MODULE 4

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HEALTH INFORMATION, SYSTEMS, AND FINANCING

MODULE 4 ■ HEALTH INFORMATION, SYSTEMS, AND FINANCING

SUMMARY TABLE

Duration of module	4 hours, 55 minutes
Timing of this module	This module corresponds with the following sessions in the *Health & Budgets Training Workshop Agenda*: • **Part of SESSION 1** on **Day 2;** • **SESSION 2** on **Day 2**; and • **SESSION 3** on **Day 2**. (Note that one session is 1 hour, 45 minutes.)

Resources needed	• Flipchart paper and markers
	• Masking tape
	• Budget Document Name and Definition Cards
	• OBI 2010 Country Summaries for countries represented in workshop
	• Decision Tree guidelines
	• Color Post-It notes with country names
	• Components and Management of Health System Cards
	• PowerPoint presentation: **Module 4 – System for Financing Health Care in Sudan**
	• In the Participant's Workbooks:
	   ➢ **TASK 4.1** ■ Health Information: Sharing Experience
	   ➢ **TASK 4.2** ■ Barriers to Information and How to Overcome Them
	   ➢ **TASK 4.3** ■ The Decision Tree: Government Decisions about Health Care
	   ➢ **TASK 4.4** ■ The Impact of the Various Health Systems and Payment Mechanisms on Access to Health Care
	   ➢ **TASK 4.5** ■ What Does My Government Commit to Provide?
	   ➢ **TASK 4.6** ■ Financing of Health Care in Centralized and Decentralized Systems
	   ➢ **TASK 4.7** ■ Accessing Health Care in Sunrise State, Polarus
	   ➢ **READING 4.1** ■ Exploring Health Information
	   ➢ **READING 4.2** ■ Essential Budget Documents
	   ➢ **READING 4.3** ■ How to Find Budget Information

> ➢ **READING 4.4** ■ Strategies for Overcoming Barriers to Health and Budget Information
>
> ➢ **READING 4.5** ■ Key Components of Health Systems
>
> ➢ **READING 4.6** ■ Donor Financing in Health

LEARNING OUTCOMES TO BE ACHIEVED

By the end of this module, participants will have:

- Named the value of health information for budget analysis and advocacy work

- Identified the content of essential budget documents relevant for budget work;

- Listed possible barriers to accessing budget information and suggested strategies for overcoming the barriers;

- Recognized the three ways governments finance the provision of health care;

- Identified key features of different health systems and how they are organized;

- Considered and discussed the implications of the different features and payment mechanisms of health systems for universal access, the right to health and equity;

- Reviewed the various components that make up the health system; and

- Discussed the role of donors in financing the provision of health care.

STRUCTURE OF THE MODULE

Health and Budget Information (1 hour, 5 min.)

1. **FACILITATOR INPUT**: Importance of Health and Budget Information   5 minutes

2. **TASK 4.1** ■ Health Information: Sharing Experiences   20 minutes

3. **PAIR WORK** ■ Essential Budget Documents   25 minutes

4. **TASK 4.2** ■ Barriers to Information and How to Overcome Them   15 minutes

Health Systems and Payment Mechanisms (1 hour, 35 min.)

5. **TASK 4.3** ■ Decision Tree–Government Decisions about Health Care   20 minutes

6. **FACILITATOR INPUT**: Three Ways Government Finances Health Care   15 minutes

7. **TASK 4.4** ■ The Impact of the Various Health Systems and Payment Mechanisms on Access to Health Care   30 minutes

8. **TASK 4.5** ■ What Does My Government Commit to Provide?   30 minutes

Government Management and Financing of Health Systems (2 hours, 20 min.)

