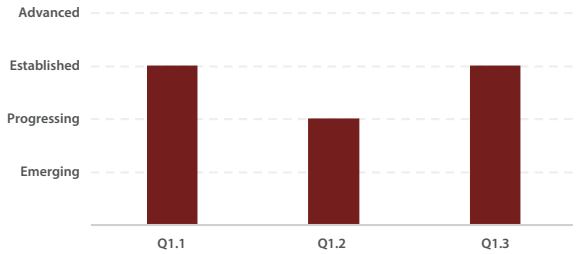


Source: Based on HFPM data collection template v2.0, Bangladesh 2021

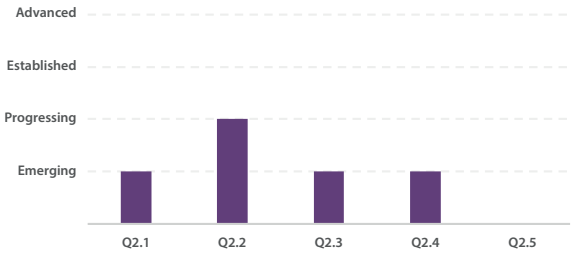
Assessment rating by individual question

Figure 8: Assessment rating by individual question

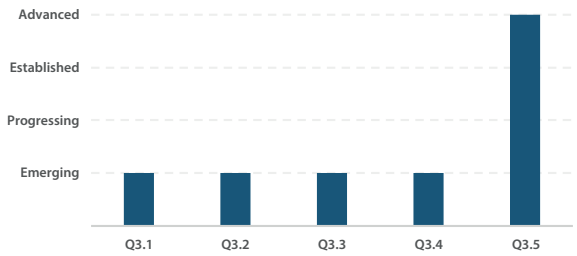
1. Health financing policy, process & governance



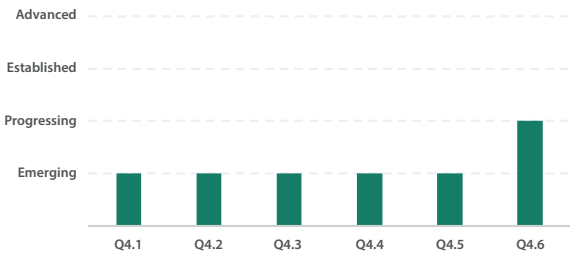
2. Revenue raising



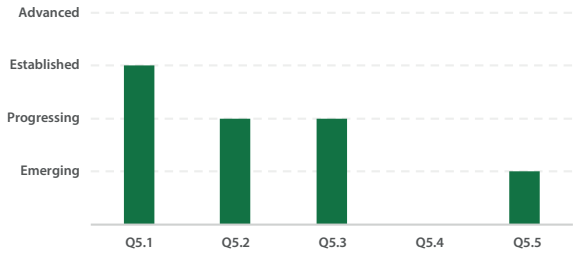
3. Pooling revenues



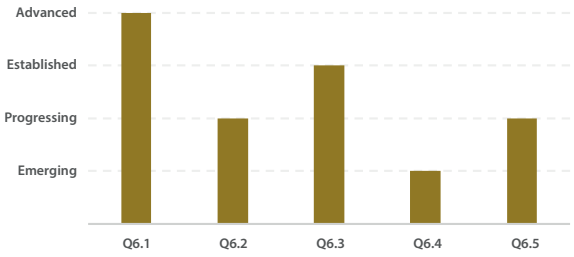
4. Purchasing and provider payment



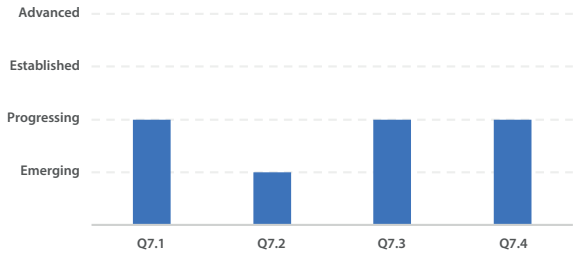
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes

