

## Foreword

Since late 2001/1380, improvements in the health of the Afghan population have largely been made possible due to significant amounts of external assistance from the international community under the leadership of the Afghanistan Ministry of Public Health. As Afghanistan works towards greater independence in health systems development and health financing, it is critical that the Afghan government continues to establish the necessary functioning governmental structures, advances an applied health economics research framework, and supports both the public and private sector to implement this Health Care Financing & Sustainability Strategy.

In this respect, I welcome the inauguration of the Health Economics and Financing Directorate in May 2009, which started developing this Strategy and establishing the first blocks of health financing activities in Afghanistan. This document is crystallizing and giving a framework to existing health financing mechanisms, i.e., demand side-financing and results-based performance in the country.

The implementation of the HCF Strategy will enable the Ministry to examine unit cost analyses of inpatient and outpatient services within the BPHS, EPHS and some national hospitals, and to investigate resource allocation and assess the efficiency of health service delivery. Moreover, there is a further need to examine in detail the costs of the BPHS to ensure universal coverage and the development of fund raising based on evidence or alternative health financing mechanisms, i.e., taxes, community based health insurance, etc.

In developing the Strategy, the Ministry has begun to address many of the challenges faced in financing its health system, i.e., estimated high levels of out of pocket payments and inequity in access to care. Likewise, there is low per capita public health expenditure in Afghanistan compared with other low income countries in the region and throughout the world. It is expected that the Strategy will seek and respond to most of the financing challenges which our health delivery system is facing and will ensure provision of high-quality health services in an equitable and sustainable manner through a variety of health financing mechanisms.

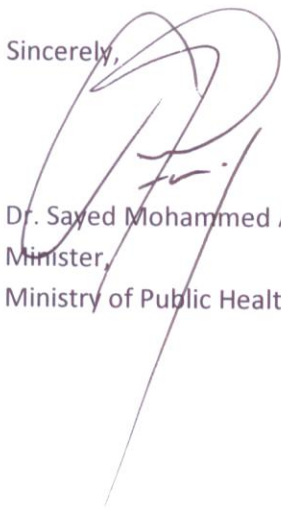
Using this opportunity, I would like to express my sincere thanks to Dr. Ahmad Shah Salehi, Director of Health Economics and Financing for professionally leading the Health Care Financing Taskforce for developing this important document. In addition, I would like to express my appreciation to professional contribution of taskforce members each Dr. Iqbal Aman, Head of Healthcare Financing Unit/MOPH; Dr. Iqbalshah Pakzad, Head of Health Economics Unit/MOPH; Dr. Ibrahim Maroof, Representative of Tech Serv; Dr. Farid, AHDS Deputy Director; Dr. Qadir, MoPH-SM Manager; Dr. Mir Massoud Atefi, DSF Coordinator/MoPH; Dr. Abdul Alim Atarud, NHA Coordinator/MoPH; and Prof. Aaron Beaston Blaakman and Ms. Marion Cros, EPOS Advisors. Further, I would appreciate the work of Dr. Ahmad Jan Naeem, Acting General Director of Policy

and Planning/MoPH as well as the Policy and Planning national consultant, Dr Daoud and EPOS Advisors Mr. Wayne Murray and Mr. David Vorst, who invested their valuable time to make sure the document follows MoPH guidelines on Strategy Development. I also thank the proof-reader, Dr. Michael Hall, EPOS/AFD Team Leader of the Blood Bank Project.

In addition, I would like to express my gratitude to the Donors community for providing constant support in the course of developing the strategy. Special thanks go to Ms Sarah Bernhardt and Mr. Randolph Augustin for their valuable comments to the strategy along its development.

Eventually, I would kindly request full support of development partners in financing and implementation of this strategy.

Sincerely,

A handwritten signature in black ink, appearing to be 'Fatimie', written over a large, stylized circular flourish.

Dr. Sayed Mohammed Amin Fatimie  
Minister,  
Ministry of Public Health, Afghanistan

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## **Abbreviations/Acronyms**

ADG Afghanistan Health Sector Donor Group  
ANDS Afghan National Development Strategy  
BPHS Basic Package of Health Services  
CBHF Community Based Health Financing  
CHC Comprehensive Health Centre  
CHW Community Health Worker  
DH District Hospital  
EC European Commission  
EPHS Essential Package of Hospital Services  
EU European Union  
GAVI Global Alliance for Vaccines and Immunizations  
GCMU Grant and Contracts Management Unit  
GDPP General Directorate of Policy & Planning  
GoA Government of Afghanistan  
HCF Health Care Financing  
HCS Health Care Service  
HCW Health Care Worker  
HNS Health and Nutrition Sector  
HNSS Health and Nutrition Sector Strategy  
HEU Health Economics Unit  
HEFD Health Economics and Financing Directorate  
HSP Health Service Provision  
JHU Johns Hopkins University  
MDG Millennium Development Goal  
MoF Ministry of Finance  
MoHE Ministry of Higher Education  
MoPH Ministry of Public Health  
NHA National Health Accounts  
NHCS National Health Care System  
NHP National Health Policy  
NHS National Health Strategy  
NH National Hospitals  
NRVA National Risk and Vulnerability Assessment  
PA per annum  
PAR Public Administration Reform  
PH Provincial Hospital  
PHCC Provincial Health Coordination Committee  
PHCS Primary Health Care Services  
PPH Provincial Public Health  
PPSP Policy and Planning Support Program  
RH Reproductive Health  
RgH Regional Hospital  
SBA Specialized Birth Attendance  
SH Specialty Hospital  
SWAp Sector Wide Approach  
TA Technical Assistance  
UN United Nations  
UNDP United National Development Program  
UNICEF United Nations Funds for Children  
USAID United States Agency for International Development  
USD United States Dollar  
WB World Bank  
WHO World Health Organization

## 1 Executive Summary

This strategy focuses on healthcare financing in terms of public, private and donor revenue sources in Afghanistan. This document is developed in line with the National Health Policy and Health and Nutrition Sector Strategy (HNSS). Indeed, the development of a National Strategy on Health Care Financing and Sustainability and National Health Accounts is one of the 18 strategies of HNSS. Furthermore, it is expected that the HCF strategy will aim at delivering more cost-efficient services, contributing to the achievements of health related Millennium Development Goals.

Specifically, from financing side, this strategy emerges a number of health policy prescriptions which have been applied in many developing countries. Based on the main recommendations of the healthcare financing study conducted in 2008 and further healthcare financing work carried out since 2001, this document identifies the main challenges faced by the Health Care Financing Sector in Afghanistan. Among others, one might highlight the lack of capacity in applied health economics and resource management, the high level of out-of-pocket payments for health services and inequity on access to care, the low per capita public health expenditures, limited data availability for informed health financing and limited aid coordination.

This document outlines **objectives**, in the light of the National Health Care Financing Policy (2007). Each of them can be reached by a **strategic direction**. In total, there are six strategic directions, which are deemed to tackle most of the mentioned challenges from 2009 until 2013. Believing that administrative capacity is an essential component of revenue mobilization efforts, more focus has been put on capacity development of the healthcare financing and health economics units to be able to explore potential funding sources and conduct various economic evaluation studies for efficient and effective implementation of health delivery programs in Afghanistan. In addition, in order to increase the utilization level of healthcare services, both demand and supply side financing approaches are introduced which are currently being tested. Sustainability of healthcare financing has been one of the major concerns of the MoPH since inception of donor supported program in Afghanistan health sector. In order to reduce the donor dependency, more efforts will be made to strengthen financial sustainability of the system through revenue collection without increasing inequity. In this respect, a few health care financing alternatives will be explored, e.g., taxation, user fees and equity fund at secondary level to raise domestic revenue, while ensuring access to health services. Exploring and promoting risk pooling mechanisms is another strategic intervention which will be examined through 2009 to 2013. Risk pooling has been tested in 2006 in Afghanistan. There will be a need to examine cultural factors in the community and provide suggestions for the adaptation of health care financing mechanisms such as community-based insurance.

Lack of economic data has created numerous problems in evidence based decision making process at the MoPH. To ensure accurate production of economic data, efforts will be made to establish economic data within both public and private sector. In addition, in order to have a clear picture of health expenditures flow in the country's health sector, production of National Health Accounts will be one of the priorities of this strategy throughout the implementation period. Eventually, throughout the implementation of the BPHS, several efforts have been made to enhance coordination among potential donors supporting the health sector in Afghanistan. To ensure coordination, a Sector Wide Approach (SWAp) in the Afghan health sector will be designed and examined. This will improve aid effectiveness and its impact on institutional development of the health system and health service delivery throughout the country.

Each strategic direction encompasses several strategic interventions, which aim to reach the given objectives. Of course, the implementation of the Health Care Financing Strategy is another challenge, as it presents risks, e.g. limited resources available and implementation capacity as well as insecurity.

To address some of these risks, the ministry costed the six strategic directions of the current document, in such a way that the MoPH can advocate towards the Ministry of Finance for a higher budget allocated to the health sector as well as to convince the donors community to get financial commitment for strategic directions which are of priorities.

#### **MOPH's Six Health Care Financing Strategic Directions 2009—2013**

1. Health Economics and Financing Directorate Capacity Development
2. Support to Mapping of Health Expenditure Flows
3. Exploring Demand and Supply-side Financing
4. Financial Sustainability, Revenue Collection, Inequity Reduction and Advancing Risk Pooling Mechanisms
5. Support to Efficient Resource Use and Allocation
6. Enhance Aid-Effectiveness in Healthcare Financing

Given the short duration for implementing the numerous strategic interventions, combined with the limitation in the capacity and resources, the Ministry will prioritize the strategic interventions. Hence, the Ministry will primarily focus on establishing the National Health Accounts along with exploring demand and supply-side financing approaches. Moreover, different ways to mobilize revenues to the health sector through earmarked taxes to the health system, and user fees as well as experimenting the prepayment and risk-pooling mechanisms. As requirement for implementing the above interventions, simultaneously the Ministry will enhance its technical capacity in the field of health economics and financing which is also of top priority.

It is to note that with regard to outcome indicators and the estimated affect of the National Strategy on Healthcare Financing and Sustainability on important markers such as the level of out-of-pocket payments in the country, the MoPH will face the challenge of entering a start-up phase in health care financing development while simultaneously testing models for future scale-up (beyond the current strategy period). As a result, limited impacts may be observed in the short-run while more significant impact of the strategy will most likely occur in the medium (5 years) to long-term (10 years).

The National Strategy on Health Care Financing and Sustainability is not an end in itself, but the beginning of a long process which will start by putting in place building blocks in health economics and financing in the MoPH to ensure effective services delivery through, among other tasks, systematic costing exercise and cost-efficiency analysis of BPHS, EPHS, population health interventions and health strategies.

The development of an operational working plan is the next logical step which will follow the HCF strategy to make the strategy implementable and lively.

## 2 Introduction

Afghanistan, as one of the post-conflict countries, although continues to increase its domestic revenue, is currently heavily dependant on external aid. At present, external assistance is estimated to represent more than 85% of total public spending on health. On the other hand the flow of such aid is hardly predictable and unstable. Meanwhile, the alignment and compliance of the external aid with government policy and strategy is challenging. Additionally, capacity in research in the field of health economics and costing analysis is limited. Moreover, the need for improving efficiency as well as the flow of financial data in the health sector is evident. Therefore, the need for the health care financing and sustainability strategy in light of its existing policy has been clearly evident.

Generally, health financing is concerned with how financial resources are generated, allocated and used in health systems. Examples of health financing issues include:

- (i) how and from where to effectively raise sufficient funds for health;
  - (ii) how to overcome financial barriers that exclude the poor from accessing health services; or
  - (iii) how to provide an equitable and efficient mix of health services at a reasonable cost.
- (WHO, 2006)

Accordingly, the implementation of a fully developed HCF strategy will guide the MoPH and both public and private sectors to establish greater resource efficiency in the provision of health services, deliver cost-effective health interventions at all levels in the health services system, and to conduct evidence-based health policy decision-making at all levels.

To provide this in context, the HCF Strategy provides insight into a brief recent history of health financing in Afghanistan since 2002, when the international community began supporting the health system. Furthermore, the strategy provides a detailed description of specific objectives and interventions that the MoPH will take to improve and advance health financing in Afghanistan during the period 2009-2013, coinciding with the timeline and agendas of the Afghanistan National Development Strategy (ANDS) and the Afghanistan Health and Nutrition Sector Strategy (HNSS), 2008-2013.

The MoPH foresees this period as one in which Afghanistan will put in place key health economics and financing related activities in the country in order to gain greater self-sustainability in improving the health of the Afghan population and achieving the country's Millennium Development Goals (MDGs). These activities will be implemented predominantly by the General Directorate for Policy and Planning and a newly inaugurated Health Economics and Financing Directorate (HEFD) (inaugurated May 26, 2009).

In June 2008, a research study commissioned by the Afghanistan MoPH and funded by the European Commission was conducted to provide an initial overview of the financial resource flows and allocation within the health sector since 2003 (Maryse Dugue et al., 2008). The purpose of this study was to begin to examine general health financing trends as well as the relationship between funding, domestic and international resources, health service provision, and disease patterns and risks. Moreover, this study investigated the existing gaps in health financing in Afghanistan and proposed important steps forward in key areas for supporting health strategy such as capacity building and the establishment of building blocks for more self-sustainable health financing.