8. **FACILITATOR INPUT AND BRAINSTORM**: The Components of Health Systems   20 minutes

10. **TASK 4.6** ■ Financing in Centralized and Decentralized Health Systems 20 minutes

11. (*Optional*) **ENERGIZER**: Debate – Centralized or Decentralized   15 minutes

12. **FACILITATOR INPUT**: Donor Financing in Health   25 minutes

13. **TASK 4.7** ■ Accessing Health Care in Sunrise State, Polarus   1 hour

HEALTH AND BUDGET INFORMATION

Duration of session: 1 hour, 5 minutes

STRUCTURE OF THE SESSION

1. **FACILITATOR INPUT:** Importance of Health and Budget Information   5 minutes

2. **TASK 4.1 ■** Health Information: Sharing Experiences   20 minutes

3. **PAIR WORK ■** Essential Budget Documents   25 minutes

4. **TASK 4.2 ■** Barriers to Information and How to Overcome Them   15 minutes

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1. FACILITATOR INPUT ■ IMPORTANCE OF HEALTH AND BUDGET INFORMATION FOR BUDGET WORK   5 MINUTES

- Introduce this module with a very short presentation on why both health and budget information are critical to health and budget advocacy work. Some talking points on this issue:

  - As was mentioned in the Module 3, people have a right to participate in public affairs. Civil society budget work is a form of exercising that right. In order to effectively participate, people need to have information—and they have a right to information.

  - It could be argued that reliable accessible health information is potentially the single most cost-effective and achievable strategy for sustainable improvement in health care.

  - Up-to-date, accurate, and accessible health information and data is important for the management and planning processes of government for the delivery of health services.

  - A critical aspect of this is reliable accessible information on the financial resources allocated towards health care.

  - Traditionally, budget processes have been very secretive and have involved a handful of officials in any country.

  - Since the mid-1990s, civil society groups have begun to engage in budget work but a major barrier to their work is lack of access to information.

  - More than any other sector in civil society, budget work is fundamentally dependent on "evidence-based" advocacy, i.e., budget work requires the presentation of "facts and figures" in an accurate and accessible format.

  - This dependence on facts and figures requires budget groups to access information on government budgets – something that is not very easy even today.

- In this session, various issues on access to information and transparency will be discussed.

2. TASK 4.1 ■ HEALTH INFORMATION: SHARING EXPERIENCES   20 MINUTES

- **The aim of this task** is to enable participants to recognize the value of health information in budget analysis and advocacy.

- Ask participants to turn to **TASK 4.1 ■ HEALTH INFORMATION: SHARING EXPERIENCES** in their Workbooks.

- Invite participants to read the text boxes and to underline what is new to them or strikes them as interesting, or useful. Then ask participants to respond to the question b) in their Workbooks: **How would you summarize the value of health information for your work?**

- After 10 minutes, ask the participants to work in pairs to share where they typically go to access the health information that they need for their work. Ask them to note down on their task sheets some of the documents and sources that they shared.

- After 5 minutes, ask participants in plenary to share any insights that they might have gained for their own health and budget projects.

- Refer participants to **READING 4.1 ■ EXPLORING HEALTH INFORMATION**.

3. PAIR WORK ■ ESSENTIAL BUDGET DOCUMENTS   25 MINUTES

- **The aim of this task** is to enable participants to review (or learn) the budget documents that are essential for their health budget work.

- Ask participants to pair up for this task. Give a set of Budget Document Name Cards to each pair of participants. Ask them to work together to match the budget document with its definition. 5 minutes for this.

- Ask participants for the definition of each budget document, in turn. Ask if there are any questions for each match of name and definition. Make sure that the following points are mentioned through the definition or otherwise discussed:

    1. The **Pre-Budget Statement** should be released by the Executive during the formulation stage of the budget process. This document is intended to disclose the parameters by which the Executive will develop its budget proposal: specifically, total estimated expenditure, total expected revenue, and amount of debt to be incurred during the upcoming budget year.

