Expert meeting to review the development of a series of health financing progress matrices

Summary report

Meeting held: 16-17th May 2018

World Health Organization

Note: this report incorporates major points of discussion rather than attempting to capture all the issues raised. Detailed presentations made during each session are available on request.

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Contents

Next steps

1. At the end of the meeting, it was agreed that a revised version of the health financing matrices would be prepared based on feedback from the expert review meeting.

2. An adapted version of the matrices will be developed for application at the country level; this will aim to capture the dialogue held, and also gauge the current situation, progress in recent years, and identified priority action points in a way which can be summarized and easily printed.

3. Country applications will begin once the application version of matrices has been developed. These are likely to vary depending on the local situation e.g. relevant ongoing processes, local capacity. In some cases, WHO staff may conduct a preliminary application for example with a key MoH official; in other countries, there may be an opportunity to use the matrices as part of more formal policy processes and hence support structure dialogue.

4. The development and initial application of the matrices will be presented at the WHO symposium on health financing for UHC to be held on Tuesday 9th October 2018 at the Fifth Global Symposium on Health Systems Research in Liverpool, UK.

5. A further review of the matrices will be conducted to review initial country applications. Dates and details to be confirmed.

6. The intention to use the matrices as the basis for monitoring country level progress, and in support of diagnostic, evaluation, planning and implementation efforts in health financing policy.

A) Meeting objectives

7. To gather a group of experts in order **to review**:
    a. the motivation for and intended use of the matrices
    b. the preliminary construct of the matrices in terms of question components and response scaling
    c. each specific matrix in detail in terms of content / questions and their link with guiding principles

B) Background

8. Whilst SDG indicators 3.8.1 & 3.8.2 provide an assessment of effective universal health coverage at the country level at a point in time, typically with a delay of at least two years, no systematic assessment currently exists of whether a country is developing and implementing policy which, based on evidence, is expected to result in progress towards UHC. To get closer to such "real-time monitoring" of health system developments in countries, WHO together with Member States and international partners are currently developing a series of health financing progress matrices. Grants from the Republic of South Korea, and from the UK's Department for International Development, are being used to fund this development phase.

9. The **primary objective** of the matrices is to develop an approach which can assess both where a country is at a point in time, in terms of whether health financing policy is consistent with the goals of UHC, and to detect change over time i.e. progress, deterioration or inactivity; SDG indicators do not capture this level of system dynamic. The matrices are not intended for diagnostic or evaluation work, but rather supporting monitoring. Importantly, the matrices will **NOT** be used for country comparisons or rankings.

10. An expected direct **benefit** of the matrices is the identification of country priorities for future technical / analytical work, as well as the timing and sequencing of that work. In addition, the matrices are expected to give **greater visibility** to, and help to demonstrate the relevance of, technical work in support of health (financing) system strengthening.

11. The **primary clients** of this work are country level policy makers, although the hope and expectation is that the matrices would form the basis of a structured conversation amongst stakeholders working on health financing policy issues, particularly where there are a range of stakeholders supporting government with technical assistance.

12. Judgments on what represents progress is, from WHO's perspective, guided by the health system framework for UHC and the contribution of health financing policy to improvements in the final coverage goals; final coverage goals are measured through SDG indicators 3.8.1 & 3.8.2. Amongst other things the progress matrices aim to capture changes in the development of health financing policy, a typically lengthy and complex process, and assess whether it is consistent with UHC. For

each health financing function WHO has proposed a number of guiding principles, detailed in the document *Developing a National Health Financing Strategy: A Reference Guide*. Guiding principles are based on country evidence of policy reforms or actions which have resulted in progress towards UHC, and are the foundation of many questions in the matrices.

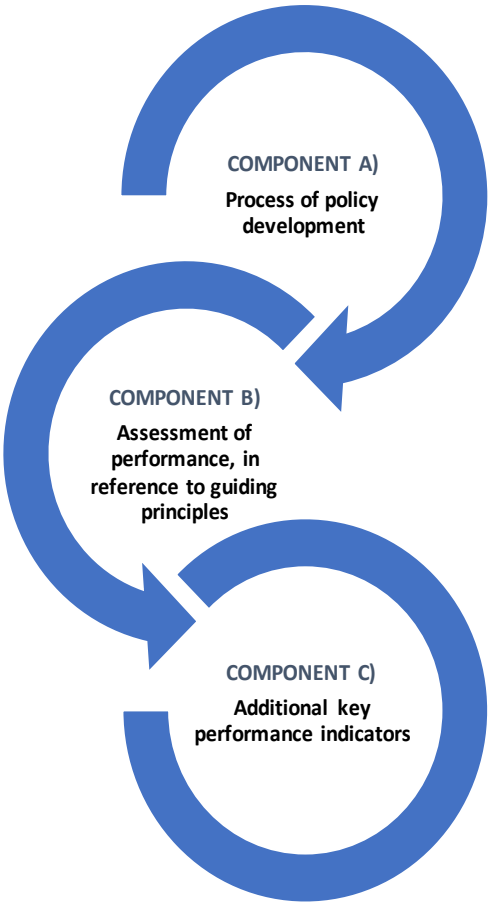
13. In preparation for the meeting, five matrices were developed based on internal discussions, and selected country consultations, based around the four core functions of health financing policy (see Figure 1), with a fifth addressing cross-cutting issues of public financial management. Each matrix comprises two (and in some cases three) components.