Nonetheless, the HCF strategy is developed in light of the existing national policy on health care financing and sustainability and could be considered largely an out-growth of the results and recommendations set forth in this study while specific components of the strategy were derived from numerous discussions and inputs among members of the MoPH and GDPP including the Health Care Financing Task Force and the previously existing Grants and

Contracts Management Unit (GCMU). Lastly, as the Government of Afghanistan (GOA) seeks to advance a more self-sustainable health care financing environment, it seeks to learn from the experiences and literature of the international community (conflict and post-conflict countries in particular) on how to implement the HCF Strategy and to achieve its stated goals and objectives.



### 3 Background on Health Financing in Afghanistan

Understanding the recent context of health care financing in Afghanistan is necessary for informed development of a suitable strategy and the real way forward for a more self-sustainable health resource management for the future. The following provides a background on health financing in Afghanistan, reference to the international context, and a summary of the challenges to be addressed by the health care financing strategy. Concluding this section, the primary objectives of the HCF Strategy are defined.

There are currently three primary sources of funding for the health sector in Afghanistan:

1. External funding (donors)
2. Public funding (government)
3. Private funding, of which the largest contribution is estimated to come from household expenditures (Individual expenditures).

#### 3.1 Funding sources for Health in Afghanistan

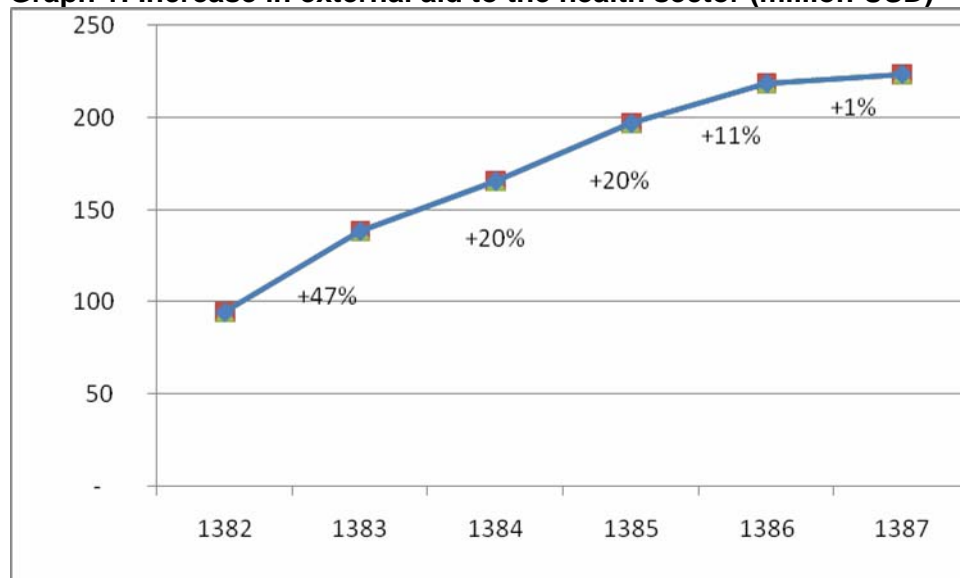
External assistance to the health sector has increased more than two-fold since 2003. Table 1 below indicates the total annual amount allocated from external funding in US dollars.

**Table 1: External assistance to the health sector in Afghanistan 2003-2008**

2003	2004	2005	2006	2007	2008
\$ 94 348 998	\$ 138 381 333	\$ 165 498 663	\$ 198 788 622	\$ 220 689 481	\$ 223 537 026

After an initial sharp increase in the conflict period (2003-2006), there recently has been a tendency to level off or stabilize external assistance. Graph 1 below shows the percentage increase in external aid to the health sector in US dollars since 2003. This leveling off suggests one reason for the MoPH to further develop and implement a HCF strategy to further advance self-sustainability of health sector resources in the future.

**Graph 1: Increase in external aid to the health sector (million USD)**



Moreover, Afghanistan’s relationship to donors and the need for less resource dependence in the future is clearly described in the Afghanistan Health and Nutrition Sector Strategy (2008-2013),

“However expedient in the short term, reliance on external funding is never an optimal strategy. The unpredictable availability of required funding, combined with frequent policy shifts of donors, has the potential to leave the HNS in a very precarious and unstable situation. With this uncertainty of medium to long term funding, and despite planning and assurances given, MoPH still has little surety of being able to implement its plans and programs as set out in this core strategic and supporting program strategies. However, any substantial reliance on internal sources of funding at present is unrealistic, evidenced by the insufficient proportion of the operating budget currently being allocated to health. Realistically, external sources of funding will be required for many years to come. The MoPH is actively initiating systems and process that will eventually set conditions for a Sector Wide Approach to longer term funding/service partnerships with donor governments and banks. Further and continuing improvement, of the demonstrable success of the HNS to date, will provide an important incentive to the donor community to continue its substantial investment for the long-term.” Source: Afghanistan HNSS, 2008

Currently, total public funding for health includes the Government core budget allocation (operating funds and the development budget, including discretionary and non-discretionary) plus external assistance. At present, external assistance is estimated to represent more than 85% of total public spending on health. Details of the data are represented in Table 2.

**Table 2: Total funding for the health sector (USD)**

Fund Category	2006	2007	2008
External Assistance	\$ 198 788 622	\$ 220 689 481	\$ 223 537 026
Operating Budget	\$ 27 640 000	\$ 30 700 000	\$ 27 700 000
<b>Total Funding</b>	<b>\$ 226 428 622</b>	<b>\$ 251 389 481</b>	<b>\$ 251 237 026</b>

In the absence of accurate and reliable census data, it is difficult to estimate the evolution of per capita spending on health since 2003. With a population estimate of 23.5 million in 2004/2005 (as per household listing estimate), and applying the fixed annual rate of 2

percent increase applied by the CSO, the per capita expenditure of public expenditure on health has increased from approximately \$8 to \$11.81 US dollars. (Dugue, 2008)

In the health care financing study, the coverage of health services was taken into account to better understand how much is actually spent per capita on service delivery. Two elements were considered: the coverage of BPHS contracts, which is estimated at 82%<sup>1</sup> for 2008, and the population living in conflict-affected areas where access to services is limited, which is at the time of preparation of the report estimated at about 22%. (Dugue, 2008) Table 3 indicates the estimated per capita public expenditure on health.

**Table 3: per capita public expenditure on health (USD)**

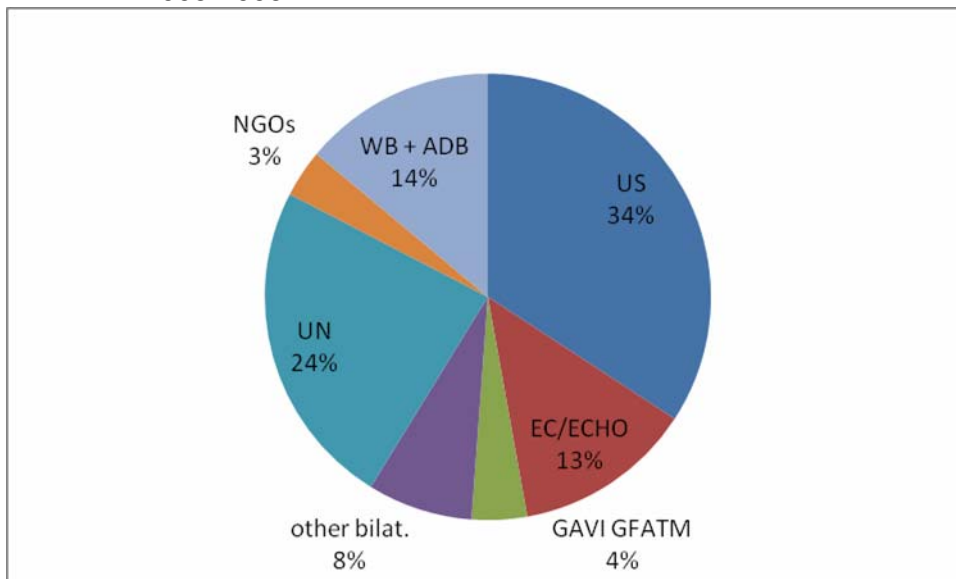
	<b>2006</b>	<b>2007</b>	<b>2008</b>
<b>Total funding</b>	\$ 231 080 622	\$ 258 433 481	\$ 277 708 026
<b>Population Estimate</b>	24 449 400	24 938 388	23 511 400
<b>USD per capita</b>	\$ 9.45	\$10.36	\$11.81
<b>with 80% coverage</b>	\$ 11.81	\$12.95	\$14.76
<b>with 60% coverage</b>	\$15.75	\$17.27	\$19.68

At present, the largest funders of the health sector in Afghanistan are the United States, European Community, the United Nations and the World Bank. The main component of UN assistance is driven by the immunization programs, which is estimated to represent 47% of the UN assistance (58% including WHO's communicable diseases programs). The data is represented in Graph 2.

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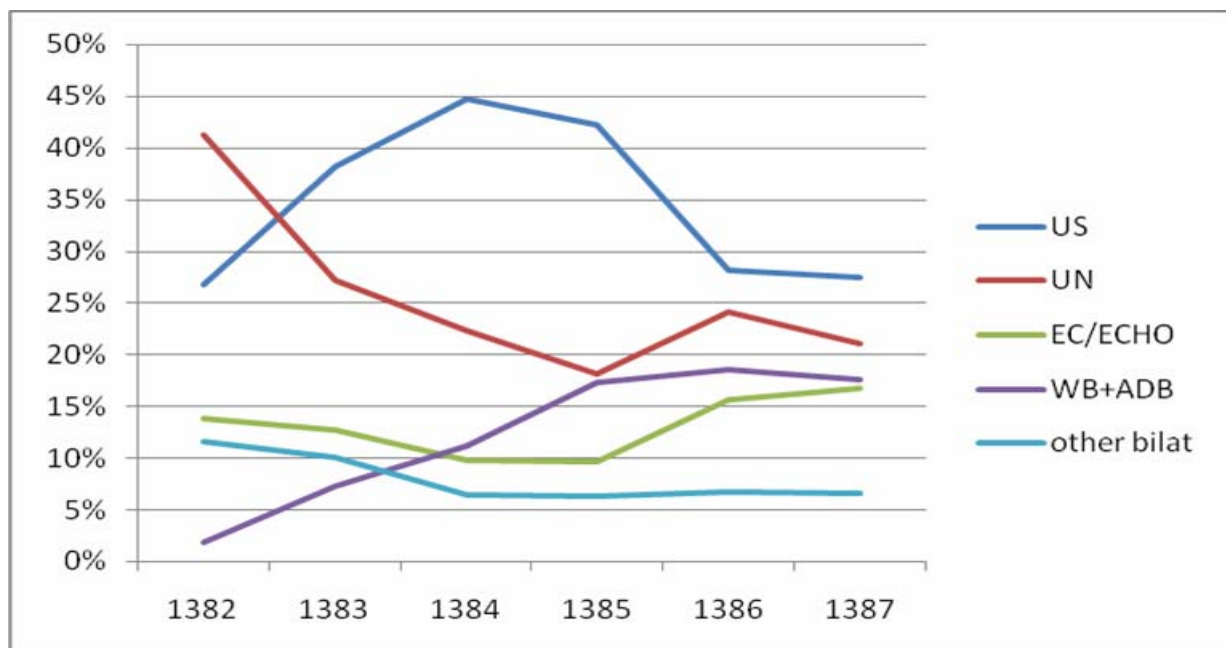
<sup>1</sup> The BPHS is currently being offered in districts in which 82% of the population lives. Due to limitations of geographical access, financial access, and insecurity, not everyone in these districts can benefit from the availability of the BPHS. Current estimates suggest that the BPHS currently reaches about 65% of the total population.

**Graph 2: Average percentage contribution of health sector financing by donors 2003-2008**



A number of bilateral actors actually disengaged in 2003, because the emergency phase was presumed finished, and also because their financial resources did not allow them to support clusters of districts, or even entire province under the BPHS approach as described in the HNSS. After initial “start-up” investments were made by the United States, UN, and other bilateral donors, the relative contribution of the donors in the health sector has not substantially varied between 2005 and 2008. The data is represented in Graph 3.