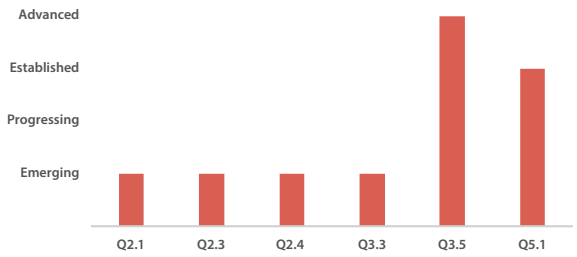


See Annex 3 for question details

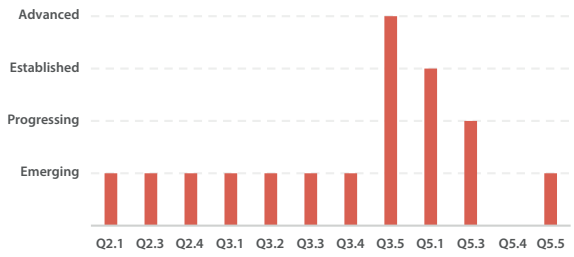
Assessment rating by UHC goals

Figure 9: Assessment rating by intermediate objective and final coverage goals

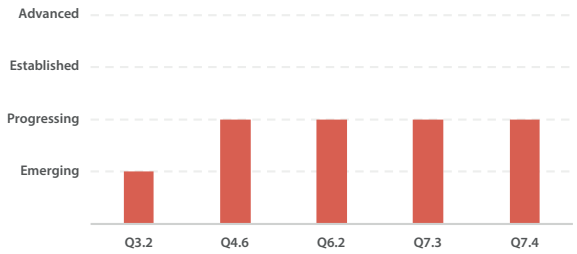
Equity in finance



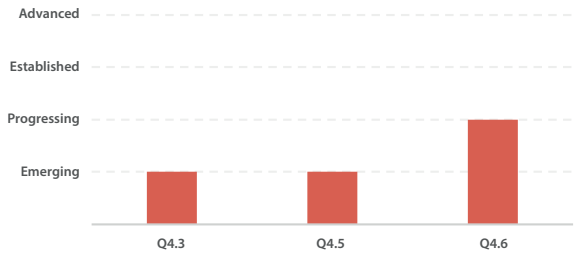
Financial protection



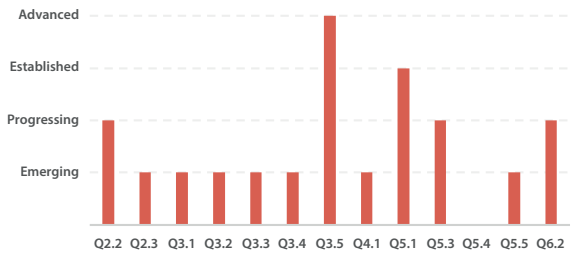
Health security



Quality



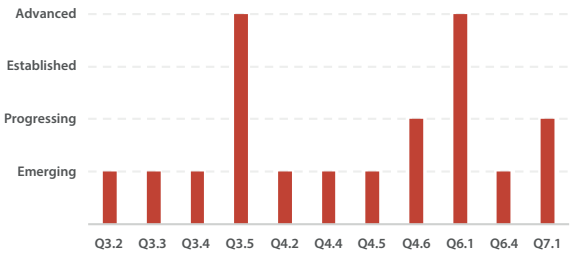
Service use relative to need



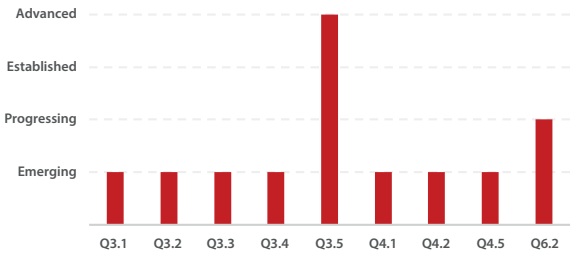
Assessment rating by intermediate objective