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

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

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

Figure 1: Proposed components of the Health Financing Progress Matrices



A) POLICY PROCESS

- **Questions in this section address**:
  - the use of evidence in policy development
  - whether an official policy statement exists
  - whether monitoring and evaluation are used to feed into the policy

B) PERFORMANCE BASED ON GUIDING PRINCIPLES

- **Questions in this section address**:
  - health financing system performance based on criteria which embody the guiding principles for health financing policy consistent with the goals of UHC. See Box 1.

C) ADDITIONAL INDICATORS OF PERFORMANCE

- **Questions in this section**:
  - Identify additional indicators which do not directly build on guiding principles, but are considered important for progress monitoring.

14. Questions in Component B aim to capture the **essence of individual guiding principles**, recognizing that there may be several policy actions or pathways which represent consistency with the guiding principle, and hence progress towards UHC. Each matrix follows a common **four-point scale** which reflects a range from, broadly speaking, "underdeveloped" to "highly developed", "weak capacity" to "strong capacity". There are many ways of scaling; in its maturity model for purchasing, the Gates Foundation uses five stages of progress: "*Doesn't exist / weak capacity / capacity in some areas / capacity improving / capacity consistent or at scale*".

C) Key points of discussion

In relation to overall motivation, initial design, and intended use

15. The matrices aim to capture information which is primarily qualitative, although selected quantitative indicators will be used where relevant. Qualitative study or mixed methods are increasingly appreciated, given that quantitative analysis tends to lack contextual stories and are limited in terms of providing guidance or direction for policy change.

16. Good models need to be parsimonious. The draft matrices comprise about 50 questions in total with the aim of capturing the essential/key aspects; some detail will necessarily be sacrificed.

17. A number of questions / issues were raised:
    a. The purpose of the matrices needs further clarification: are they for monitoring, diagnostics, planning, something else, or several of these?
    b. How should the matrices be applied when there are multiple coverage schemes, or sub-systems within a country's health system?
    c. Scales need to be sensitive enough to capture movement / progress
    d. There is considerable variation in capacity at country level to complete the matrices; it will be important to simplify and break down many of the questions.
    e. How should the matrices be applied in a decentralised setting?
    f. How should the matrices be applied in health systems with extensive private sector activity?
    g. The language is overly technical at times and needs simplifying.
    h. A matrix could begin with some straightforward but useful descriptive questions e.g. coverage, before going into detail.
    i. Prior to using the matrices, there needs to be a summary which helps describe and hence understand the country in question's health system in general e.g. different coverage schemes, is there a minimum package of services, fund flow analysis, information on outcomes.
    j. Some questions assume that social health insurance exists (e.g. Pooling Q6); either rewrite or allow these questions to be ignored.
    k. Some questions are framed positively and some negatively, which is confusing and should be standardised.
    l. Rather than "artificially" differentiating the matrices from existing products and processes e.g. WHO guides to diagnostics and strategy development for health financing, frame the matrices are integral to those processes. The distinction between diagnostics and evaluation is not so clear; the matrices can be used in support of both.
    m. Each matrix would benefit from being motivated by a paragraph of text explaining why it is important; this text would relate back to the framework, overall goals and objectives, and the guiding principles.
    n. Whilst many questions bundled several discrete elements, these become difficult to answer, and hence should be unbundled. This needs to be balanced with efforts to reduce the number of indicators used to monitor progress more broadly in the health sector.

o. We should consider trying to capture capacity to implement “identified actions”.

In relation to specific matrices:

18. **Revenue raising**
    a. The issue of equity in revenue sources is complex and goes beyond health; think whether/how to incorporate this.
    b. Sub-national and external revenue flows need consideration.
    c. Ability of MoH to engage effectively with MOF, national assembly etc.