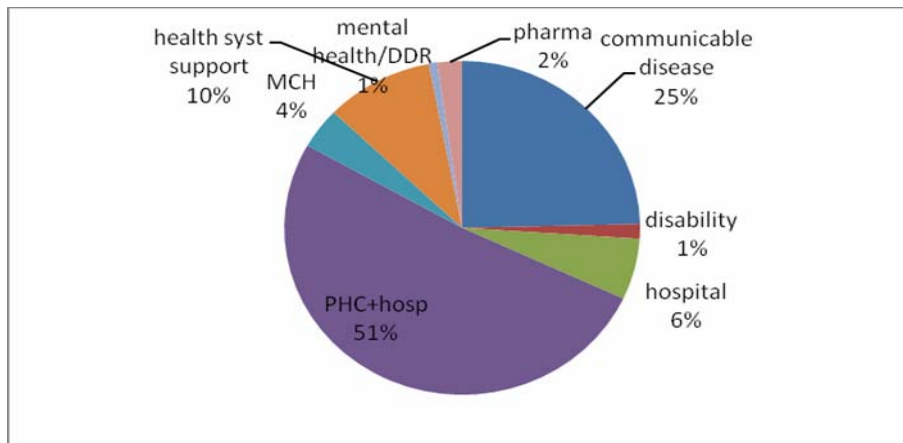
**Graph 3: Main financial contributors to the health sector in Afghanistan from 2003-2008**



### 3.2 Financing by health program

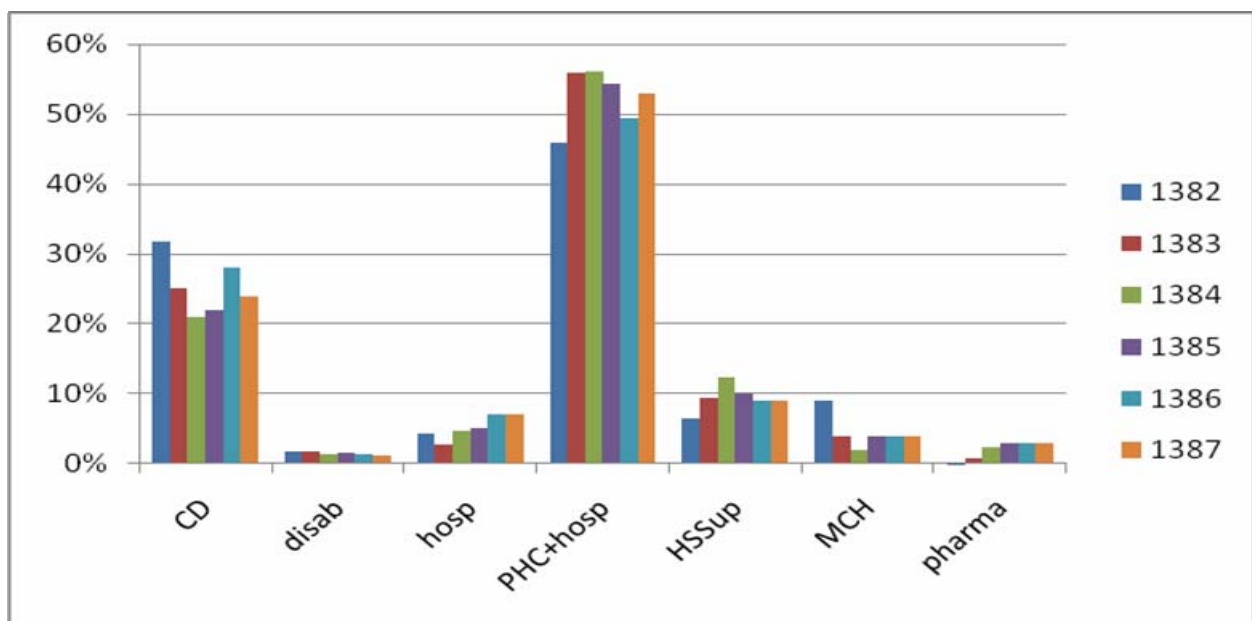
The main programs financed through the MOPH public sector from 2003 to 2008 are presented below. Because of the difficulty to separate (i) BPHS and EPHS, and (ii) construction/renovation of PHC clinics and provincial hospitals, data is presented combining primary health care and hospital care. What is clearly identified as hospital (investment and support to central and regional hospitals, as well as investment in blood banks), is counted separately as “hospital”.

**Graph 4: Allocation of health financing by health program, total aid budget (external and development)**



Allocation by program has been relatively constant over the years as shown below in Graph 5, with a large share allocated to primary health care and hospital service delivery through BPHS and EPHS, as well as communicable diseases, in line with what is known about the communicable diseases prevalent throughout Afghanistan.

**Graph 5: Evolution of the allocation of health financing by program, 2003-2008**



The establishment of the BPHS and EPHS and the commitment of all major stakeholders, Government and donors, to the system have been instrumental in maintaining a steady flow of funding towards priority health services delivery. Of the combined category “PHC plus hospital”, 54% correspond to BPHS plus EPHS and an additional 31% to primary health care-related expenditure. Until 2009, the average cost per capita of BPHS has been estimated to cost approximately \$4.50 USD. Recently additions to the BPHS have increased this amount to approximately \$5.00.

Expenditure on communicable diseases is dominated by immunization programs, which represent 60 percent of this category. Expenditure on tuberculosis represents 8 percent of spending on communicable diseases. Other communicable disease programs are targeted at malaria, avian influenza and Leishmaniasis, while spending on HIV/AIDS has until now been very small.

To date, no fund have been allocated to non-communicable diseases, although they represent an increasing burden in Afghanistan. Investment in the drugs and pharmaceutical area is minimal and largely insufficient. Similarly, only 3 % of external aid was allocated to mental health (although mental health has now been included in the BPHS), most of it for drug demand reduction.

An estimated 1 million Afghans are drug users, and new programs are being implemented since 1386, with 17 facilities operated by the MOPH (with CNTF support) and 23 by NGOs.

No data has been collected on investments in water and sanitation programs or other environmental health priority areas which constitute the cause of many illnesses despite being identified as MOPH priorities as they have either not been funded or are classified as “non-health” in donor’s assistance. An example being the high incidence of diarrhea (notably amongst the poor) reported in all the surveys making these investments a public health priority and justifies their integration in the plan for the future National Health Accounts of Afghanistan. In addition, there is no cost data available on health interventions highlighted in the HNSS, i.e., Diabetes, road accidents, eye care, dentistry etc.

### 3.3 Health Financing: Afghanistan and the International Context

Table 4 shows health care financing indicators for Afghanistan, and in the region and other post-conflict countries, (WHO, 2006). Taking health care financing indicators from the region (Iran, India, Pakistan, and Central Asia) and from a few other post-conflict countries (Sierra-Leone, Timor-Leste and Rwanda), data indicate that the Afghanistan scenario presents similar HCF patterns to its neighbors and selected post-conflict countries (see Table 4).

The high level of personal “Out-of-Pocket” expenditures as % of private health expenditures in Afghanistan (97.2%) is a similar trend which is noticeable in several of its neighboring countries, i.e., Pakistan (97.9%), Uzbekistan (97.1%), Tajikistan (97%) and Kyrgyzstan (95.4%). Afghanistan’s private health expenditures as % of total health expenditure is also high with 72.5%. However, it is slightly less than its 3 close neighbors, i.e., India (80.4%), Pakistan (83.6%), and Tajikistan (77.4%). These figures indicate both for Afghanistan and its neighbors, inequity in terms of financial access to health services as well as the lack of risk-pooling alternatives, i.e., social health insurance, private health insurance, pre-paid payments etc.

In 2008, in Afghanistan, the proportion of external funding as proportion of total public health expenditures was more than 90%. However, the proportion of external funding is lower, as a proportion of total expenditures on health. In 2006, external resources for health as proportion of total expenditure on health is 20.1%, which seems to be high, but common in

post-conflict countries, where the donor community provides a large proportion of financial support. In post-conflict countries, this proportion is even more elevated, i.e., Rwanda (38.2%), Sierra Leone (45.1%) and Timor Leste (44.6%) than non-post-conflict countries. This might stem from the fact that the current political situation of these countries is more secure and stable than Afghanistan.

**Table 4: Health Care Financing Indicators in Afghanistan, the region and post-conflict countries, 2006**

Country	General government expenditure on health as % of total government expenditure, 2006	Out-of-pocket expenditure as % of private expenditure on health, 2006	Private expenditure on health as % of total expenditure on health, 2006	External resources for health as percentage of total expenditure on health, 2006	Total expenditure on health as percentage of gross domestic product, 2006
Rwanda	27.3	62.5	36.3	38.2	10.4
Sierra Leone	7.8	100	51	45.1	3.5
Afghanistan	4.4	97.2	72.5	20.1	5.4
Iran (Islamic Republic of)	9.2	94.8	44.4		7.8
Iraq	3.4	100	27.5		3.8
Pakistan	1.3	97.9	83.6	3.2	2
Sudan	6.3	98.7	62.9		3.8
Kyrgyzstan	8.7	95.4	56.7	6.1	6.4
Tajikistan	5.5	97	77.4	6.4	5
India	3.4	94	80.4		4.9
Timor-Leste	16.4	37.2	11.2	44.6	16.4

Source: <http://apps.who.int/whosis/data/Search.jsp>

### 3.4 Summary of issues to be addressed by the Health Care Financing in Afghanistan

The 2008 health financing study (Dugue et al., 2008) and current work being conducted within the MoPH points out the following needs to be addressed to advance health care financing and sustainability in Afghanistan:

- *Capacity Building at Central and Provincial Level in applied Health Economics and Resource Management.*

As in many of the developing government systems in Afghanistan, capacity building in applied health economics and resource management at both central and provincial levels is an essential building block for advancing health financing initiatives throughout the country.

- *Estimated high levels of out-of-pocket payments leading to inequity in access to care.*

It is difficult to estimate total health expenditures because households' out-of-pocket expenditures are estimated to be the largest source of financing, representing an estimated 80 % of a total health spending of around \$45 US dollars per capita in Afghanistan (Dugue 2008). Although these expenditures are not well understood at the moment, it is estimated that this large proportion is paid directly by patients at the point of delivery and raises concerns about equity in financial access to health services. Furthermore, as in many developing countries, this situation presents a significant challenge for risk pooling. Moreover, the supply of essential medicines is a primary issue in Afghanistan, and the budget allocation for drugs and medical supplies seems largely

inadequate at all levels. Lastly, equity in geographical access to health services is seemingly low. One of the major barriers to access to health services is distance from health providers, and there are still substantial gaps in the central and north-east regions.

- *Low per capita public health expenditure.*

Public spending on health in Afghanistan remains low when compared with other low income countries in the region and throughout the world, just under 3 percent of GDP: 2.9 percent in 1386 (2007/2008) and 2.7 percent of 1387 (2008/2009). Although revenue collection has increased sharply for the past 5 years from 4.7 to 8.2 % of GDP, it remains one of the lowest in the world, which leaves most Government's expenditure funded by external assistance. For the health sector, the total external funding (through core and external budget) is estimated at above 85 percent.

- *Limited Data and Analysis Available for Informed Health financing (including limited costing information).* Limited data are currently available to guide informed decision-making within the Ministry of Public Health with regard to the economics and financing of health service provision. Studies on the cost of delivering BPHS and EPHS services and the establishment of a National Health Accounts (NHA) for Afghanistan are critical for improving the efficiency of service delivery, maximizing the health of the population, and achieving millennium development goals within a context of limited resources. Lastly, a number of strategies are under development, and in order to efficiently implement these strategies, knowledge of their costs and impacts is critical. (Beaston-Blaakman, A., Swerdlin, D., et al., 2006)

- *Aid Coordination.*

Another challenge is the alignment of strategic and operational investment planning and accountability by GOA and contributing aid partners. This involves vertical programs, donor agency projects, technical support agencies and other partners, all of whom contribute to the national health system in various ways but use differing accounting processes, different timeframes for expenditure and different methods of reporting results of investment.

- *Limited financial data of private health care providers.* Although the MoPH is working towards developing relationships with the private sector, limited data are currently available with regard to private providers, particularly in the area of health financing. As the private sector grows in Afghanistan, understanding and supporting the private sector will be critical.



## **4 Health Care Financing Strategy for Afghanistan (1388/2009-1391/2013)**

The health care financing strategy in Afghanistan represents the implementation arm of the Health Care Financing Policy. Clearly defining the link between strategy and policy is critical for meeting the goals of the policy. The following is a brief of the Health Care Financing Policy for Afghanistan, established in 2008.

### **4.1 Healthcare Financing Policy - Vision, Mission and Principles**

In a review of policy recommendations to the G8, the Task Force on Global Action for Health System Strengthening indicates that “even after adjusting for purchasing differences, health spending in the poorest countries, at \$US 20-50 per capita, is one-thirtieth the level of that in developed countries...This lower level of spending buys developing countries lower levels of coverage by effective health interventions....Increasing spending can clearly help to improve coverage and access.”

G8 Hokkaido Toyako Summit Follow-Up, Global Action for Health System Strengthening, Policy Recommendations to the G8. Task Force on Global Action for Health System Strengthening (2009)

Given the substantial need to increase overall health spending while promoting efficient resource use overall, it is critical for the MoPH Afghanistan to implement a health financing strategy that encompasses all necessary components for resource management and mobilization to maximize the health of the population and to reach currently targeted MDGs.

The mission of the Health and Nutrition Sector as defined in the HNSS is “To improve the health and nutritional status of the people of Afghanistan through quality health care service provision and the promotion of healthy life styles in an equitable and sustainable manner.” (HNSS, 2008-2013) The vision, mission, principles and interventions for the Afghanistan Healthcare Financing strategy have been formulated keeping in mind the mission of the national policies, including the National Health Policy 2005-2009, Health and Nutrition Sector Strategy 2007-2013, and the National Health Care Financing Policy.