    2. The **Executive's Budget Proposal** is the draft budget which should be made available to the public before the actual budget law is passed by the legislature, so that citizens have the opportunity to provide their input into the drafting of the budget law before it is finalized and passed. It should detail the policies and priorities the government wants to pursue in the upcoming budget year, including specific allocations to each ministry and

agency. The Executive's Budget Proposal above should contain the following information:

Expenditure classifications
- administrative
- functional
- economic
- program

Revenue classifications
- tax
- non-tax

Debt
- stock at the beginning and at the end of the budget year (yearly additional borrowing)
- composition of debt (different instruments, different maturities, interests, currencies, domestic vs. external)
- interest rates

Macroeconomic information
- different information can be relevant for different countries (e.g., oil-producing countries)
- basic information is: GDP growth, inflation, unemployment, interest rate
- changes in the macroeconomic framework can have a significant impact on the budget (on both the revenue and expenditure sides)

Multi-annual data
- future projections
- past data

Public policy information
- new policies as distinct from existing policies
- links between policies and budget
- links between budget and policies to fight poverty

3. The **Enacted Budget** is a document that is approved by the legislature and passed into law as the budget to be implemented for the upcoming fiscal year.

4. The **Citizens Budget** is a non-technical representation of the terms and the concepts in the budget that can be understood by citizens who do not have technical knowledge of budgets or fiscal policy.

5. **In-Year Reports** should be produced and made available to the public on a monthly or quarterly basis and they should report on the implementation of the budget, including the revenue, expenditure, and the debt situation of the government.

6. The **Mid-Year Review** provides a comprehensive update regarding the implementation of the budget, including a review of the economic assumptions underlying the budget and an

updated forecast of the budget outcome for the current budget year.

7. The **Year-End Report** should be produced and made available to the public by the executive branch, and it should report extensively on the government's fiscal activities and performance for the entire budget year.

8. The **Audit Report** is the annual report issued by the Supreme Audit Institution attesting to the government's year-end final accounts and whether public resources have been utilized effectively.

- After reviewing all of the essential budget documents, be sure to mention that the Open Budget Index, which is produced by the International Budget Partnership every two years, reflects the extent to which governments make these eight essential documents available to the public. Pass out copies to participants of the most recent OBI summary for their country, and provide them with the link to the OBI results so they can refer to it when they want to:

  http://internationalbudget.org/what-we-do/major-ibp-initiatives/open-budget-initiative/

- Also mention that additional (official) information that is necessary to obtain a deeper perspective regarding the budget includes:

  - Demographic information
  - Sector-specific documents (e.g., health, education, defense)
  - Sector-specific information (e.g., geographical distribution, number of teachers/doctors in different regions, epidemiologic profile of the country)

4. TASK 4.2 ■ BARRIERS TO INFORMATION AND HOW TO OVERCOME THEM
15 MINUTES

- **The aim of this task** is to have participants identify typical barriers to accessing health and budget information and develop ideas for overcoming these barriers.

- Introduce this task by highlighting the following points:

  - Budget documents maintained by national governments frequently do not disclose all the information in a format that is in line with international good practices.

  - Health information maintained by national governments frequently does not provide information in a format that is in line with international good practices.

  - However, lack of transparency in budgets is affected by many other factors.

  - This session will focus on the typical barriers to accessing information at both national and local levels as well as techniques of overcoming these barriers. The participants should draw on the case study that they have read for these discussions.

- Write up on two sheets of flipchart paper the headings "Barriers" and "Strategies for Overcoming Barriers." In plenary, invite participants to call out some barriers.

- A typical list of barriers could include:

  - Lack of knowledge or limited knowledge on what information is kept by the government.

  - Lack of knowledge or limited knowledge on which government department keeps the information that you want.

  - Lack of knowledge or limited knowledge on which government official keeps the information that you want.

  - The government official who has the information that you need is repeatedly evasive, not available, or absent when you visit his/her office.

  - Government official(s) respond with hostility when you request information.

  - Record-keeping practices are poor and documents are not available, or only partly available, in government office(s).

  - Records are maintained in very poor condition and/or are illegible.

  - Records are voluminous and technical.

  - Records are misleading or contradictory.

  - Websites are not updated or contain very large files that are difficult to download (or there is limited access to Internet and/or it is too slow).

- Acknowledge the barriers suggested by participants and add any others from the list above. Participants can record the barriers in their Workbooks, using the left-hand column of the table under **TASK 4.2 ■ BARRIERS TO INFORMATION AND HOW TO OVERCOME THEM**.

- Now invite participants to suggest some strategies for overcoming each of the barriers. Briefly review and acknowledge the strategies emerging from the group. Sum up by confirming or highlighting the following strategies.