19. **Pooling**
    a. This matrix is relatively difficult to interpret e.g. what does an in-depth diagnosis mean in terms of pooling.
    b. What does full capacity for redistribution mean?
    c. Weights are implied in certain questions: review these.
    d. The issue of coverage needs to come through in more detail.
    e. The matrices could be more positive in nature e.g. capture pathways, rather than primarily normative.

20. **Purchasing and provider payment**
    a. Be careful on language: Estonia doesn’t call what it has a global budget, (ed. but costs are contained).
    b. Institutional aspects particularly important in the purchasing function - may have DRGs but without good managerial capacity may not reap the benefits.
    c. Consider how alignment with service delivery etc. may be reflected
    d. Capture whether the purchaser has leverage capacity? Lack of accreditation may be ok if purchaser has the right to select who to buy from?
    e. Regarding the question on "claim forms", turn this into an attribute to capture other interventions e.g. unique id.
    f. The issue of coherence across purchasers is important i.e. whether there are parallel funding flows and if so whether incentives to the provider are coherent.
    g. Pharmaceuticals are a major issue from OOPs perspective; where to capture? Possibly in purchasing matrix.
    h. Don’t forget the objectives: we want to see improvements in quality of service, often greater quantity, also effective cost control
    i. Consider dividing into sub-functions e.g. contracting, provider payment, rate setting, performance monitoring
    j. Revisit the guiding principles – currently they are too specific.

21. **Benefits and entitlements**

a. The normative basis is not entirely clear or agreed for Q7 "*Extent to which benefits prioritize priority population groups (e.g., based on need, income status, demographic characteristics), certain services (e.g., communicable diseases, public health), etc.***"** and may be inconsistent with Q6 "*Extent to which benefits coverage reflects population health needs and promotes equity in access to health services (e.g., by adjusting cost sharing/co-payment based on health needs or capacity to pay).*"
b. Restructure / clarify the guiding principles.
c. Component A questions could be reframed in terms of procedural and institutional criteria**.**
d. By listing criteria around BP (equity, FP etc) Q6 and Q7 could be cut. Non-personal services need to be included.
e. Other issues to capture: how well content reflects the criteria used; how prices are negotiated e.g. for medicines (price takers versus price setters); difference between mandated and effective coverage; level of awareness of entitlements.

22. **Public financial management and governance**
    a. Separate out the two components into individual matrices.
    b. Not trying to do full PFM analysis; keep tightly focused on bottlenecks in the health sector and two types of alignment, one with sector priorities and another with fiscal situation. Health needs to move towards programme budgeting.
    c. Other issues to capture include improving budget execution; accountability mechanisms for example through civil society engagement, formal committees; the reporting and control part of the PFM cycle is missing, or in the generic governance section. Probably need a specific question on financial management.

In relation to application of the matrices:

23. Issues raised included:
    a. How would the matrices be implemented in a non-biased way? Is it possible to make indicators more objectively verifiable, to minimise contestation and political interference given the subjective nature.
    b. The right entry point needs to be identified to use the matrices at the country level; try to engage with ongoing processes and potentially use one matrix, or part of a matrix at a certain point in time, rather than all at once.
    c. A guide for facilitators would be useful.
    d. Policy-makers need to get something useful out of the time they put into completing the matrices; can they get feedback such as "*if this is your problem then consider this…..*".
    e. For the first application, the matrices need to capture work or progress which has happened in the preceding few years.
    f. Where and when to implement needs working out: obligation, capacity, ongoing processes, political entry points.

D) Appendices

Agenda

Day One: Wednesday 16th May 2018		
08.30 – 09:00	**Registration of participants** **Welcome coffee**	Main WHO Reception UNAIDS meeting room area
09:00 – 09:15	**SESSION 1:** **Welcome, introductions and meeting objectives**	- Agnes Soucat, Director HGF
09:15 – 10:00	**SESSION 2:** - **Motivation for the development of Health Financing Progress Matrices** - **Objective of the Progress Matrices**	- Joe Kutzin (WHO-HEF) - Matt Jowett (WHO-HEF)
10:00 – 10:30	**SESSION 3:** **Initial design of Progress Matrices: an overview of structure**	- Prof: Soonman Kwon (Seoul National University)
10:30 – 11:00	**COFFEE/TEA BREAK**	
11:00 – 12:45	**SESSION 4:** - **Reflections on motivation, objectives & design** - **Country perspectives** - Reactions and discussion	- Discussant: Lorena Prieto - Discussant: Aurelie Klein (Webex) - Discussant: Edwine Barasa (Webex)
12:45 – 13:45	**LUNCH**	
13.45 – 14.45	**SESSION 5:** - Small group brainstorming: "***Alternative design of the matrix in terms of components and scaling.***"	- Brainstorm & sketch out how you would further develop, or re-develop the matrices.
14.45 – 15.30	**SESSION 5: (continued):** - Feedback from small group work:	-
15:30 – 16:00	**COFFEE/TEA BREAK**	
16:00 – 17.00	**SESSION 6:** - **Revenue raising matrix – overview** - Discussants perspective	- Overview: Soonman Kwon - Discussant: Hong Wang - Discussant: Henrik Axelson
17:00 onwards	**DRINKS RECEPTION**	**UNAIDS cafeteria**