#### **Vision**

The Ministry of Public Health ensures the provision of high-quality health services in an equitable and sustainable manner through a variety of health financing mechanisms. (National Health Financing Policy, 2008-2013)

#### **Mission**

“The Ministry of Public Health will develop and implement health financing arrangements which increase total financing available and predictability of financing streams for the Afghanistan health system and contribute positively to:

- expanding population access to health care, particularly for the most vulnerable groups;
- improving the quality and cost-effectiveness of health services;
- appropriate access to and utilization of health care services;
- health facility fiscal autonomy;
- bottom-up health planning and budgeting from communities and provinces to the central level;
- pooling of the financial risk of illness to avoid catastrophic health expenditure;
- Implementing effective preventive services (public health / population health);

- Improved predictability and allocation of funding streams through the establishment of National Health Accounts; and
- greater community participation in and ownership of the health system.” National Health Financing Policy, 2008-2013”

### **Principles**

The HCF Strategy has been developed in the light of the following principles stipulated in the National Health Care Financing Policy:

- |   |                                    |
|---|------------------------------------|
| <b>1. Ensuring access</b>                           | <b>2. Improving quality</b>        |
| <b>3. Enhancing equity</b>                          | <b>4. Attaining sustainability</b> |
| <b>5. Promoting accountability and transparency</b> | <b>6. Generating efficiency</b>    |
| <b>7. Advancing simplicity</b>                      | <b>8. Results-oriented culture</b> |

#### 4.2 Objectives of the HCF Strategy

Based upon the above described issues to be addressed by the Healthcare Financing Strategy, the objectives of the HCF Strategy are as follows (not in any particular order of priority):

- 1) Develop capacity of the MoPH at central and provincial levels in applied Health Economics, Health Financing, and Resource Management;
- 2) Further assess and reduce high levels of out-of-pocket expenditures for health and inequitable access to health services;
- 3) Increase per capita public health expenditures;
- 4) Advance an efficient and effective health service delivery system by establishing and making available economic data within both the public and private sectors;
- 5) Establish economics and financial information on BPHS, EPHS and public health strategies for evidence-based policy decision-making and production of NHA in Afghanistan;
- 6) Increase or maintain the level of external funding in the health sector and enhance transparency and accountability of donor assistance;
- 7) Advance sustainability of health service systems in Afghanistan; and
- 8) Improve Aid Effectiveness in the health sector through better coordination mechanisms in health care financing

#### 4.3 The Historical Role of Health Financing in the MoPH Afghanistan

Over recent years, health financing has played an important role in the work of the MoPH, and is increasingly making a greater contribution to the overall functioning and activities of the Ministry. Within the General Directorate of Health Policy and Planning of the MoPH, the Grant and Contract Management Unit (GCMU) and Health Care Financing Department was established in April 2003.

The purpose of GCMU was to manage and oversee health project proposals, recommend actions for grant release and expand the delivery of the basic and essential packages of health services in collaboration with the United Nations (UN), NGOs, international donors and private sector; strengthening MoPH leadership in health resource management. GCMU held the primary responsibility within the MoPH to manage donor related contracts including BPHS and EPHS. The Health Financing Department had the responsibility to facilitate the early stages of program budgeting and to manage the Healthcare Financing Taskforce. This

taskforce has begun to explore many of the issues associated with demand-side health financing and health financing pilot studies such as Results-Based Financing.

In a reform of the GDPP with recognition of the growing importance of healthcare financing and economic research in strategic planning and policy formulation within the MOPH, the GCMU and HCF Directorate have now been restructured and formed into the newly created Health Economics and Financing Directorate (HEFD) of GDPP, inaugurated May 29, 2009. This directorate is now a critical component for managing and advancing health financing activities within the MoPH, and will play a significant role in advancing the HCF Strategy in Afghanistan in partnership with the broader MoPH, the GoA, and international community.

### **Scope of Work for HEFD**

Thus far, clear gaps in health economics and financing have impeded the development of evidence-based policies and strategies linked to routine decision analyses and economic data. For example, to-date, unit cost data pertaining to EPHS and national hospital services have yet to be established in Afghanistan while similar information relating to BPHS is limited by the small sampling of BPHS facilities (Newbrander et al., 2004). When reliably established, these data can be useful for program budgeting and planning at central and provincial levels.

Furthermore, key economic analyses such as cost-effectiveness and benefit-cost analyses, national health accounts, and health financing studies are very important for supporting policy-decision making within the MoPH as the ministry strives to maximize the health of the population within a limited health budget. Lastly, the MoPH leadership has further identified that a single department within the MoPH should be tasked with the application and oversight of economic analyses throughout the ministry and that such a department should ensure that the following research and health financing areas are properly covered: costing of all health priority strategies, data collection and analyses for national health accounts, cost-effectiveness and benefit-cost analyses and piloting of alternative health financing mechanisms.

Together, these activities will assist the MoPH to efficiently contribute to the reduction of causes and prevention interventions, expand access to care, improve quality and cost-effectiveness of health services, and manage financial risk of illness among the population, as indicated in the National Policy on healthcare financing and sustainability; and ultimately to be structured into a Sector-Wide Approach (SWAp).

#### **4.4 Health Care Financing Functions**

The ultimate functions of the HCF Strategy for Afghanistan include:

- 1. Resource Mobilization**
- 2. Development of risk pooling options**
- 3. Implementation and support of efficient resource allocation and purchasing of services**

Resource Mobilization refers to revenue collection e.g., community-based health insurance, general revenue collection and taxation, private payments, etc. Risk pooling, a way of collectively guarding against financial loss in the community (i.e. insurance schemes), is important for establishing financial protection among the population. Both taxation and insurance can serve the function of risk-pooling. An appropriate definition of the GOA Constitution will be required to facilitate further development in this area as resource allocation refers to how health services are paid for and how resource inputs are dispersed.

The failure to implement a health financing strategy and policy prevents the realization of improved health outcomes from current and possible future levels of investment in health.

In order to effectively implement these functions, it is vital for HCF Strategy to encompass a series of activities or components that will ultimately support an on-going and, more self-sustainable health financing environment in Afghanistan. More specifically, these components include developing health economics and financing research activities to examine questions of resource decision-making and health policy, the establishment of governmental structures to support health financing, and examining alternative health financing mechanisms to improve the functions of revenue collection, risk-pooling, and resource allocation and purchasing of services.

#### 4.5 Benchmark Indicators for Health Care Financing in Afghanistan

The health care financing strategy (2009-2013) for Afghanistan represents a mixture of “start—up” or development activities to establish an infrastructure for more advanced health financing interventions as well as directly targeted health care financing interventions over the period. As a result, indicators to be tracked include both process and outcome variables associated with each of the intervention components described below. The following is a summary of health care financing key process and outcome indicators to be examined at baseline, during implementation, and at completion of the strategy period in 2013.

##### **Process Indicators**

- Proportion of capacity building in MoPH in relation to baseline needs assessment
- Number of seminars conducted in applied Health Economics
- Number of costing studies conducted
- Fully established and institutionalized National Health Accounts processes
- Level of financial management autonomy
- Number of programs and sub-programs developing and submitting health budgets
- Number of established Public/Private Partnerships
- Risk-pooling mechanisms developed
- Number of families enrolled in demand-side financing
- Number of facilities operating under results-based financing

##### **Outcome Indicators**

- Proportion of out-of-pocket payments in relation to total health spending
- Proportion of households reporting distress or difficulty in paying for health services by wealth quintile
- Per capita Government expenditure on health
- Proportion of Gross Domestic Product spent on health
- External resources for health as a percentage of total health expenditures
- Public domestic resources for health as a percentage of total health expenditures
- Level of inequity in the provision of health services
- Proportion of health facility revenues covered by a health financing scheme

#### 4.6 Description of the Seven Primary Strategic Directions

The following provides a general description of the seven intervention components developed to address the primary HCF issues in Afghanistan (addressing the six issues described in 2.4) and to advance the public administration activities of the MoPH in this key focus area. This description is followed by a list of intervention components and responsible departments within the MoPH, along with specific tasks and targets.

### **Strategic Direction 1 - HEFD Capacity Development**

#### **Strategic Objective:**

- Develop capacity of the MoPH at central and provincial levels in applied Health Economics, Health Financing, and Resource Management

#### **Essential Indicators:**

- Proportion of Capacity Building in MoPH in relation to baseline needs assessment;
- Number of staff trained in Applied Health Economics;
- Number of seminars conducted in applied Health Economics; and
- Number of costing studies conducted.

Building capacity within HEFD is critical to supporting the MoPH in health financing and for achieving the goals of the health care financing strategy. Capacity building will be a joint-effort between the MoPH and various sources of technical support. Health financing experts from various donor agencies will work with HEFD on developing two core units of the directorate, notably Health Economics Unit and Health Financing Unit. These experts will work with staff from HEFD to develop capacity for active support in each of the three units. More specifically, the experts will provide capacity development and guidance to the units as follows over the period of the strategy until 2013:

#### **Strategic intervention 1.1 Health Economics Unit Capacity Development**

- a. Conduct a needs assessment in the unit with regard to capacity building in cost data collection and cost analysis;
- b. Develop a costing ToR for BHSP/EPHS, Public Health Interventions and implementation plan;
- c. Conduct two initial seminars with HEU staff on all aspects of applied health economics;
- d. Design spreadsheet-based costing methodologies specific to Afghanistan including BHSP, EPHS, and Public Health Strategies;
- e. Establishment and institutionalization of National Health Accounts (NHA);
- f. Identify data sources and track economic data;
- g. Pilot test cost data collection forms, clean data, and finalize cost estimates;
- h. Training of MoPH staff on conducting cost analyses including unit costing and advanced methods in applied cost-effectiveness and benefit-cost analysis;
- i. Training of MoPH staff on the application of cost and economic data for policy-making.;
- j. Conduct two workshops on cost data collection and organization, and cost analysis techniques; and
- k. Develop a brief costing reference guide specific to Afghanistan BHSP, EPHS, and Public Health Strategies including cost-minimization, cost-effectiveness, and benefit-cost analyses (where appropriate).

## **Strategic intervention 1.2 Health Financing Unit Capacity Development**

- l. Conduct a needs assessment with regard to capacity building in the health financing unit;
- m. Develop a ToR for capacity development;
- n. Conduct initial seminar with HFU staff on all aspects of applied health financing;
- o. Identify data sources and track health financing data;
- p. Establish a baseline cultural and community analysis for health financing pilot tests;
- q. MoPH staff training to pilot test and examine outcomes of health financing initiatives and insurance options;
- r. Training of MoPH staff on ways to improve strategy costings from central and provincial levels;
- s. Training of MoPH staff on the application of health financing data for policy-making;
- t. Conduct two workshops on health financing data collection and organization, and health financing analysis techniques; and
- u. Develop a brief health financing reference guide specific to implementing health financing initiatives in Afghanistan.

GDPP and the HEFD leadership have also estimated a shortage of five staff members that will be hired over the strategy implementation period to execute several of the health economics and financing components. These staff members will be trained on several of the aspects outlined above.

## **Strategic Direction 2 - Support to the mapping of health expenditures flows**

### **Strategic Objectives:**

- Establish economic and financing information on BPHS, EPHS and Public Health Strategies for evidence-based policy decision-making and production of National Health Accounts in Afghanistan.

### **Essential Indicators:**

- Fully established and institutionalized National Health Accounts processes

## **Strategic intervention 2.1 Establishment and Institutionalization of National Health Accounts (NHA)**

NHA is a framework for measuring total public, private, and donor, national health expenditures. Formatted in a standard set of tables, NHA methodology organizes, tabulates, and presents information on health spending in a user friendly format. This format can be easily understood and interpreted by policymakers, including those without a background in economics. Typically, NHAs disaggregate health expenditures by type of service. For example, in Afghanistan the NHAs can reveal where most public and private funds go. Tracking where the money goes is an excellent way to determine the extent of private sector participation in the country. In addition, NHAs include a description of public and private providers. With Development of NHA in Afghanistan, useful information on demand for health services and health expenditures (public and private) can be obtained. Initiation of National Health Accounts in Afghanistan health system will enable the policymakers to make informed and evidence based decisions for improvement of health status of Afghan population.

## **Rationale for National Health Accounts in Afghanistan**

NHA is designed specifically to assist policymakers in their efforts to understand their health systems and to improve system performance. NHA information is useful to the decision making process because it provides valuable information to policymakers, such as status reports on the current use of financial resources, the monitoring of health expenditure trends, and globally accepted indicators to allow for comparison of the Afghanistan health system performance relative to that of other countries. NHA methodology can also be used to make financial projections of the health system needs.

Likewise, NHA can highlight equity imbalances in distribution of health expenditures. Essentially, NHA contributes to “evidenced based” or “informed” policy decisions. The finding from NHA will enable the MoPH to find out whether donors’ direct spending on health are in line with the overall health strategy of Afghanistan. What distinguishes NHA from other forms of health expenditure review is that it provides:

- Rigorous classification of the types and purposes of expenditures and of the actors in the health system including households, public and private sector providers, NGOs, UN technical agencies, service organizations (military, police, security forces), ad hoc funding (PRT funds), etc;
- Complete accounting of all spending for health, regardless of the origin, destination, or object of the expenditure; and
- Rigorous approach to collecting, cataloging, and estimating those flows of money
- A structure intended for institutionalized, ongoing analysis as opposed to one-time study.

Specifically within Afghanistan, these data are very important for improving the public health budgeting process at both the central and provincial levels, identifying underfunded health sectors, regulating the private sector, and increasing the overall health value for money invested in the health sector.

A key component of NHA is household out-of-pocket spending data.

Important household data can answer questions like:

- What is the burden on households to pay for health care?
- Are household paying significant portion of their available income, thus pushing them further into poverty?
- Where is the burden the greatest? In which regions of Afghanistan?
- To what extent do inequities exist in accessing health care?
- How are households financing their health payments?
- Are Afghan households financing health payments from borrowing or selling assets?
- Where are Afghan families spending and seeking care? In the public, private, formal, or informal sectors?

When household data has both financing and utilization information, both can be combined to inform issues relating to efficiency, equity, and effectiveness.

Within Afghanistan, there are a significant number of unknown factors regarding household expenditures for health services. The establishment of NHA will assist the country to examine these factors and to capture data for informed decision-making regarding demand-side financing initiatives and other risk-pooling opportunities as appropriate.