IDENTIFY SYMPATHETIC OFFICIALS

- No government is a monolith: while some public officials are hostile to civil society's requests for information and assistance, others are extremely forthcoming.

- The latter can be critical allies in an effort to obtain information on public programs.

- To win over officials who are less forthcoming but not completely opposed, civil society groups can try to persuade them of the need for transparency, provide an example of how transparency would benefit them, and/or appeal to their egos by offering them an opportunity to showcase their work.

- One way to obtain information from hostile officials is to pressure them, by, for example, going over their heads, that is, appealing to their bosses.

- Alternatively, civil society organizations can work to build a relationship of trust with both officials who are not completely supportive as well as those who are initially hostile to them.

USE "RIGHT TO INFORMATION" LAWS

- Approximately 90 countries around the world have laws that guarantee citizens the right to information.

- An access to information law can be central to an organization's strategy for conducting a social audit.

- Even if their country has such a law, however, groups will not always be able to obtain needed information.

- Information requests can run into a variety of obstacles, including claims that files are missing or that their disclosure would harm national security.

- An excellent collection of studies on access to information laws, including implementation problems, is available at www.freedominfo.org.

USE INDIVIDUAL AGENCY DISCLOSURE POLICIES, COURTS, AND CIVIL PETITIONS

- In countries where there is no law guaranteeing access to information, individual agencies may sometimes have disclosure policies or charters on citizen rights that can provide for such access.

- Some countries that do not have access to information laws do have provisions or laws for access to public procurement information.

- In other countries, the national constitution may protect individual liberties that include the right to information.

- Citizens have successfully used constitutional provisions to file petitions in national courts to obtain information, though this is obviously a complicated process that can take years to complete.

COLLABORATE WITH AUDITORS, LEGISLATORS, AND DONORS

- Public audit institutions can be an excellent source of information.
- Legislators too often have much more information on public projects than ordinary citizens do, and civil society groups may be able to obtain extensive information through a sympathetic legislator.
- Similarly, in countries that are highly donor-dependent, donor organizations may have access to information on public projects – especially the projects these donors fund.
- Donors may be very forthcoming to a social audit process given their interest in ensuring that the funds they have donated are spent properly.

DIRECT ACTION AND CAMPAIGNS

- The pioneer of non-violent direct action, Mahatma Gandhi, encouraged the use of direct action campaigns to demand changes from the government.

- He described the government response to such a campaign as follows: "First they ignore you, then they laugh at you, then they fight you, then you win." Organizations that are repeatedly denied information might choose a strategy that relies on direct non-violent confrontation with the government agency that denies them information.

- Such a strategy should be undertaken only after careful deliberation given its possible consequences, including violent retribution from the government.

KEEP IN MIND

- When conducting analysis and advocacy work using health and budget information, don't jump to conclusions about the information or data that you cannot see. Be honest about the limitations of your findings, stressing that they are based on the limited information available.

- When publicly available information is limited, use this as an opportunity to demand more information so that you can have a better understanding of what is really happening with regard to the particular development issue that you are working on.

- It is valid to make your own choices and decisions regarding the use of limited data and/or incomplete information in your advocacy work, but always explain these decisions. If the government says that you are wrong, ask them to offer a more complete picture.

- Participants will find information on the points above in **READING 4.4 ■ STRATEGIES FOR OVERCOMING BARRIERS TO HEALTH AND BUDGET INFORMATION** in their Workbooks.

HEALTH SYSTEMS AND PAYMENT MECHANISMS

Duration of session: 1 hour, 35 minutes

The aim of this session is to enable participants to understand the different features of health systems and payment mechanisms.