Figure 9 (continued): Assessment rating by intermediate objective and final coverage goals

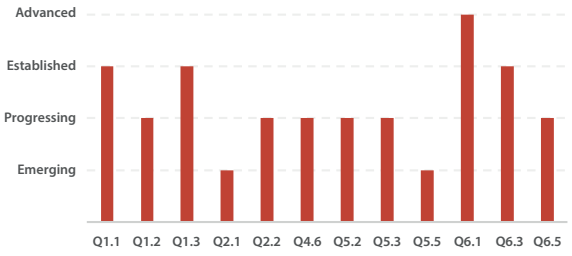
Efficiency



Equity in resource distribution



Transparency & accountability



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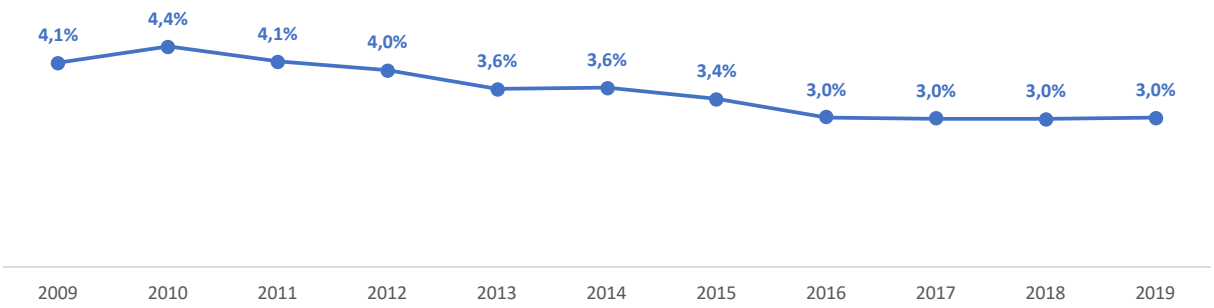
Annexes

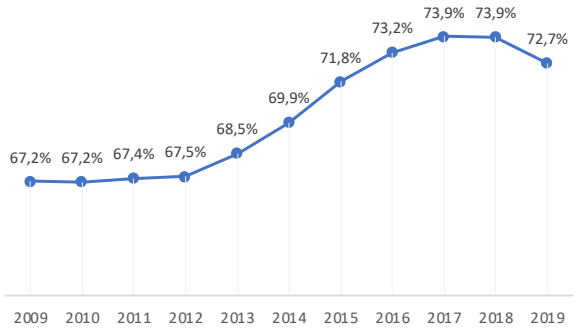
Annex 1: Selected contextual indicators

Figure 10: Health expenditure indicators for Bangladesh

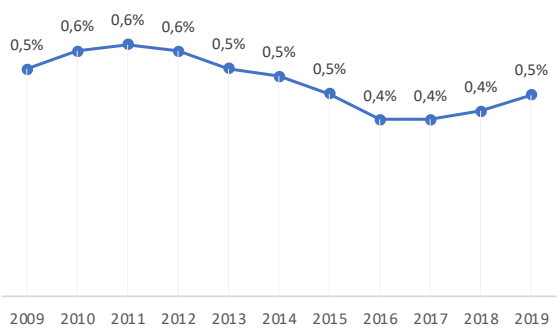
General government expenditure (GGHE% GGE)



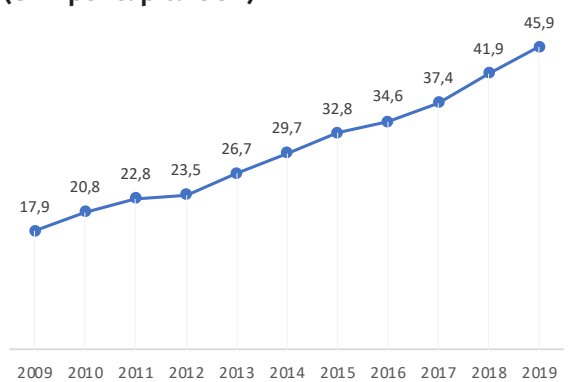
Out of pocket spending (OOPS%CHE)