When constructed properly, the Afghanistan NHA will complement other reporting systems to provide a more complete picture of the performance of the health system. Because of the similarity between measurement concepts underlying the NHA and the system of national

accounts used to estimate a country's gross domestic product (GDP). Health accounts can also be used to illuminate the interrelationship between health spending and the total output of the economy. Because of the way in which financing is displayed, health accounts can help in understanding the roles of government, industry, households, and external organizations (such as USAID, EC, WB) in the purchase of health care. Because of its reliance on standardized classifications of providers and functions, NHA illustrate the linkages between financing and delivery and outcomes of health services and goods.

Health accounts will be helpful in answering the following questions (Guide to produce national health accounts, WHO 2003):

- How are resources mobilized and managed for the health system?
- Who pays and how much is paid for health care?
- Who provides goods and services, and what resources do they use?
- How are health care funds distributed across the different services, interventions and activities that the health system produces?
- Who benefits from health care expenditure?

### **NHA Institutionalization**

Institutionalization of NHA means that the activities of collecting, analyzing and reporting total health care spending is systemized to the point where it is undertaken routinely by a designated unit/department within the MoPH and/or other related Ministries within the GOA which follows a predetermined standards and protocols.

Institutionalizing NHA should be looked at as a government responsibility that ought to be enveloped into the government routine processes with the objective of forming a core dataset for health policy development, monitoring and evaluation.

This implies that for NHA to become a consistent activity it should meet two principles:

- 1) Become a core activity within the MoPH responsible for producing it; and
- 2) Be closely linked to policy requirements in order to be useful.

The main institutionalization activities are focused around the changes in how data is being compiled and reported nationally. In the short-term, defining the component tasks and building the needed technical capacity for executing NHA will be the focus. An environment that enables the initiation, growth, and sustainability of the NHA activities must incorporate supportive policies, standardized methods for data reporting, effective leadership and adequate resource allocation which emphasizes the importance of NHA as a policy planning tool.

Within Afghanistan, NHA will be first developed in the Health Economics and Financing Directorate (HEFD) within the Ministry of Public Health. One NHA Coordinator and two full-time data collectors/analysts are hired and trained to conduct and coordinate all NHA related activities. These activities include survey design and administration for both institutional and household sectors, NHA data collection and cleaning, data analysis, reporting, and providing analyses for key policy decision-making. Ultimately, NHA will be institutionalized in the GOA, and may require the support of other Ministries within the GOA.

Efforts will be made that any institution providing health services should be mandated to provide financial report to Ministry of Public Health on regular basis. These reports need to



be in line with the International Classification of Health Accounts as per the context of Afghanistan. Since there are different sources of healthcare funding in Afghanistan it is important to have different mechanism for data collection and institutionalization on NHA in the country which are discussed below:

### **Institutionalization of NHA in public healthcare institutions**

Public healthcare institutions play a major role in provision of healthcare through owning health clinics, general and specialty hospitals in all over the country. Institutionalization at the public sector needs promulgation of well defined regulations to mandate public health delivery institutions to report as per NHA requirements. The following steps are necessary for institutionalization of NHA at the public sector:

1. Promulgation of regulation by the MoPH.
2. Development of well defined financial reporting mechanism for public health institutions.
3. Training of the financial officers of the public health delivery institutions on NHA.
4. Advocate for continual support from the leadership of the MoPH.

### **Institutionalization of NHA in Nongovernmental Organizations and Donor Agencies**

Institutionalization of NHA in NGOs which implement the Basic Package of Health Services (BPHS) is not a major challenge; however, it needs joint efforts both by the MoPH and the NGOs.

Mandating the NGOs to report as per the NHA requirement can be one of the most efficient ways for institutionalization of NHA in Afghanistan. Generally the following steps are necessary:

1. Mandating the NGOs to report as per the NHA requirements.
2. Enhancing coordination with NGOs and Donor Agencies.
3. Providing all necessary technical support to NGOs, including training them on NHA requirements.
4. Advocating for continual support from the leadership of the MoPH.

### **Institutionalization of NHA in Private Sector**

Household out of pocket expenditure constitutes more than 80% of the overall health expenditure in Afghanistan. This expenditure is mainly paid by the patient at the time of service. The followings can be some of the efficient ways for institutionalization of NHA in private sector of Afghanistan:

1. Mandating the private sector by law and regulations to provide financial reports as per NHA requirements.
2. Assisting and encourage the private sector to efficiently develop their financial system.
3. Encouraging establishment of private sector associations which would liaise between the MoPH and the private sector health care facilities.
4. Institutionalizing NHA related questions in National Risk and Vulnerability Assessment (NRVA) which is regularly conducted by Central Statistics Office (CSO).

In general, the main institutionalization activities are focused around the changes in how data is being compiled and reported nationally. In the short-term, defining the component tasks and building the needed technical capacity for executing NHA will be the focus. An environment that enables the initiation, growth, and sustainability of the NHA activities must

incorporate supportive policies, standardized methods for data reporting, effective leadership and adequate resource allocation which emphasizes the importance of NHA as a policy planning tool.

In summary, the following principles will be considered in developing the NHA for Afghanistan:

- The process of developing national health accounts will be driven by the information needs of Afghanistan's policy makers and other data users;
- Attention will be given to helping Afghanistan develop its statistical capabilities; and
- The developed NHA will allow comparisons with other countries, with a view to understanding and explaining differences.

NHA will contribute to the evidence-based approach to health financing for Afghanistan to become more self-sufficient overtime in securing and managing resources in the health sector.

### **Strategic Direction 3 – Exploring Demand and Supply-Side Financing**

#### **Strategic Objectives:**

- Further assess and reduce high levels of out-of-pocket expenditures for health and inequitable access to health services.

#### **Essential Indicators:**

- Per capita government expenditure on health;
- Proportion of health facility revenues covered by a health financing scheme;
- Number of families enrolled in demand-side financing; and
- Number of facilities operating under results-based financing.

Central to the idea of Afghanistan achieving higher levels of self-sustainable, health financing is exploring alternative health financing mechanisms that increase demand for health services, provide incentives to health service providers, to develop viable risk-pooling options, implement and support efficient resource collection and purchasing of services, all within the context of the Health Financing Policy of Afghanistan. Health financing options can be described as coming from the “supply-side or the demand-side” for health services. For example, incentives to patients to access health services would be considered a demand-side option, while performance-based incentive payments for staff at a health center would be considered a supply-side option. At present, there are health financing options from both sides that are currently being explored or that will be implemented in the near future to provide more evidence about “what might work and what might not work” with regard to achieving the objectives of increasing demand, increasing efficiency, etc. This strategic component is organized in way that provides an overview of the current options being tested and explored for scale-up in Afghanistan as well as a description of the approach to be taken by the MoPH over the 3-4 years to advance sustainable health financing.

### **Health Financing Mechanisms Currently Under Exploration**

#### **Strategic intervention 3.1 Demand-Side Financing**

Demand-side financing has been shown to be effective for increasing utilization of health services in several countries.

Randomized trials (in Mexico, Nicaragua, and Honduras) indicate that substantial improvements in utilization and health status can be achieved through such initiatives.

Through funds provided by The GAVI Alliance (formally known as the Global Alliance for Vaccines and Immunizations), the MoPH is pilot testing in four provinces a demand-side financing approach by providing an incentive to families that use existing maternal and child health services, immunization, antenatal care, and skilled birth attendants. Until now, only this approach is being explored on a small scale in Afghanistan by a few NGO implementing agencies. It should be noted, this program will be evaluated along with the Community Health Worker incentive program which is also being piloted in four Provinces.

The goal of the demand-side financing approach is to increase access to services and in particular, for overcoming socio-cultural obstacles that impede the use of services especially by women. This health financing intervention is viewed as a short-term solution to stimulate demand so that women are convinced of the value of the services. As Afghanistan moves towards a model of mixing both demand and supply-side approaches, it will be critical to explore the impact of such subsidies on the elasticity of demand for health services.

### **Strategic intervention 3.2 Supply-Side Financing**

#### **Results-Based Financing**

While the provision of services and quality of care have significantly improved in Afghanistan, household surveys continue to show that the coverage of key services remain low by global standards. Advancing efficient resource use from the supply-side is also critical in Afghanistan.

One of the means of improving performance and allocating health resources more efficiently from the supply-side is to provide health workers with incentive payments that are linked directly to the amount and quality of the services they provide. This method of linking health outputs and outcomes to performance is called results-based financing (RBF). Currently, the GoA holds a grant to implement and test RBF from the Health Results Innovation Trust Fund (HRITF) that is managed by the World Bank and to which the Kingdom of Norway is a significant contributor. The project will begin during the fall of 2009.

The HRITF is a multi-donor trust fund that has been established to support countries to design, implement, monitor and evaluate results-based financing (RBF) interventions in order to achieve the goals outlined in their national health plans, and especially those that related to alleviating child malnutrition, child mortality and maternal mortality. The RBF project is a component of the Strengthening Health Activities for the Rural Poor (SHARP) that is testing innovative approaches to increase utilization of health services. SHARP is a grant to the Islamic Republic of Afghanistan from the World Bank that will help finance the costs associated with the provision of health services to the Afghan population with particular attention to basic health services for women and children in underserved areas.

The strength of the proposed RBF project in Afghanistan is that it will be implemented within the BPHS, thus, working within the framework of the existing health system. This intervention will be evaluated to determine if linking results to incentives improves coverage of priority indicators in Afghanistan.

This intervention will offer non-governmental organizations (NGO) that are currently contracted to deliver health services and MoPH-Strengthening Mechanism (MoPH-SM), the direct service delivery areas of the MoPH, a performance-based payment for achieving improved coverage of essential maternal and child health interventions. Intervention provinces are selected mainly on the basis of the following criteria:

- a) are secure enough to be accessible for regular monitoring;
- b) are under a single management for health care delivery; and
- c) are not implementing the GAVI-HSS demand side financing intervention.

Facilities within a province will be randomly assigned to either a treatment or control group. The facilities in the treatment group will get incentives based on their performance while the control facilities will follow their current operations with no additional funds.

An annual performance-based bonus of up to 10% of the contract value will be awarded to selected NGOs and MoPH-SM provinces that achieve the performance standard (i.e. an amount for each additional output for each indicator achieved above the baseline). The RBF contract will stipulate that 90% of this amount must be distributed to the health workers.

To ensure that this allocation will occur, the NGOs and MoPH-SM will be required to have explicit contracts with HFs. The other 10% will be allocated to NGOs and SM at the management level. To ensure alignment of incentives between Provincial Health Office (PHO) and the implementers, the PHOs will also receive performance-based incentives for participating in monitoring the RBF implementation. An independent third party will conduct the household and facility surveys. HEFD will have primary responsibility for managing the RBF project.

#### **Strategic Direction 4 – Financial Sustainability, Revenue Collection, Inequity Reduction and Advancing Risk Pooling Mechanisms**

##### **Strategic Objectives:**

- Advance sustainability of health service provision in Afghanistan
- Further assess and reduce high levels of catastrophic expenditures for health

##### **Essential Indicators:**

- Per capita government expenditure on health
- Proportion of Gross Domestic Product spent on health
- Proportion of Out-of-Pocket Payments in relation to total health spending
- Proportion of catastrophic expenditures in relation to total health spending
- Level of inequity in the provision of health services

As Afghanistan seeks to increase the equitable and efficient allocation of resources within the health sector it is important for the MoPH and the HEFD to examine possibilities for revenue generation to support the sector and to examine the appropriate social and community conditions for introducing viable health care financing mechanisms for managing financial risk and reducing out-of-pocket payments among the population. These options include, but are not limited to, community-based health insurance, social insurance, private-market insurance, etc.

To meet health financing objective previously described in this strategy, the Government of Afghanistan must explore a variety of health financing/resource mobilization mechanisms. Furthermore, given the historical and cultural complexities of introducing such mechanisms in Afghanistan, the HEFD will seek the assistance of other disciplines such as a cultural anthropology, sociology, and the legal system to explore communities that are ready for piloting and evaluating risk-pooling and insurance options.

Prepayment and risk-pooling mechanisms, earmarked taxes to the health system, user fees are different ways to mobilize revenue. The Ministry of Public Health will prioritize these

activities as current capacity does not allow starting these 3 health financing schemes/resource mobilization mechanisms at the same time. Starting assessing the feasibility of user fees together with a waiver system at secondary and tertiary care, will be a first priority, as its administrative system is easier to design and manage than risks pooling mechanisms and earmarked taxes to the health sector. Furthermore, user fees have been experimented in a few Afghan hospitals and lessons learnt can be drawn from this. Setting up user fees also implies costing of most common secondary and tertiary services, based on which prices can be fixed, which is on the agenda of the National Strategy on HCF & Sustainability.

Certainly, user fees at secondary and tertiary care should be initiated after consideration of other options and should be an initial step towards other health financing mechanisms (Addis Ababa Consensus on Principles on Principles on Cost-Sharing in education and health in Sub-Saharan Africa in 1997)

#### **Strategic intervention 4.1 Examine User Fees**

When national health services are free, individuals have an incentive to over consume, simply because they no longer bear the full cost of medical services.

User fees or charges to patients for accessing health services generally provide a way to reduce the over-demand for care.