STRUCTURE OF THE SESSION

5. **TASK 4.3** ■ The Decision Tree: Government Decisions about Health Care 20 minutes

6. **FACILITATOR INPUT**: Three Ways Governments Finance Health Care   15 minutes

7. **TASK 4.4** ■   The Impact of Various Health Systems and Payment
         Mechanisms on Access to Health Care   30 minutes

8. **TASK 4.5** ■ What Does My Government Commit to Provide?   30 minutes

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5. TASK 4.3 ■ THE DECISION TREE: GOVERNMENT DECISIONS ABOUT HEALTH CARE   20 MINUTES

- **The main aim of this task** is to provide the participants with an opportunity to share their understanding and experience of their health system and the various payment mechanisms involved in financing health care in their context. **Another key aim** is to draw the participants' attention to the impact that these various financing mechanisms have on the health system and ultimately on people's access to health care.

- Draw a "decision tree" on a piece of flipchart paper. Explain that when it comes to the provision of health care, there are some fundamental choices a government makes:

    1. *First Choice:* Government can decide to <u>commit</u> to be responsible for health or <u>not commit</u> to be responsible for health. If it does <u>not commit</u>, this means leaving citizens to fend for themselves in the market, spending their own money on private care.

    2. The key here is to make sure to distinguish between the word "commit" in abstract decision terms, and commit in actual expenditure terms and a legal framework. The decision tree is a tool for understanding the decision confronting a government. In reality, governments may avoid choosing, or may make mixed choices and this will be reflected in actual expenditure and whether or not they comply with the legal framework.

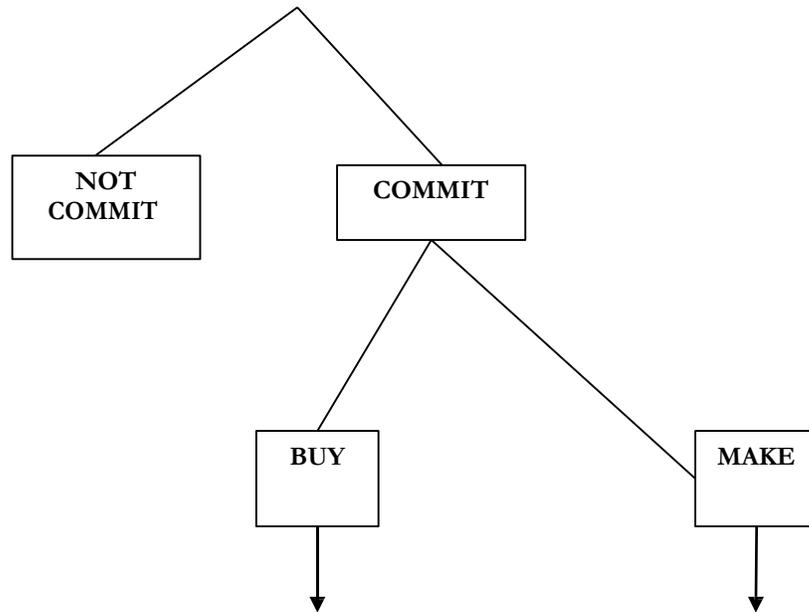   3. *Second Choice:* If Government decides to commit, then it can decide to <u>make</u> or <u>buy</u>.

- Ask if any of the participants are familiar with "Make or Buy" decision. If anyone is familiar, allow them to describe it. If not, explain:
  - "Make or Buy" decisions are those taken when, for example, a company must decide whether to produce inputs for some product itself, or to buy them from another supplier.
  - This distinction is often applied to companies, but even NGOs make such decisions. For example, your NGO may require cleaning services. You must decide whether to hire a person on staff who will do the cleaning ("make") or find a company that provides cleaning services, and pay them to come clean your office ("buy").
  - Likewise, you may make such decisions with respect to maintaining a website or producing brochures. Do you make these things inside the organization using available talent ("make"), or do you pay someone outside the organization a fee to produce these things on your behalf ("buy")?
- Clarify that in this discussion of "make" or "buy" decisions, health care cannot be merely reduced to a commodity and emphasize that it is a public good—and it is a human right. Governments have an obligation to ensure people's access to health. A government cannot wash its hands of the issue, saying it is entirely up to people themselves. A government may use private systems ("buy") or a government system ("make"). A rights framework does not dictate *how* a government should go about guaranteeing people's right to health. Whichever approach it uses, however, the end result must be that people have access to health and to a health care system of sound quality.
- Return to the example. Ask the group: "Can you think of an example of how 'make' or 'buy' would be relevant for a government that has decided to commit to health services for the population?"
- Depending on the level of response, provide a first example, or use an example provided by one of the participants. Either way, the first example should be built on with other examples. Three examples are: medicines, buildings (or infrastructure), and personnel.
- It may be useful to introduce the concept of insurance and discuss how insurance fits into the "make"/"buy" model. Insurance may be public or private. When the government provides insurance, then it is committing to "buy" health services.
- The government could provide a mixture of public insurance ("make") and/or public health care services by reimbursing private providers ("buy"), or leave it to a voluntary private system in which contributions are made to private insurers either via their companies or out-of-pocket.