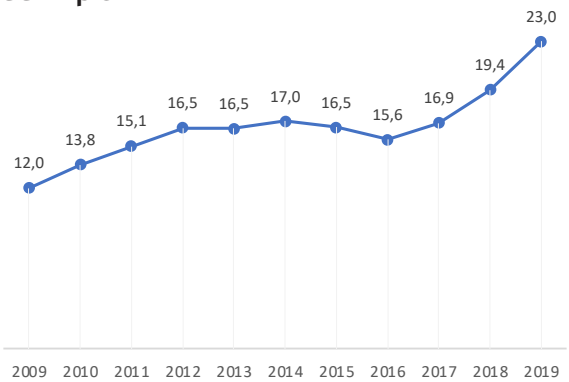
Public spending on health as % GDP (GGHE-D%GDP)



Total health spending (CHE per capita USD)

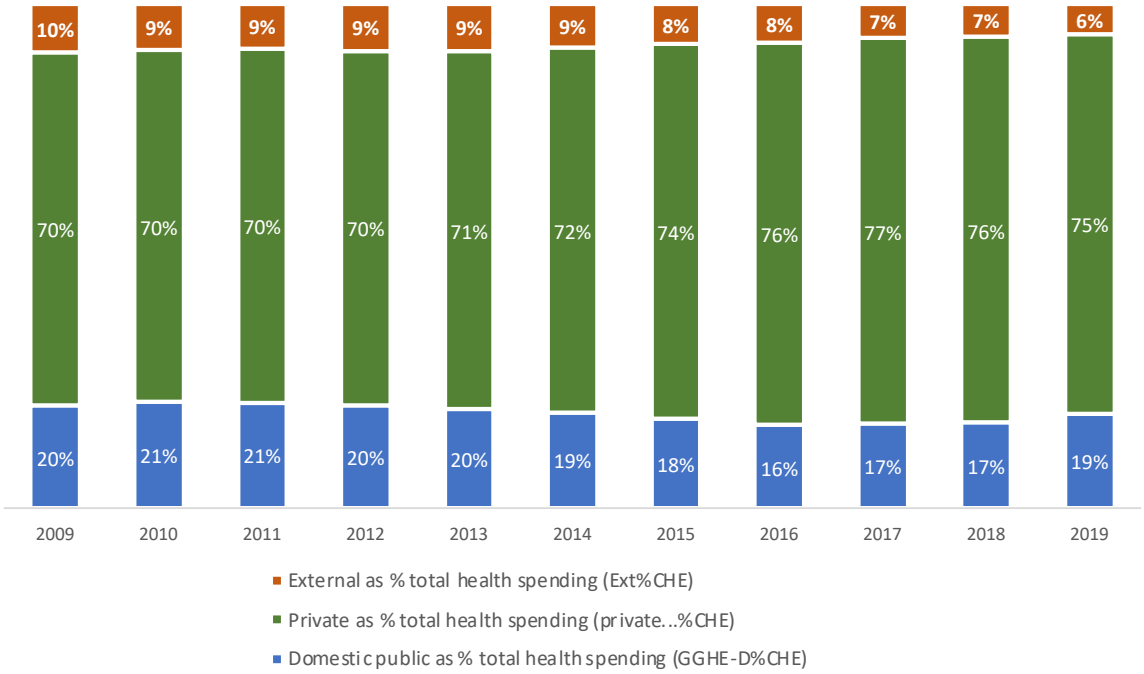


GGHE p.c.