User fees were abolished at the BPHS level in 2008 after researchers from Johns Hopkins University identified that the administration of user fees was not a cost-effective approach to raising revenue (Johns Hopkins University Report, 2008). Furthermore, given the recent history of Afghanistan, the country is currently in a phase of working towards stimulating the demand for care given that approximately 30-35% of the Afghan population still does not have access to BPHS services.

As the Afghanistan health center and hospital system expands to improve access to services under BPHS, EPHS, and the National Hospitals, at some future point in time, user fees may begin to play a useful role in the system to help manage demand (if necessary) while providing some level of petty cash that could be used at the facility-level under more autonomous operations. The issue of user fees is complex in Afghanistan given the current national constitution and the availability of “free services” to the population under BPHS and EPHS. User fees and their economic impact on access to health services, projected revenue levels, etc. will need to be explored by the MoPH and in particular, the HEFD.

#### **Strategic intervention 4.2 Examine Health Equity Fund**

If the GoA does eventually institute user fees in the health sector, another option potentially to be explored is the concept of a Health Equity Fund. A Health Equity Fund is a demand-side financing mechanism to promote access to priority public health services for the poor in an environment where user fees are charged.

The main purposes of a Health Equity Fund are:

1. To contribute to poverty reduction by protecting the poor from unaffordable routine and catastrophic health expenditures.
2. To reduce out-of-pocket expenditures for health by the poor.
3. To overcome barriers to access and to provide access for the poor to priority public health services.
4. To help integrate poor patients as users into public health system.
5. To increase utilization of public health services by the poor.

6. To help improve the quality of services in the public health care system.
7. To provide a social safety net for the poor and contribute towards the development of a uniform national universal health coverage system.

#### **Strategic intervention 4.3 Taxation for the Health Sector**

Increasing revenues for the health sector in Afghanistan is a challenge that requires an innovative approach given the developing market economy. There are several possible revenue sources, including taxation of markets that result in negative externalities or in other words, adversely impact the health of the Afghan population.

Two specific potentially taxable markets include tobacco sales and the import of vehicles into Afghanistan. Smoking, traffic accidents and emission hazardous gases from vehicles are examples of market-related behavior that can adversely impact the health of the population.

In addition, more recently, the international community has introduced airline taxes to fund health care interventions around the world. These taxes essentially represent a type of “surcharge” for each airline ticket that is purchased. Despite this small increase in cost to the traveler, there have been little to no externalities experience as a result of this tax.

These types of taxation (and other to be explored) may be effective for increasing revenues for the health sector in Afghanistan. Staff within the MoPH and HEFD will conduct analyses to forecast the anticipated annual revenues associated with levying such taxes to increase financial sustainability.

#### **Strategic intervention 4.4 Examine Community-Based Health Insurance**

Ekman (2004) conducted a systematic review of Community-Based Health Insurance in low-income countries. Ekman suggests that there is strong evidence that community-based health insurance provides some financial protection by reducing out-of-pocket spending among population segments of low-income countries. Furthermore, he suggests, there is evidence of moderate strength that such programs improve cost-recovery at the health facility level. He also suggests there is weak or no evidence that schemes have an effect on the quality of care or the efficiency with which care is produced. Lastly, his findings suggest that these types of community financing arrangements are complementary to other more effective systems of health financing and should be implemented as part of a larger health financing system or plan.

Community-based health insurance will be explored in Afghanistan as a possible option for revenue generation and risk-pooling. After an assessment of the community and cultural factors necessary to implement a community-based approach (such as level of solidarity, transparency, security, income levels, etc.), a community-based health insurance program will be piloted and evaluated.

#### **Strategic intervention 4.5 Examine Social Insurance Programs**

In 2007, the World Bank developed a report on *Social Health Insurance in Developing Nations*. The authors of this report indicate that implementing social insurance is complicated and efficient implementation takes many years. Such a model may be viable in the future, but within the scope of a four-year Health Care Financing Strategy for Afghanistan is unlikely. As HEFD further develops its capacity in health economics and financing, it will begin to build the foundation necessary for the exploration of social insurance alternatives in the future.

#### **Strategic intervention 4.6 Examine Private-Market Insurance**

As indicated previously in this Strategy, leveraging the private sector is critical for the growth and development of the health system in Afghanistan. The MoPH will support the pilot testing of private-market insurance models in Afghanistan including providing tools to the private-sector to explore medical insurance models, included benefits, and the cost of services provided under such schemes.

As for looking at risk-pooling mechanisms, the health economics and financing units will be focusing on the feasibility and possible design of prepayment mechanisms and CBHI, before assessing the feasibility of social health insurance system and private health insurance schemes. The current unemployment rate and revenue of Afghan families do not allow the Afghan population to monthly contribute to a social health insurance system and a small proportion of the Afghan population only is employed in the private sector or by international organizations offering a private health insurance package.

#### **Strategic Direction 5- Support to Efficient Resource Use and Allocation**

##### **Strategic Objectives:**

- To advance an efficient and effective health service delivery system by establishing and making available economic data within both the public and private sectors; and
- Advance sustainability of health service provision in Afghanistan.

##### **Essential Indicators:**

- Number of cost and cost-effectiveness studies conducted;
- Number of public/private partnerships established;
- Level of financial management autonomy;
- Number of programs and sub-programs developing and submitting health budgets; and
- Level of efficiency in the allocation of health resources.

#### **Strategic intervention 5.1 Strengthening Integrated and Decentralized Health Costing and Budgeting at Central Program and Provincial Levels**

As the MoPH works toward strengthening health financing in Afghanistan, it is critical that it supports the improvement of governance processes related to planning, managing, and delivering health resources at various levels within the health sector. This work will also be conducted via the GDPP and HEFD of the MoPH and via the relationships between HEFD other GDPP directorates and departments and other governmental departments (within MOPH and intersectoral) at both the central and provincial levels.

More specifically, these activities include the following:

- Working within the MoPH to advance working with Directorates and Departments to develop annual budgets and strategy costing;
- Aggregating provincial cost data at the central level for MoPH budget submission to the MoF;
- Further advancement of the development and implementation of budgeting and planning tools including those applied during the annual budgeting exercise at the MoPH level;

- Developing provincial budgeting tools and linking provincial resource planning into the central MoPH level;
- Providing instruction and guidance in provincial workshops and pilots of provincial-wide costing in conjunction with the health sector strategic plan; and
- Annual data management of provincial cost data and tabulations necessary for preparing the MoPH annual budget.

Under the piloting process of integrated strategic health planning and budgeting (central and provincial) health activity costing, staff from HEFD will assist provincial staff to understand and explain the process of determining provincial budgets and costing within budget envelopes in relation to the provincial strategic plan. Furthermore, HEFD still will assist provincial staff to develop their skills in the budgeting process with practical application of their knowledge in developing budgets for the draft strategic plans. As a result, provincial staff will understand and explain the importance and process of negotiating the development of the costed strategic plan with local stakeholders and central programs.

Ultimately, these representatives will have undertaken the process of negotiation locally and centrally and achieved consensus on a costed strategic plan for their province.

### **Strategic intervention 5.2 Enhancing Health Facility Financial Management and Greater Autonomy**

Most donors and the MoPH agree that as public financial management systems continue to improve and local capacity to plan and execute projects in a more efficient and transparent manner is built up, more of the External Budget will be converted to Core Budget support, making therefore improving financial management systems a priority. Weaknesses in this area, together with lack of coordination and strategic vision of external assistance will prevent any progress towards an ultimate Sector Wide Approach.

As a result, it is critical that the MoPH (and relevant departments) supports the overhaul of financial management within the health sector. In a context of severe resource constraint, improving hospitals and health centers is a challenge and a priority.

Although the MOPH has elaborated a National Hospital Policy, the system remains fragmented between different systems of financing, management and organization. As pointed out by the national Hospital Assessment, hospitals' financial management systems are weak or inexistent.

The MoPH and HEFD will support the private sector in examining costs for establishing appropriate charges or fees. These tools will also be used to examine appropriate user fees at hospitals in conjunction with demand analyses which investigate the willingness to pay of clients.

More specifically, the HEFD will develop a pilot study to evaluate financial autonomy within a public hospital. The study will apply concepts as outlined in the WHO manual for hospital managers (Shepard et al 2000).

The types of questions to be addressed by the study include the following:

- How does financial autonomy influence the delivery of health services within a hospital setting?
- What activities are necessary to maintain transparency in financial management?
- Does financial autonomy improve the management of services?



- What is the impact of financial autonomy on the unit cost of hospital services?

As results are identified from the pilot study, HEFD and MoPH staff will review the possibility of expanding financial autonomy of health facilities in discussions with Parliament, the MoF, and the broader GoA as necessary.

### **Strategic Intervention 5.3 Developing Private Sector and Public/Private Partnerships**

To meet the MDGs for Afghanistan, it is vital that the MoPH and public sector looks for ways to work with and support the advancement of the private sector throughout the country.

At present, little is known about the existing capacity of the private sector to deliver health services at both health center and hospital levels. An important component of the HCF Strategy is the advancement of the private sector to deliver efficient health services to the Afghan population at a reasonable cost. Many of these services include those “over and above” those services that are provided “free of charge” to the Afghan population as described in the Afghan Health Law. The MoPH will work to support the private sector in health financing initiatives by advocating for private providers to development viable, solid business plans indicating capital expenditures, recurrent expenditures, anticipated client volume and revenues.

As international partner organizations make credit funding available to health service providers in the private sector, it will be critical for these providers to develop and execute these plans. An example of such an initiative is the International Finance Corporation which offers subsidized health insurance to the over 22,000 employees and their families of a technology company in Lagos, Nigeria. Such plans will also stimulate the overall economy of the health sector in Afghanistan.

The MoPH and HEFD will support private sector development by providing information about possible credit opportunities, conduct workshops with private sector providers regarding business plans, cost and revenue analyses, and business organization. Furthermore, the MoPH will seek out ways in which the public and private sectors can work together to advance health financing. One example is the possible introduction of lending institutions getting involved in communities such as Mazar Sharif, Herat, and other Afghanistan communities to finance premiums in community-based health insurance programs. The MoPH and HEFD will actively seek out such opportunities where the public sector can play a support role in designing and implementing incentives for the advancement of such programs.

Overall, the public and private sectors must work together to advance health financing throughout the country and examine further opportunities for establishing revenue collection, risk-pooling, and the purchasing of services within an agreed definition of the national constitutional constraints for the provision of free services for all Afghans.

### **Strategic Direction 6-Enhance Aid-Effectiveness in Healthcare Financing**

#### **Strategic Objectives:**

- Advance sustainability of health service provision in Afghanistan
- Improve Aid Coordination in the Financing and Delivery of Health Services

#### **Essential Indicators:**

- Feasibility and design of a SWAp Assessed;
- Aid-Effectiveness Analysis Completed;
- Regular mechanisms of Coordination, i.e Health Sector Retreat, CGHN meeting and number of Afghanistan Health Sector Donor Group (ADG) meetings;
- Updated HNSS framework indicators; and
- A draft Medium Term Expenditure Framework linking internal and external funding with achievement of indicators from the HNSS

### **Strategic intervention 6.1 Explore Sector-Wide Approach (SWAp) for the Afghan Health System**

Under the perspective of national health sector stewardship and an international movement towards donor harmonization and the alignment of external inputs with the Health and Nutrition Sector Strategy and systems (as formulated a. o. in the 2005 Paris Conference on Aid Efficiency), the MoPH is exploring the possibility to develop donor coordination under the mechanism of a sector wide approach (SWAp) to the health sector in Afghanistan. The basis of a SWAp is a jointly agreed working method between a Government and Development Partners (DP), i.e., Donors, and NGOs, aiming at jointly implementing consistent sector policy and strategies rather than a specific program. SWAPs enhance the beneficiary country ownership of the development process and the management of the assigned resources. There are several grid criteria/elements to define a SWAp on which the Afghan MoPH might look at for developing its own Health SWAp.

**The criteria of the Paris Declaration are one of them and comprise:** degree of ownership, alignment, harmonization, managing for results, mutual accountability in countries operating a SWAp. The OECD and other donors have adopted a similar grid to the Paris Declaration with slight changes (see Annex 1: summary of SWAp Criteria used by different agencies in Walford (2003), Defining and Evaluating SWAp)

### **Existing aid coordination mechanisms / health SWAp patterns in Afghanistan**

Although Development Partners and MoPH are not using the word SWAp in Afghanistan, there are several mechanisms which show that some of the Paris Declaration's criteria are underway. The following represent some examples:

- **Ownership and Harmonization:**
  - The yearly Health & Nutrition Sector Planning Retreat is organized with the objective of identifying challenges based on the outcomes of the results conference. This Retreat is a mechanism to improve coordination & communication between GoA/MoPH and its development partners and to identify collective recommendations to facilitate the way forward.
  - The Consultative Group for Health and Nutrition (CGHN) is a mechanism through which Donors discuss policies and issues with the Ministry of Public Health on a weekly basis. The 2 above mechanisms allow to improve harmonization between DP and MoPH and to avoid duplication of programs. The Retreat, organized by the MoPH, also witnesses MoPH's ownership, all the more the National Health Policy and the implementation of the Health and Nutrition Sector Strategy are usually reviewed during this session.
  - Health Sector Review conducted jointly by the European Commission (in charge for Health Financing Review); USAID (in charge for the Private

Sector Review) and World Bank (in charge for the Human Resource and Institutional Development Reviews)

- Implementation of the BPHS and EPHS is such a way that Donors and MoPH do not duplicate and are funding the BPHS and EPHS in different provinces allowing that 85% of the population be covered by the BPHS
- **Alignment:**
  - **WB** is operating on the highest level of decentralization, with its funds channeled through the structures of the Afghan Government, i.e. the Ministry of Finance.
  - **USAID** has recently done a step into the same direction with their scheme of “Host Country Contracting”.
  - **The EC** is still managing service procurement and financial disbursement in a centralized manner, though in coordination with the MOPH, and considers channeling their BPHS/EPHS budget through the ARTF as a next step.