- Have participants fill out the remaining "branches" of the Decision Tree. 10 minutes.

- Ask for examples of goods or services provided and how they might look if the government were to "buy" them, and if it were to "make" them.
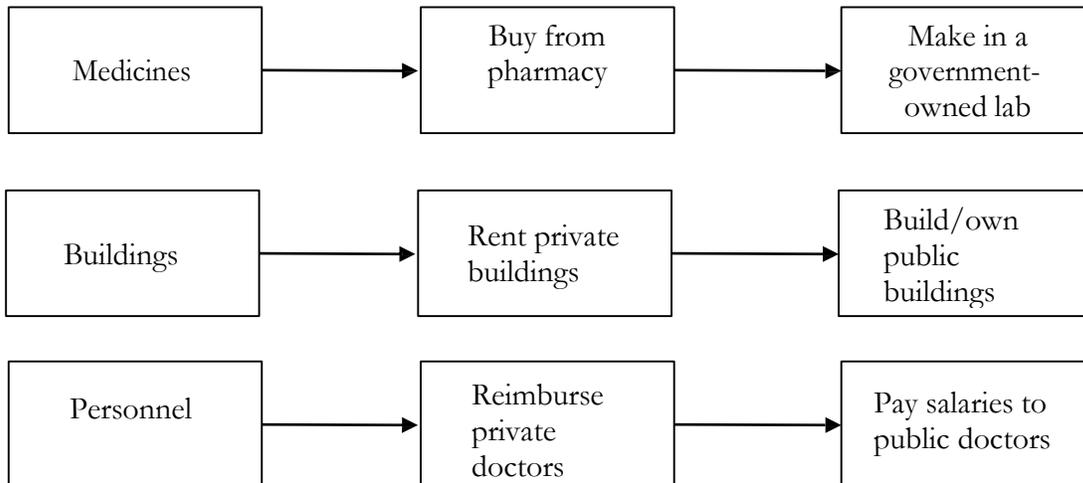
GUIDELINES FOR DRAWING THE DECISION TREE

Copy out the terms written in the boxes onto colored Post-It Notes. Have them ready to stick up on a sheet of flipchart paper – or a whiteboard – when facilitating the discussion "private" and "public" funding mechanisms for health care.

GOVERNMENT DECISIONS ABOUT HEALTH CARE

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                          /\
                         /  \
                        /    \
          ┌──────────┐ /      \ ┌──────────┐
          │   NOT    │/        \│          │
          │  COMMIT  │          │  COMMIT  │
          └──────────┘          └──────────┘
                                /          \
                               /            \
                    ┌──────────┐            ┌──────────┐
                    │   BUY    │            │   MAKE   │
                    └──────────┘            └──────────┘
                         │                       │
                         ▼                       ▼
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The following examples can also be written out on Post-It notes and placed on the display to show the difference between "buy" and "make."

Medicines	→	Buy from pharmacy	→	Make in a government-owned lab
Buildings	→	Rent private buildings	→	Build/own public buildings
Personnel	→	Reimburse private doctors	→	Pay salaries to public doctors

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6. FACILITATOR INPUT ■ THREE WAYS GOVERNMENTS FINANCE THE PROVISION OF HEALTH CARE   15 MINUTES

- Link the previous discussion of make (Public) and buy (Private) to a discussion about the three ways that governments finance the provision of health care, namely:

  a. The government does not commit to provide health care – PRIVATE: PRIVATE

  b. The government commits to buy health care – PUBLIC: PRIVATE

  c. The government commits to directly provide health care – PUBLIC: PUBLIC

- Write the three options above on sheets of large Post-It note paper. Using the Post-It notes, link the three options by placing the notes on a wall or flipchart paper as follows:

  a) PRIVATE: PRIVATE next to **b)** PUBLIC: PRIVATE;

  b) PUBLIC: PRIVATE next to **c)** PUBLIC: PUBLIC; and

  c) PUBLIC: PUBLIC next to **a)** PRIVATE: PRIVATE.