Day Two: Thursday 17th May 2018		
09:00 – 09:45	**SESSION 7:** **Pooling of funds matrix**	- Overview: Soonman Kwon - Discussant: Caryn Bredenkamp - Discussant: Kara Hanson (Webex)
09:45 – 10:30	**SESSION 8:** **Purchasing health services matrix**	- Overview: Soonman Kwon - Discussant: Triin Habicht - Discussant: Jack Langenbrunner
10:30 – 11:00	**COFFEE/TEA BREAK**	
11:00 – 11:45	**SESSION 8 (continued):** **Purchasing health services matrix**	- Overview: Soonman Kwon - Discussant: Triin Habicht - Discussant: Jack Langenbrunner
11.45 – 12.45	**SESSION 9:** **Benefit design matrix**	- Overview: Soonman Kwon - Discussant: David Evans - Discussant: Melanie Bertram
12:45 – 13:45	**LUNCH**	
13.45 – 14.30	**SESSION 10:** **Public financial management matrix**	- Overview: Soonman Kwon - Discussant: Helene Barroy

14.30 – 15.30	**SESSION 11:**
	- Small group breakout:
	  - How you would apply the matrices in a country you know well?
	  - Feedback to group
		- 30 minutes
		
		- 30 minutes

15:30 – 16:00	**COFFEE/TEA BREAK**	
16:00 – 17.15	**SESSION 12:** - Short review, reflection of discussions - Next steps	- Soonman Kwon - Joe Kutzin, Matt Jowett
17:15	**CLOSE**	

List of participants

	EXTERNAL PARTICIPANT (PRESENT)	ORGANISATION
1	Soonman Kwon	Seoul National University
2	Caryn Bredenkamp	World Bank
3	David Evans	World Bank
4	Hong Wang	Bill & Melinda Gates Foundation
5	Jack Langenbrunner	Bill & Melinda Gates Foundation
6	Michael Borowitz	The Global Fund
7	Jo Keatinge	DfID-UK
8	Triin Habicht (day 2 only)	Independent
9	Henrik Axelson	ThinkWell
10	Taehwan Kim	Seoul National University

	EXTERNAL PARTICIPANT (REMOTE)	ORGANISATION
11	Edwine Barasa	KEMRI-Welcome Trust, Kenya
12	Kara Hanson	LSHTM, London
13	Cheryl Cashin	R4D

	World Health Organization	
14	Agnes Soucat	WHO Geneva (HGF)
15	Joe Kutzin	WHO Geneva (HEF)
16	Matt Jowett	WHO Geneva (HEF)
17	Helene Barroy	WHO Geneva (HEF)
18	Ke Xu	WHO Geneva (HEF)
19	Inke Mathauer	WHO Geneva (HEF)
20	Fahdi Dkhimi	WHO Geneva (HEF)
21	Susan Sparkes	WHO Geneva (HEF)
22	Elina Dale	WHO Geneva (HEF)
23	Julius Murke	WHO Geneva (HEF)
24	Tessa Tan Torres	WHO Geneva (EAE)
24	Melanie Bertram	WHO Geneva (EAE)
25	Justine Hsu	WHO Geneva (EAE)
26	Karen Kinder	WHO Geneva (Services Organization and Clinical Interventions)
27	Ana Lorena Prieto	WHO AMRO (PAHO)
28	Aurelie Klein	WHO Laos – remote connection
29	Claude Meyer	P4H Network

Group photograph

List of additional contributors

Many thanks to those who took the time to review the matrices and send detailed comments, in particular those listed below.