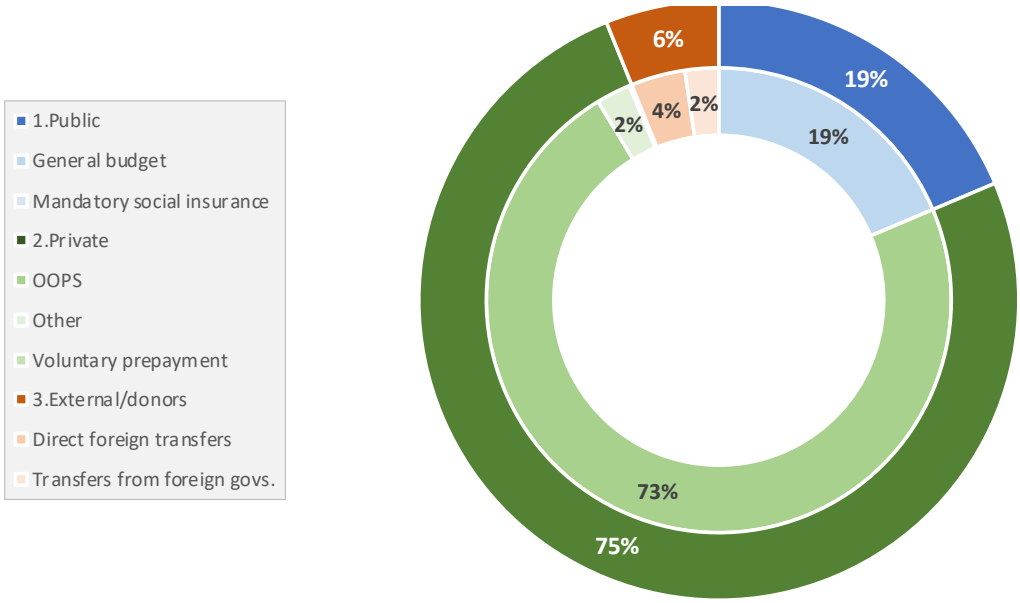
Source: WHO Global Health Observatory, 2020 (https://apps.who.int/nha/database/Home/Index/en)

Figure 11: Revenue sources for health in Bangladesh



Source: The Global Health Observatory, 2020 (https://apps.who.int/nha/database/Home/Index/en)

Figure 12: Revenue sources disaggregated 2019

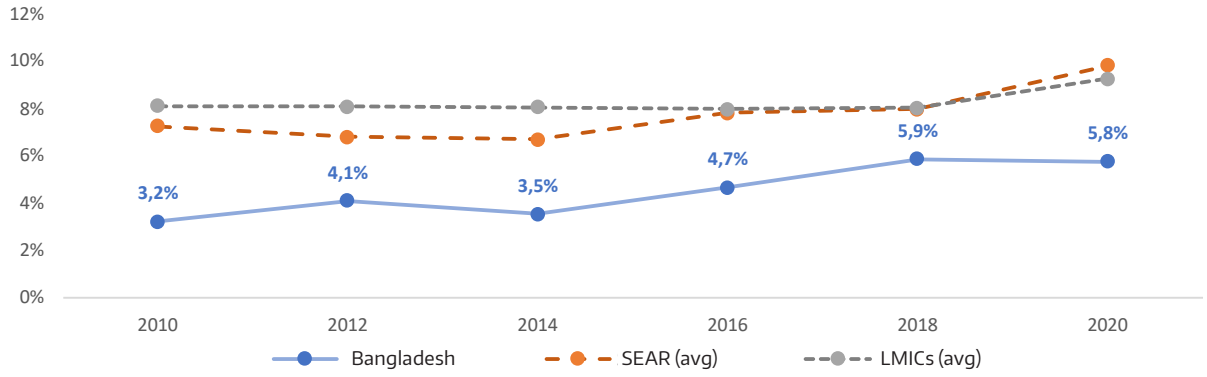


Source: WHO Global Health Observatory, 2020 (https://apps.who.int/nha/database/Home/Index/en)