### **Current Limitations to Implementing SWAp in Afghanistan**

The total estimated cost of the Health and Nutrition Sector Strategy (HNSS) over the period of 2009-2013 is \$500 million USD. The HNSS will be supported by the three traditional donors, EC, USAID and WB as for the implementation of the BPHS and EPHS. Additional donor support will include the Afghan Reconstruction Trust Fund (ARTF) and bilateral Donors, i.e., JICA.

Though the donors subscribe to the same MOPH policies as for BPHS and EPHS implementation, the scope of works contracted out to national and international NGOs and the detailed funding mechanisms and financial management schemes are not harmonized between donors. USAID, EC, and WB have their own way to implement BPHS and EPHS.

Likewise, Policies and Strategies are sometimes developed in a way, which does neither follow the MoPH strategic guidelines, nor HNSS’ indicators.

Unpredictability of funding is also a critical issue. The Program Budgeting witnesses that some donors commit funding for specific health sectors but finally decide to withdraw their funds, which does not allow the MoPH to plan properly. This is marginal though and the partial disbursement rate of program budgeting also stems from limited capacities of program managers.

As an interesting note, the external funding of the health sector is estimated at above 90 percent of the total public funding for health sector. The remaining amount is captured by the program budgeting (operational budget and development budget). In the light of a SWAp, the MoPH is interested in having a more efficient mapping of these funds, which a jointly agreed working method between a GoA and Development Partners (Donors and NGOs), would facilitate.

### **Assessing the feasibility of a health SWAp in Afghanistan to improve aid effectiveness and impact indicators**

Further mechanisms could be set up to improve aid effectiveness, in addition to the above mentioned existing one. One hereafter proposed is the Afghanistan Health Sector Donor Group (ADG) which would be held three times a year (two regular meetings and the health sector retreat) to enhance the dialogue between MOPH and DPs, in which latest

developments and perspectives of the Ministry would be shared with a view of a more integrated approach to managing development support.

The objectives of the ADG meetings would be as follows:

- To strengthen the partnership between the GOA/MOPH and the donor community.
- To establish a coordination framework for enhanced harmonization and alignment of development concepts.
- To enhance the level of knowledge and understanding about ongoing programs and perspectives and to identify support opportunities for areas not covered under the 'mainstream' programs.
- To improve dialogue and consensus on joint and complementary working methods and actions to improve aid efficiency and effectiveness in the public health sector.

**These coordination mechanisms will be strengthened once an assessment of a Health SWAp is conducted.**

Based on the above, the MoPH would like to hire a consultant (Donor funded) to assess the feasibility of a SWAp (capacity of the MoPH, willingness of the Donors to support a Health SWAp under Paris declaration's criteria etc...). The Consultant would also design the implementation and monitoring structures required, and formulate the mechanisms to make these structures operational. Likewise, the Consultant should assess the feasibility of one of the following aid modalities for the Afghan health sector as follows:

- 1) **General Budget Support:** Non-earmarked support to state budget;
- 2) **Sector Budget Support:** earmarked support to state budget with focus on the sector plan and indicators, and participation in the sector dialogue;
- 3) **Pooled funding:** Earmarked support for a sector plan or a Plan of Work (PoW) of a sector wide or sub-sector program. Channelled through joint financing arrangement. ARTF is a pooled funding;
- 4) **Direct support through** (bilaterally agreed) projects (between GOA and Governments or multilateral / global organizations, International Financing Institutions) with mixed contributions (funds, TA, procurement of services, works, and goods).

With WB and USAID channeling their BPHS and EPHS budget via the MoF and EC exploring the possibility of channeling its BPHS/EPHS Budget via ARTF, the MoPH is trying to ensure that Donors commitment move to greater reliance on Afghan Government financial management and accountability system.

Over the next four years of implementation of the HCF Strategy and HNSS, the MoPH will begin to work towards the following SWAp outputs:

1. An updated HNSS framework indicators;
2. A Medium term expenditure program, based on a HNSS framework indicators, to clarify what is the expected level of available internal (core budget) and external resources and how these resources will be linked to achieve the HNSS;
3. An agreed process for moving forward towards harmonized systems for reporting, budgeting, financial management and procurement;
4. A formalized process of donor coordination and working groups for HNSS components;

5. A systematic mechanism of consultation with MoPH, Governmental Authorities and Development Partners.

Ideally, on a long term perspective, the Health SWAp should have a positive effect on impact indicators, i.e., mortality rate. It is to note that the HCF strategy will only start looking at the above outputs, which might be finalized in the next HCF strategy. Countries with experience in health SWAp show that it takes to 1 to 4 years to have a workable SWAp framework.

Finally, the Technical Advisor recruited by MoPH to assess the feasibility of SWAp within MoPH should also consider DFID assignment conducted in 2009 on “**the Suitability and Readiness of SWAp Development Assistance for Afghanistan**”. The DFID/World Bank Consultant looked at the readiness of MoPH to start a SWAp in the health sector. His assessment is based on the following six factors: 1) Sector Policy and Strategy. 2) Institutional Framework; 3) Sector Budget and Public Financial Management; 4) Sector Performance Monitoring; 5) Sector and Donor Coordination; 6) Donor Support Options and Harmonization. His conclusion was “that the health sector is not deemed to be SWAp ready as it lacks a fully functioning donor coordination mechanism and the MoPH lacks a full overview regarding TA provision”<sup>2</sup>.

#### 4.7 HCF Strategy Directions and Responsible Departments

Table 6 indicates strategic directions along with the responsible department within MoPH for the advancement and implementation of each component. Improvement of Health Care Financing is not the responsibility of one department or unit within the Ministry. It requires collaboration and coordination across different program units and departments to come together and develop systems and processes.

**Table 6: HCF Strategic Directions and Responsible Departments**

No	Strategic Directions	Responsible departments
1	HEFD Capacity Development	HEFD
2	Exploring Supply and Demand-Side Financing	Health Care Financing Unit
3	Financial Sustainability, Revenue Collection, Inequity Reduction and Advancing Risk Pooling Mechanism	HEFD, discussed with HMTF under GD HSP and HCF Unit
4	Support to Efficient Resource Use and Allocation	Health Financing Unit/Health Economics Unit and PPP Unit under GDPP
5	Support to the mapping of health expenditures flows	Health Economics Unit and HMIS
6	Aid Effectiveness	GDPP, but also GDA, DGHR and GDHSP

#### 4.8 Implementation Plan (Interventions and Timeline)

<sup>2</sup> To make the health sector ready for initiating a SWAp, he recommends to establish a better Coordination, i.e., create a fully functioning donor coordination mechanism. The DFID/WB Consultant pointed out that the MoPH has a clear “strategic framework and is otherwise well-functioning”, in such a way that it should be possible for the MoPH to establish functioning donor coordination mechanisms “within a relatively short period of time”. The assessment also highlighted that further aspects require improvements – e.g. the operating budget management and development budget execution, the involvement of the PHOs in M&E and a proper costing of MoPH strategies, including HNSS – can be further developed as part of a SWAp process. (Source: Sector Wide Approach, assessment of the suitability and readiness of SWAp Development Assistance for Afghanistan, Phase II)

Table 8 indicates the timeline for tasks of the Health Care Financing Strategy, largely to be implemented through the Health Economics and Financing Directorate with some assistance from the international community. The timeline is coordinated with the timeline of the ANDS and HNSS, from 2009-2013. The main activities of the timeline are associated with the HCF Strategy components including capacity building of HEFD, costing activities, the development and institutionalization of national health accounts, provincial budgeting and costing, health facility and resources management, alternative health care financing pilots, and aid coordination activities leading towards a Sector-Wide Approach (SWAp).

#### 4.9 Coordination Mechanisms – MoPH and Beyond

To institutionalize the activities of health care financing within the MoPH, it is critical for the Ministry to further establish coordination mechanisms with the various directorates, units, at the level of the MoPH leadership and with other Ministries in the GoA as well as Development Partners. The following provides a brief overview of proposed coordination mechanisms, and does not include routine coordination mechanisms within the Ministry of Public Health.

##### **Within the MoPH**

###### **Coordination Mechanisms**

- Health Economics Task Force
- Health Financing Task Force
- NHA Technical Team's Technical meetings
- Hospital Management Task Force, within which costing exercises are discussed and further worked out in the scope of the Health Financing Task Force
- Other Task Force under GDPP, i.e., PPP

###### **Coordination with the Ministry of Finance**

The implementation of the Health Care Financing Reforms, e.g., Financial Autonomy at Hospital Level or taxation etc..., will imply a strong cooperation and dialogue with the Ministry of Finance. The Ministry of Finance and Ministry of Health have already developed regular working relationships with the program budgeting.

###### **Coordination with other National Stakeholders**

The implementation of Health Care Financing Strategy implies the need for a strong linkage with various stakeholders. For instance, the NHA Technical Team will be working with external entities of the MoPH, i.e., Ministry of Higher Education, Ministry of Economics, to collect data on health financing flows. Likewise, the MoPH will closely work with the CSO while collecting data through the NRVA and institutionalizing the NHA. In this case, the NHA Steering Committee is a good example of a coordination mechanism, mainly bringing entities beyond the MoPH.

**Coordination with Development Partner - Donors and NGOs-** (see Strategic Direction 6 on Aid Effectiveness)

#### 4.10 Risks and Possible Limitations

##### **Resources**

At present, the MoPH has secured some resources (as indicated in the summary costing) to implement the health care financing strategy but will need to obtain further funding for full implementation.

### **Implementation Capacity**

Given the short time period for implementing the strategy, possible changes in staffing, and historical absorptive capacity issues that have developed in the health sector, limitations in overall implementation capacity could have an impact on the roll-out of the strategy and its effects within Afghanistan. Preparations will be taken early on in the implementation to document strategy components and the MoPH will work to address such issues as they arise.

### **Security**

The current security situation in Afghanistan is unpredictable and may cause unforeseen events that could have impact on the implementation of the health care financing strategy. The strategy may be altered if necessary to adjust to these conditions.

### **Development Phase and Expected Impact on Health Financing Indicators**

With regard to outcome indicators and the estimated affect of the HCF strategy on important markers such as the level of out-of-pocket payments in the country, the MoPH faces the challenge of entering a start-up phase in health care financing development while simultaneously testing models for future scale-up (beyond the current strategy period). As a result, limited impacts may be observed in the short-run while more significant impacts of the strategy will most likely occur in the medium (5 years) to long-term (10 years).

## 5 Conclusion

In the foreseeable future, it is unlikely for the MoPH to provide healthcare services to Afghan population without support from the donor society. However, through this strategy efforts will be made to introduce and examine various revenue generation schemes for healthcare financing in the country. In addition, this strategy aims towards working simultaneously across the multiple programs and various existing and prospective financing sources available to increase total financing and improve predictability of financing streams. The strategy discusses development of various costing studies, pilot projects to explore health financing mechanisms in the country and building coordination among various stakeholders involved in health sector of Afghanistan. The success of the strategy will depend on its implementation, which will rely on the availability of domestic, public and private funding which will support it. The development of an operational working plan is the next logical step which will follow the HCF strategy to make the strategy achievable and lively.

On the other hand, it is difficult to predict the direct impact of the current Healthcare Financing strategy on the health population of a country, in particular, looking at potential risks linked to insecurity. Despite potential risks, should fund be available, the Healthcare Financing Strategy will have effect on a short and long term basis on the systematic development and sustainability of the healthcare system in Afghanistan. On a short term to mid-term basis, one may expect immediate achievement like availability of costed plans for programs, introduction of pilots to test various risk-pooling mechanisms, successful production of National Health Accounts, implementation of demand-side financing and results-based financing and tax modeling.

On a longer basis, strategic interventions, e.g., results of demand side and result based financing, risk-pooling approaches, special taxes as possible options, will guide the Ministry of Public Health to reduce proportion of out-of-pocket payment and increase proportion of public domestic resources for health as percentage of total health expenditure. Furthermore, key economic evaluation exercises, national health accounts, and health financing studies are very important for supporting policy-decision making as the ministry strives to maximize the health of the population with scarce resources. When reliably established, these data can be useful for program budgeting and planning at central and provincial levels. Applying the findings from economic evaluation schemes will ensure the provision of cost-efficient and high quality services, having a possible impact on MDGs indicators and sustainability of health care services in the country.

Eventually, the strategy will pave the way for a possible sector wide approach within the health and nutrition sector and guide the way for effective coordination of funds. The implementation of the Healthcare Financing and Sustainability strategy will need to be linked with other systemic and institutional development pillars of the ministry, including Human Resource Development, Monitoring and Evaluation, and it will benefit from legal framework, allowing the piloting and implementation of strategic interventions presented in the Healthcare Financing Strategy.