Loraine Hawkins	Independent Consultant
Midori de Santo	Instituto de Estudios Peruanos, Peru
Sheila O'Dougherty	Abt Assoc (Tanzania)
Milly Kayongo	USAID Tanzania
Max Mapunda	WHO Tanzania
Sophie Witter	Professor, Queen Margaret University, UK
Cheryl Cashin	R4D
Lluis Vinyals	WHO SEARO

Written contributions from additional contributors

General comments on overall approach, matrix structure, country application	
Loraine Hawkins (Independent)	Somewhere in the introductory sections - recognizing that LICs and LMICs may not be able to avoid having substantial OOP because they do not have revenue raising capacity to provide a large enough BP, it would be good to flag somewhere that the UHC strategy in these contexts in particular also needs to pay attention to regulation of markets and if necessary prices in markets for some health services that contribute to continuing catastrophic costs. In a number of countries, OOP on pharmaceuticals persists as the largest component of OOP and a substantial cause of catastrophic expenditures. A regulatory mix that pays attention to the right mix of competition-promoting policies, price regulation, and consumer info and consumer protection legislation may need to be on the agenda for achieving UHC final coverage goals in these country contexts.
Cheryl Cashin (R4D)	I think Figure 2 is good in a technocratic sense, but it omits all of the stakeholder engagement, process design, institutional strengthening and political economy management (that precede implementation and continue during implementation), which are where the process often breaks down. Calling out these aspects of policy formulation and implementation may help take them out of the black box that we technocrats do not typically concern ourselves with—but should.
Cheryl Cashin (R4D)	BOX on **Guiding Principles**: • Pooling: do you want to add something like "de-linking resource allocation and purchasing from funding source" (this has come up in Vietnam and now Indonesia) ○ I think this is actually the essence of Matrix 1/Component C/#8 but may also be a guiding principle • Purchasing: I think it's not only about managing expenditure growth (especially when spending still needs to increase) but also about staying within the budget each year and fully executing the budget each year
Cheryl Cashin (R4D)	Figure 3—design of the matrices A. Policy process—maybe add "transparency and stakeholder engagement"
Milly Kayongo (USAID Tanzania)	[Ref: first question on matrix re existence of diagnostic work] What is the expected source of these assessment/ diagnosis? In some instances- the GoT may not have requested for formal assessments- but these have been done through project or other related activities- how is that information used to inform this scoring? If the idea is to restrict to "formal" processes supported through the GoT or DP activities- then perhaps that distinction may have to be made.
Max Mapunda (WHO Tanzania)	[Ref: first question on matrix re existence of diagnostic work] In each matrix we assess if a diagnostic has taken place. It will be of use if the framework for diagnosis is understood in order for assessors to make an informed judgment.
Cheryl Cashin (R4D)	[Ref: first question on matrix re existence of diagnostic work] The first indicator in policy design for each of the matrices has to do with a diagnosis/assessment having been done. I think a lot more guidance could be given here on the kinds of analyses provide evidence to design policies around revenue raising, pooling and purchasing that go from less sophisticated to more sophisticated, that could indicate progress.

General comments on overall approach, matrix structure, country application	
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: first question on matrix re existence of diagnostic work] Useful to include as a question but very complex and difficult to assess (does it mean only assessment done by MoH or can it include assessment done by partners?) Lao PDR is planning to develop an MTEF
Sophie Witter (Independent)	[Ref: Component A questions] Would it be better to integrate the policy process questions across the domains, as they are the same questions and often the processes are linked too (e.g. analysis of RR will also have covered PR)? Make the whole tool a bit more streamlined too, which must be a good thing!
Sophie Witter (Independent)	[Ref: scaling questions] How easy will it be for people to distinguish (in their marking) between the relatively good and very good categories? Not self-evident; I think this applies to most of the questions.
Aurelie Klein (WHO Lao PDR)	[Ref: overall] • Many questions are too long, wordy, too academic and don't translate well into other languages. Need to be able to assess more quickly – currently takes considerable time. • Potentially separate out compulsory / priority questions, from other lower priority questions; this would help ease and speed of use. • Scaling could reflect a) policy b) policy plus implementation c) policy, implementation and monitoring d) policy, implementation, monitoring an action • Some questions are contingent on previous questions i.e. some filtering required to make easier to use. • Quantitative indicators such as public spending per capita across geographical regions would be useful to make assessments related for example to equity. If data is not available, the question may stimulate further analysis.
Lluis Vinyals WHO (SEARO)	[Ref: overall] • Many answers are too ambiguous and can lead to different interpretation/ results. • Separate the process / qualitative part from the quantitative one. In each function, the patterns holds. First three questions are process and then many of the rest could be brought to the quantitative part. I think both areas need further expansion and somehow make them more explicit. • About half of the questions included in the matrix could be removed and transformed into metrics. If the questions remain, it would be good to make an explicit link between the two.
Sheila O'Dougherty Abt Assoc (Tanzania)	[Ref: overall] I read it and like it. I'm sure there'll be evolution during the meeting so thinking more in terms of broader comments: **1. Three categories of A, B, C:** • It starts out with great logic and flow. But honestly speaking, having B) of Performance Based on Guiding Principles and then C) of Additional Indicators of Performance, seems to undermine the impression of logic and organization. B) Based on Guiding Principles is awesome (I get that it's a powerful link to health financing functions + PFM and aligning indicators to it substantially deepens this linkage).....but then C) seems to undermine this impression of logic and organization by just throwing a third category (C.) on the wall that is not conceptually different than the second category (B.). In other words, it gave me the impression that you just added a Miscellaneous category.