Health taxes

Figure 13: Cigarette affordability in Bangladesh

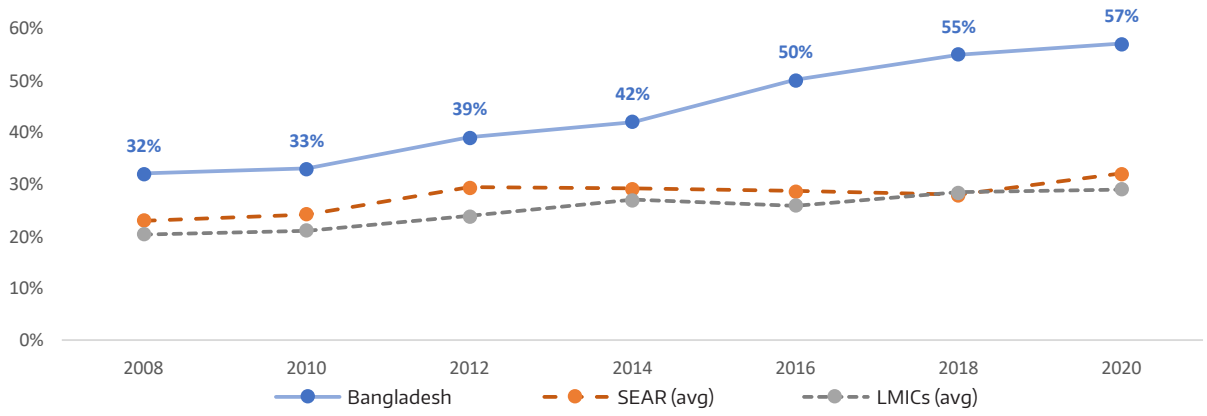
Reducing affordability is an important measure of the success of tobacco tax policy. In the longer term, a positive, higher measure means cigarettes are becoming less affordable. Short term changes in affordability are also presented.



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

Figure 14: Excise tax share in Bangladesh

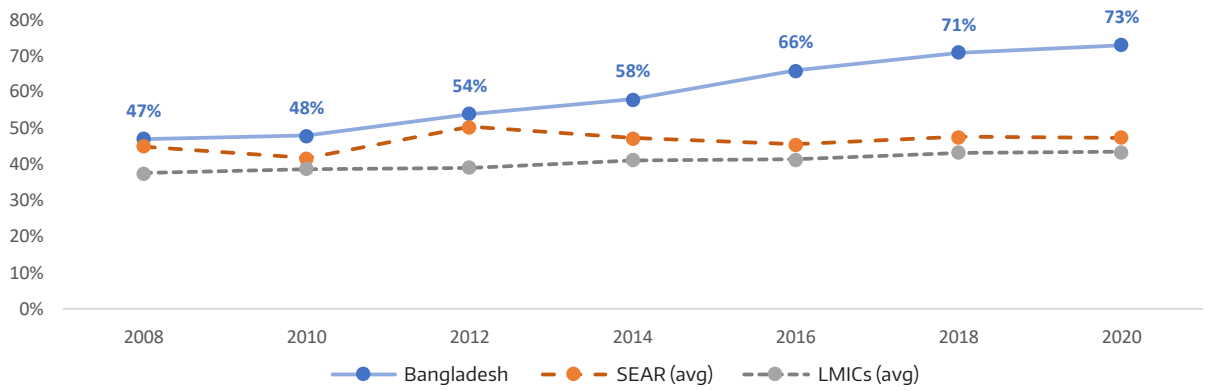
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



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

Figure 15: Total tax share in Bangladesh

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



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

Annex 2: Desirable attributes of health financing

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

Table 1: Desirable attributes of health financing systems

Health financing policy, process & governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups

Table 1: Desirable attributes of health financing systems		
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs
Public health functions & programmes[3]	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

Annex 3: HFPM assessment questions

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

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

Annex 4: Questions mapped to objectives and goals

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

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

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

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

The Health Financing Progress Matrix (HFPM) is WHO's standard approach to assessing country health financing systems. HFPM reports provide policy-makers with an up-to-date assessment of current strengths and weaknesses, in relation to best practice, together with guidance on priority directions for reform in order to support progress towards UHC.

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