## 6 References

- Beaston-Blaakman, A., Swerdlin D., et al., 2006 Rwanda Health Center and Hospital Cost Study, Twubakane Decentralization and Health Project, USAID Published Report 2006.
- DFID, SECTOR-WIDE APPROACH Assessment of the Suitability and Readiness of SWAp Development Assistance for Afghanistan – Phase I, 2009
- Dugue, M., Health Sector Review and Health Financing Afghanistan (2003-2008).
- Ekman, B., Community-based health insurance in low-income countries: a systematic review of the evidence. *Health Policy Plan*, 2004 Sep;19(5):249-70
- Hatt L.E, Fleisher, L.K, Toward Solving Health Financing Challenges In Africa – A Way Forward, USAID Africa Bureau, 2009
- Health Care Financing Strategy of Pakistan
- Health Financing Task Force: [http://resultsfordevelopment.org/hfff\\_home.php](http://resultsfordevelopment.org/hfff_home.php)
- IFC, The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives, the result of research on the role and impact of Africa's private health sector, 2008
- IFC Helps Low-Income Nigerians Get Affordable Health Care, 2008
- Innovations for Health Financing in Sub-Saharan Africa: A Roundtable Discussion, USAID Africa Bureau, Dec 2008
- Kingdom of Cambodia, Strategic Framework for Health Financing, 2008 -2015, Bureau of Health Economics and Financing Department of Planning & Health Information, April 2008
- Lagomarsino, G., Nachuk S., Singh Kundra S. *Public Stewardship of Private Providers in a Mixed Health Systems. Synthesis Report from the Rockefeller Foundation- Sponsored initiative on the Role of the Private Sector in Health Systems in Developing Countries.* Result For Development Institute, The Rockefeller Foundation, Washington DC, 2009
- Loevinsohn B, Practical Issues in contracting for primary health care delivery: lessons from two large projects in Bangladesh. Washington, DC, World Bank, 2002
- Ministry of Public Health, Strategy Development, a developer's guide, May 2008
- Newbrander, W., Yoder, R., Debevoise, A.B., Rebuilding Health Systems in Post-Conflict Countries: Estimating the costs of basic services, *Int J Health Plann Mgmt* 2007; 22: 319–336.
- Shepard, D., Hodgkin, D. & Anthony, Y. *Analysis of hospital costs: a manual for managers.*, Geneva: World Health Organization, 2000.
- Sohail Agha, The Context for and Development of a Voucher Program in Rural Pakistan, USAID, 2009
- WHA Resolution 58.33: Sustainable health financing, universal coverage and social health insurance
- WHO, World Health Report, Chapter 5, 2000.

WHO, Health Financing Policy, [http://www.who.int/health\\_financing/functions/en/](http://www.who.int/health_financing/functions/en/)

WHO, Strategy on Health Care Financing for Countries of the Western Pacific and South-East Asia Regions, 2006-2010

WHO, Guide to produce national health accounts, 2003

## Annexes

### I. Glossary

**Allocative efficiency:** A situation in which it is not possible to improve the welfare of one person in an economy without making someone else worse off.

**Catastrophic health expenditure:** A situation where a household spends more than 40% of its income on health care, after paying for subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency or by low cost and high frequency events.

**Community financing or community-based health insurance (CBHI):** A micro-insurance scheme managed independently by community members, a community-based organization whereby the term community may be defined as members of a professional group, residents of a particular location, a faith-based organization. Collective action of local communities to finance health services through pooling of out-of-pocket payments and ensuring services are accountable to the community.

**Contracting:** The process in which a legal agreement between a payer and a subscribing group or individual such as purchasers, insurers, takes place which specifies rates, performance covenants, and the relationship among the parties, schedule of benefits and other pertinent conditions.

*Contracting in:* In the Afghanistan health system, the MoPH manages and delivers services in a few provinces through the Ministry of Public Health Strengthening Mechanism (MoPH-SM). The provinces are contracted by the central MoPH similar to normal commercial contracts. The World Bank provides funds for this mechanism.

*Contracting out:* Health services in the majority of provinces and districts (other than MOPH-SM) have been contracted out to NGOs.

**Co-payments:** Direct payments made by the users of health services as a contribution to their cost but not full-cost recovery (e.g. prescription charges).

**Core budget:** Funds channeled through the government treasury: comprises of development portion which is entirely funded by donor agencies while the operating portion is mainly funded by domestic revenue.

**Cost sharing:** A direct payment made by users of services to providers of those goods and services in addition to funding from another source e.g. government.

**Demand Side Financing (DSF):** 'Demand side' financing describes the mechanisms of channeling a part of government subsidy for health services directly to households allowing them to purchase health services themselves or through an agency relationship. Demand side financing is a strategy for reaching the poor which directs subsidies to the target group to enable them to purchase specific services and goods.

**Effectiveness:** The impact of an activity and the end results, outcomes or benefits for the population achieved in relation to the stated objectives.

**Efficiency:** The effect or end results achieved in relation to the effort expended in terms of money, resources and time.

**Equity:** The absence of systematic disparities in health between social groups who have different levels of underlying social advantage or disadvantage—that is, different positions in a social hierarchy. Inequities in health systematically puts groups of people who are already socially disadvantaged such as by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group at further disadvantage with respect to their health.

**External budget:** Refers to the portion of donor funding which is not channeled through the Afghanistan Ministry of Finance treasury.

**Fair financing:** Health financing is considered to be perfectly fair if the ratio of total health contribution to total non-food spending is identical for all households, independently of their income, their health status and their use of health services.

**Funders:** Organizations contributing to the coverage of health care expenditures or providing the funding for health care through budgets, contracts, grants or donations to a health care provider.

**Gross Domestic Product (GDP):** The total market value of goods and services produced within a country in a given year equal to consumer, investment and government spending, plus the value of exports, minus the value of import.

**Health insurance:** Financial protection against medical care costs arising from disease or injury. The reduction or elimination of the uncertain risks or loss for the individual or household, by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member.

**Loans (grants, donations):** External aid used to fund services, usually with a set of conditions attached.

**National Health Accounts (NHA):** A framework and methodology for measurement and presentation of information on total national health expenditure including public and private sources of funds. NHA tracks financial resources from sources, to providers and functions. Since health systems are complex, NHA are a tool for policy makers to analyze health financing, how and how much resources are used in a health system, what are resource allocation patterns, financing uses and options.

**Out-of-pocket (direct) payments:** Payment made by a patient to a provider. Payment out of private purse as opposed to public, made directly by a patient to a health service provider without reimbursement.

**Private health insurance:** A health insurance scheme characterized by the following features: voluntary, managed outside the social security system with risk-rated or community-rated premiums, managed by an independent legal entity (an incorporation, organization, association or foundation) not by a state/quasi state body, operating for profit or non-profit. Voluntary insurance to cover health care costs based on the individual's level of risk.

**Resource allocation:** The process by which available resources are distributed between competing uses as a means of achieving a particular goal.

**Results-based financing (RBF):** Transfer of money or material goods conditional on taking a measurable health related action or achieving a predetermined performance

target. The synonym terms are: Pay for Performance (P4P), Output-Based Financing and Performance-based Contract

**Risk pooling:** A way of managing contributions from a community or society to ensure that the risk of a single individual having to pay for health care is borne by all rather than by the individual.

**Social health insurance:** Compulsory health insurance, regarded as part of a social security system, funded from contributions-often community rated and managed by an autonomous state/para-state legal entity. Compulsory contributions to a health insurance fund gaining individual or group entitlement to health care benefits usually based on employer and employee contributions.

**Sustainability in Health Care Financing/ Financial Sustainability:** The most popular definition of sustainability can be traced to a 1987 UN conference. It defined sustainable developments as those that "meet present needs without compromising the ability of future generations to meet their needs"(WECD, 1987). In the health care financing context, Sustainability can be read as providing the future generation ways to fund their health system and be the owner of it.

**Technical efficiency:** Using only the minimum necessary resources to finance, purchase and deliver a particular activity or set of activities (e.g. avoiding waste).

**User Fee:** User Fee is an amount of money paid by the patient at the time receiving healthcare services. This mechanism is advocated for cost sharing and community participation to (in theory) increase the sustainability and quality of health services.

## **II. An experiment with Community Health Funds in Afghanistan-final report**

As Afghanistan rebuilds its health system it faces important challenges in financing health services. Since donor funds currently provide much needed support for the delivery of basic health services, it is important to develop sustainable local financing mechanisms. A second challenge is to reduce the high out-of-pocket payments for health care experienced by Afghans. Community based health insurance (CBHI) schemes are one solution; they offer the possibility of raising revenues from communities and at the same time providing financial protection by pooling resources.

This report describes the performance of one type of CBHI scheme, the Community Health Fund (CHF), which was piloted in five provinces - Parwan, Saripul, Wardak, Hilmand and Nimroz - of Afghanistan between May 2005 and October 2006. In each province, the CHF program was introduced around pre-selected health centers. The CHF was essentially a pre-payment scheme where households paid an annual premium and a nominal co-payment to access curative health services. Non-members paid a consultation fee and drug costs. Importantly, households which are very poor and female headed were enrolled into the program free of cost. Preventive and promotive health care were also free for all individuals. The program was fully implemented in Parwan and Saripul, partly implemented in Wardak and Nimroz, and not implemented at all in Hilmand. The prevailing security situation prevented the program from being fully implemented in Hilmand, Wardak and Nimroz.

The performance of the CHF program highlights important issues regarding the feasibility and effectiveness of pre-payment schemes in Afghanistan. Its implementation demonstrates that fairly complex community based health financing schemes can be implemented in resource poor post-conflict settings like Afghanistan. However, a key issue was the inability of the CHF to attract a large number of members. In all provinces, paid membership tended to be low and ranged from 1% to 38% of the catchment area households. In terms of cost recovery, the CHF program was able to recover a modest fraction (below 16%) of the clinic's total operating costs, though it recovered up to 32% of a clinic's non-salary operating costs.

In all pilot facilities, the majority of CHF revenues were expended on quality improvements at the clinic. In particular, drug and supply shortages were overcome by using CHF revenues to purchase these commodities from the market. No evidence of financial protection at the community level was found, though there is indirect evidence that the CHF offered financial protection to members through greater accessibility. Importantly, the exemption program of the CHF did not adequately target the poorest individuals in the community and there were substantial leakages in terms of non-poor households being enrolled free of cost. CHF members strongly supported the program's continuation. The main reasons among non-members for not enrolling were – being unaware of the program, high premiums and the low quality of services at the CHF clinics.

The short duration the CHF pilots were fully operational prevented active experimentation with different strategies to increase membership and fine tune the program. Considering the performance of the CHF in its totality, it appears that by itself the CHF program is insufficient to raise substantial revenues for the health sector, though it offered a degree of financial independence at the facility level. The solution to making the health sector financially sustainable seems to lie in a combination of financing sources such as community financing, public taxation and other sources rather than any single mechanism.

### III. Sector Wide Approach Concept (SWAp)

SWAp is a jointly agreed working method between a Government and Development Partners (DP), i.e., Donors, and NGOs, aiming at jointly implementing consistent sector policy and strategies rather than a specific program.

There are several grid criteria/elements to define a SWAp on which the Afghan MoPH might look at for developing its own Health SWAp. **The criteria of the Paris Declaration are one of them and comprise:** degree of ownership, alignment, harmonization, managing for results, mutual accountability in countries operating a SWAp.

- **Ownership:** A SWAp mandates a Ministry of Health with the leadership in developing and implementing its national development strategies.
- **Alignment:** Donors countries use country systems and procedures to the maximum extent possible disburse aid in a timely and predictable fashion, rely to the maximum extent possible on transparent partner government budget, accounting mechanisms and procurement system.
- **Harmonization:** Donor work together to reduce the number of separate, duplicative, missions to the field reviews. Partner countries provide view on donors 'comparative advantage and on how to achieve donor complementarities at country or sector level
- **Managing for results:** means managing and implementing aid in a way that focuses on the desired results and uses information to improve decision-making
- **Mutual accountability in the use of development resources:** Countries reinforce participatory approaches by involving a broad range of DPs when assessing progress in implementing of the health sector strategy and donor provide timely transparent information on aid flows to enable countries to present comprehensive budget reports to their legislatures and citizens.

## **VI. The Role of Health Economics and Health Financing Units within HEFD**

### **1. Health Economics Unit**

The Health Economic Unit is an analytically oriented unit, such that its studies' outcomes should serve the operations and activities of HEFD and the broader MoPH. This unit will focus on studies of cost, cost-effectiveness, and benefit-cost analysis. As a first step in conducting economic analyses of health services, the HEU will examine the feasibility and design of National Health Accounts (NHA) and conduct baseline costing studies of BPHS, EPHS, and public health strategies of the Ministry.

In addition, this unit will develop tools to assist hospital managers in analyzing and managing costs of services. Such activity also includes supporting the private sector in examining costs for establishing appropriate charges or fees. The unit will then be able to apply economic tools to examine policy areas of interest to the MoPH. The Health Economics Unit will be led by a Head of Health Economics Unit.

### **2. Healthcare Financing Unit**

Within the Health Financing Unit, activities will involve assisting costing strategies of the MoPH, supporting annual provincial budgeting, and implementing various health financing schemes including both demand-side and supply side-financing initiatives. An analytical sub-unit will look at the feasibility of several supply and demand side financing schemes, and in particular the design of Result Based Financing (RBF) pilots in several provinces of Afghanistan. Together, these activities will assist the MoPH to expand access to care, improve quality and cost-effectiveness of health services, and manage financial risk of illness among the population, as indicated in the National Health Financing Policy. In addition, this unit will explore various ways for resource mobilization for health service delivery in the country. The Healthcare Financing Unit will be lead by head of Healthcare Financing Unit.