General comments on overall approach, matrix structure, country application	

	• **Options:**
	  • Link everything to Guiding Principles – because everything links in one way or another, why not just link it? Doesn't have to be a one-to-one match and I'd guess you can find a way to frame any performance indicator you want to be related to Guiding Principles (or vice versa)
	  • Embed C. within B. by some kind of sub-categorization (1=performance on Guiding Principles, 2=additional indicators). Meaning that distinguishes the two without undermining the conceptual framework.

Sheila O'Dougherty
Abt Assoc (Tanzania)
	2. Don't shoot me but even though it's more continuous and framed to show progress, etc. it accomplishes this without really taking implementation or management into account:
	• It's still a bird's eye or DP or M&E point of view—with categories of policy and then monitoring of what actually happened or what was actually implemented. There's a huge black hole in the middle of policy and monitoring…..where 80% or so of the action takes place.
	  • It's not a black hole for most of business operations but seems to be so in international development. For example, in the car industry, there's something in the middle between Ford Motor Board of Directors approving a new line of electric cars and the cars beginning to roll off the assembly line.
	  • Even taking into account that health financing functions by definition extend into management as they break it down into functions or pieces, there's still a big hole in what is actually done to implement or manage the process.
	  • And in most low or middle-income countries under an input-based budgeting and payment system, what's missing seems to have a lot to do with assembling inputs (chase after syringes when only vaccines not syringes come on the medical supply truck), and actually manage the delivery of the output. Again, the business example—auto industry workers piling up inputs (pistons, tires, steering wheels) next to the assembly line are not paid as well as the guy in charge of keeping the assembly line running.
	
	• I'm starting to use the words implementation and management interchangeably. And to distinguish between management (the majority of tasks) and monitoring (international development priority and also the focus of the progress matrices).
	  • A critical aspect of differentiating them is the variable of time which is very important for "progress" focus and the majority of time needed is for management not monitoring
	
	• My two cents or thoughts on options to deal with it:
	  • Big bang--add another category in the middle such that A,B,C becomes policy, management (or implementation), and monitoring performance based on Guiding Principles. Framing of management (or implementation) can also be based on Guiding Principles.
	
	  • More incremental or embedded—in all performance indicators (Guiding Principle ones and additional ones), you could sprinkle in some management/implementation, action, process or milestone indicators. With the same type of specification something like:

General comments on overall approach, matrix structure, country application	
	• Extent to which steps have been developed and are being implemented to harmonize health information and operating systems for clinical information and financial/claims management • Extent to which steps have been developed and are being implemented to introduce and harmonize output-based provider payment systems for different funds flows to mitigate pooling risk, better match payment to priority services, ensure unified payment rates or consistent financial incentives at facility level, and empower facilities to use their increased autonomy and improve management.
Max Mapunda (WHO Tanzania)	[Ref: country application] Those making the assessment based on the tool will need to understand the basic concepts of health financing; assuming that anyone can make the assessment may come up with wrong outcome. For example, "equitable source of financing" needs to be understood to those completing the matrix [ref Q1.8].
Midori de Habich (Instituto de Estudios Peruanos, Peru)	Completely agree that the purpose of the tool should not be for comparisons or ranking among countries. It is also very important that the tool does not "impose" one vision and allows different pathways to be defined by the countries. In countries with a strong presence of donors, having the DPs agree on the guiding principles and the indicators of the matrices is very important and will be a real challenge. Probably this discussion needs to take place at the global level. In countries were the DPs provide significant funds (in a highly uncoordinated and fragmented way), actual progress will not be possible without their active participation in the change process: of their own policies and processes and those of the governments of the countries in which they work. **Unpacking assumptions:** This relates to making some basic prior considerations. 1. Has the country decided to adopt UHC? 2. If so, how is UHC understood? (Validation of WHO definition?). 3. Has the country defined goals for UHC? Explicitly, health system goals related to UHC? 4. Has the country adopted legislation/government orders regarding UHC? From the perspective of the public sector, an approval of some kind of formal norm is key to be able to allocate efforts for taking further action. Remember that in the public officials can only do what is allowed by "law", i.e. a formal mandate of some kind that translates into somebody´s function and responsibility. 5. Has the country defined who is responsible for designing the health financing policy for UHC? 6. Is there an agreement on the design process and the participants? 7. Has the country discussed and agreed upon the guiding principles in Box 1? The validation of the Guiding Principles is key to achieving understanding and ownership of these principles by those that will have the responsibility of applying them. Maybe in this validation process, not all of the guiding principles will be accepted as such, some may be adapted, and some may be dropped. In this last case, this would be equivalent to prioritization/selection, that could translate in the selection of some of the items in the matrices.
WHO staff Geneva	[Ref: country application] We need to clarify how and even more when is this matrix to be applied, and by whom. I understand that the aim is to monitor progress at country level, but we should be clear as to know who is going to do this exercise. Is that a progress matrix

General comments on overall approach, matrix structure, country application	
	we want a WHO staff to apply and share the results with the MoH? Would be very relevant to clarify this because it will also force us to adapt the language (generally the questions are long, very technical, so there is an underlying assumption that this is going to be used by an expert – if so, this should be made explicit). Furthermore, I think there is a need for a write up that explains a bit more in details the structure, the dimensions of the matrix: how is it structured, what is the scale about, etc...

Revenue raising	
Milly Kayongo (USAID Tanzania)	[Ref: first question on matrix re existence of diagnostic work] Could we make some reference to the fact that the assessments when conducted- have also been reviewed and discussed with the relevant stakeholders. This is because at times- the assessments are done- they are extensive and updated- but are sitting somewhere on a shelf- i.e. they have not been discussed, and options vetted within the relevant stakeholders. Perhaps some language would be added around score 2-3 that includes this additional requirement for action i.e. analysis and reflection on the assessment reports etc.
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: first question on matrix re existence of diagnostic work] Useful to include as a question but very complex and difficult to assess (does it mean only assessment done by MoH or can it include assessment done by partners?) Lao PDR is planning to develop an MTEF
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: Q2] Lao PDR has a commitment to allocate 9% of general government expenditure to health. The basis for the commitment is not so clear but there is consensus around it.
Sophie Witter (Independent)	[Ref: Q2] How common is this, and how essential for good RR? Not sure how relevant it is as an indicator
Max Mapunda (WHO Tanzania)	[Ref: Q2?] When we talk about low budget allocation it can be a relative issue; maybe we can help assessors to describe what we consider to be low budget allocation.
Milly Kayongo (USAID Tanzania)	[Ref: Q4 scale 4] Appreciate that distinction- but could some more objective measures be used for quality? If possible?
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: Q4] Not so clear what is meant by information on performance. Does this link to information collected through the NHA?
Sophie Witter (Independent)	[Ref: Q4] Might be worth building in the notion of integration here. There is always info on RR in some sources and for some streams, but the question is more whether it is presented in integrated and easy-to-analyse format somewhere on a regular basis
Loraine Hawkins (Independent)	[Ref: Component A] Do you want to add to Component A - Review of the efficiency of revenue sources and revenue collection (preferably conducted as part of broader tax policy and tax administration review)? And corresponding performance indicators?
Cheryl Cashin (R4D)	[Ref: Component A] In the policy development section should there be some criterion related to dialogue between health and finance and/or the quality of the engagement of the health sector in the budget process? Should there be an indicator somewhere that the actual amount of revenue from government sources is in alignment with commitments, priorities, and estimates of resource requirements?

Revenue raising	
Milly Kayongo (USAID Tanzania)	[Ref: Q5] Perhaps rank the scores based on objective measures like proportion-e.g. minimal could be open to interpretation- by whomever is undertaking the scoring? Some proposed benchmarks could be: 1-9% – minimal 10-4%5- Some 50-74%- Most Above 75%- Significant. Just some potential ideas.
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: Q5] Does this link to the NHA data? Based on the discussions we assumed that Lao PDR is somewhere between 2 and 3. Difficult to assess if you consider different elements simultaneously (private, public, external) not necessarily evolving in the same directions.
Sophie Witter (Independent)	[Ref: Q5] Useful to put rough thresholds here? Also, are you wanting to capture change? If so, should be more about direction of travel, than a static picture (for all of these). Worth adding an indicator on OOPs?
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: Q6] Formal in-year budget adjustments are rare. Off-budget external aid is a big issue.
Milly Kayongo (USAID Tanzania)	[Ref: Q7] Just a thought on whether distinctions might be required- some funds for example have higher execution rates- like the Health Basket Funds as opposed to other types of public funds. Would be important? [Common issue around assessing different components/schemes separately & making an overall system assessment]
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: Q7] There was agreement that health is a high priority for the country and decision makers but timely disbursements are a huge and important challenge. Maybe excluding one item or splitting into two questions (priority and efficient budget execution).
Lao PDR: discussions between WHO, NHIB & DoF	[Ref: Q8] In the case of Lao PDR, the informal sector is covered through a tax-based scheme so equity of pooling is currently not the main challenge. The scale includes items which are beyond the control of the health sector (tax-evasion, non-compliance of tax-payments).
Lao PDR: discussions between WHO, NHIB & DoF	[In ref to following question since removed]: **"Has out-of-pocket payment at the point of service utilization decreased over the 5 years (in real terms and as a proportion of total health expenditure)?"** The different options led to confusion and we could not agree which one should be selected to reflect the current context in Lao PDR. Also, the source of data was not clear. In the Lao case, information on technical revenue of public health facilities is available. However, an increase could result from provision of services not in the benefit package, a decrease would only count a decrease of official payments. Unofficial payments can only be monitored through surveys which would be irregular and costly.

Revenue raising	
Pooling	
Loraine Hawkins (Independent)	[Ref: Q3] Suggest adding e.g. of differences in budget/payment execution rules and reporting requirements (both fin reporting and reporting on quality and other performance indicators) across sources.
Max Mapunda (WHO Tanzania)	[Ref: Q6] The level of coordination between tax financing and health insurance needs also to be outlined in a framework which is easily understood to those making the assessment.

Purchasing	
Milly Kayongo (USAID Tanzania)	[Ref: Q1] Issue of expected sources: this question in particular - I have seen a paper presented at a conference on the different schemes- but cannot find similar data in the formal DP and GoT Documents.
Loraine Hawkins (Independent)	[Ref: Component A] Focuses too narrowly on provider payment. Suggest adding in to each row (assessment/ policy/monitoring framework/use of info & evidence) reference to contracting as well – covering contracting strategy and contract design (service specs and standards etc in contracts; decision process on from whom to contract including use of competition for the market or patient choice/competition within the market; use of non-financial incentives and financial penalties in contracts).
Cheryl Cashin (R4D)	[Ref: Component A] ○ I think there should be some criterion in policy development related to provider payment methods explicitly linked to service delivery objectives ○ I think the use of information collected for payment to carry out other types of analysis is an important mark of maturity in purchasing and provider payment ○ There should possibly be a criterion related to institutional structure—are roles and responsibilities clear?
Sophie Witter (Independent)	[Ref: Q6] To the extent that VHI exists everywhere, the answer will always be yes to this question, I would think. Need to make clear that this relates to core public or mandatory schemes?
Sophie Witter (Independent)	[Ref: Q12, scaling text 2&3] As many of these questions have 2 components, how to mark the countries where the answer to one is yes (e.g. output based payments) but maybe they still operate in a fixed budget (so no to the nominal component, in this example)?
Loraine Hawkins (Independent)	[Ref: Component B] Could amend indicators to refer to "provider payment **and contracting"** where appropriate; I also suggest adding an assessment indicator to capture performance in use of contracting to increase the efficiency of the service delivery network and innovation in service delivery.

Purchasing	
Sophie Witter (Independent)	[Ref: Q14] This is useful information but is it always normative? i.e. can we assume, as implied by the scale, that paying the full costs is always better (in all contexts) than covering non-salary recurrent ones? Surely it depends. Also, where you have multiple schemes, how do you answer this? In relation to which one?
Loraine Hawkins (Independent)	[Ref: Component C] I suggest to say "or just non-wage recurrent costs" – because the common and most troubling issue is exclusion of personnel costs from purchasing/payment. Including capital is hard to do well in countries with public delivery systems and I am inclined to the view that there are pros and cons of leaving it out even in rather high capacity countries.

Benefit design	
Midori de Habich (Instituto de Estudios Peruanos, Peru)	General comment: we have seen that in many countries it is advisable to start with a relatively small universal package particularly associated to the primary care level (with explicit inclusion of promotion and prevention), based on consideration of affordability and allocative efficiency. How can this be reflected?

PFM & Governance	
Lluis Vinyals WHO (SEARO)	[Ref: Q1] Issue of expected sources: this question in particular - I have seen a paper presented at a conference on the different schemes- but cannot find similar data in the formal DP and GoT Documents.
Sophie Witter (Independent)	[Ref: Q6 & Q7] Some of this seems to repeat facets above, e.g. on budget execution
Sophie Witter (Independent)	[Ref: Q8] For many of these, the answer will be: yes for some institutions and no for others. How will they then be scored?