- Discuss the fact that governments may say they are doing one thing, but actually do another. For example, governments may claim that they are committed to "make" and will provide public facilities, but then the government may not actually have the resources to "make" enough health care available, leaving citizens to fend for themselves. This results in a mix of PRIVATE: PRIVATE and PUBLIC: PUBLIC.

- For example: South Africa commits to provide health care, but due to huge disparities within the health care system, the quality of health care available to the large majority of the population is of poor quality. This has resulted in the South African government drawing on PUBLIC: PRIVATE interactions, in which public money is being used to buy services from the private sector. This has included private doctors working in understaffed public facilities and private companies providing services to public facilities, such as catering and laundry. In addition, despite the South African government's promotion of equity within the health system, division within the South African health sector between rich and poor as well as insured and uninsured have deepened. By 2003/04 the total national health expenditure captured by the private sector had risen to 62% and that for the public sector had fallen to 38%. Yet, the private sector now serves between 14 to 20% of the population with the vast majority still depending on the public sector. It is important to add here that there is provision for social insurance to cover a small proportion of the population, so the health system in itself promotes inequitable access – guaranteed health care for a small proportion and limited entitlement for the majority.

- If this does not come into the discussion, draw the participant's attention to the various ways in which health workers are remunerated. The government may, for example, choose:
  - *Capitation:* A fixed prepayment, per patient covered, to a health care provider to deliver medical services to a particular group of patients. The payment is the same no matter how many services or what type of services each patient actually gets. Under capitation, the provider is financially responsible.
  - *Fee for services:* Doctors or other providers bill separately for each patient encounter or service they provide. This method of billing means that the insurance company or the government pays all or some set percentage of the fees that hospitals and doctors set and charge.
- In addition, there are various ways in which the insurance can be provided.

7. TASK 4.4 ■ THE IMPACT OF VARIOUS HEALTH SYSTEMS AND PAYMENT MECHANISMS ON ACCESS TO HEALTH CARE   30 MINUTES

- **The aim of this task** is to encourage participants to consider the impact that various health systems and financing mechanisms have on access to health care.
- It is important to link the previous discussion about the three ways government finances the provision of health care with a discussion on the impact that these financing mechanisms have on who is able to access health care (issues of equity and the right to health care) and how (universal access and the right to health) individuals access health care and at what cost.
- Divide the participants into pairs. Ask them to turn to **TASK 4.4 ■ THE IMPACT OF VARIOUS HEALTH SYSTEMS AND PAYMENT MECHANISMS ON ACCESS TO HEALTH CARE** in their Workbooks.
- Working with their partners, invite participants to discuss the question: "*What impact, if any, do you think the Private: Private, Public: Private, and Public: Public financing mechanisms have on those accessing the health system and on what it costs them?*"
- Ask the participants to write down any key points from their discussion. Allow the participants 15 minutes of discussion.
- In plenary invite the participants to share their discussions. Allow about 10 minutes for feedback.
- It is important to draw the participants' attention to the fact that the various financing mechanisms have implications for those accessing the health care system, as well as who is being discriminated against and at what cost.

- Be sure to stress what was already mentioned: that the right to health means that governments cannot say that health care is not a concern for them. Thus the *Private: Private* option would violate people's right to health.

- Where a government chooses to use the *Public: Private* approach, a key issue is whether the government is complying with its obligation to *protect* people's right to health, by monitoring the private provision of health care services and ensuring that private providers are making health care available, accessible, acceptable and of good quality (as guaranteed by the right to health).

- Possible examples of different approaches to health care provision could be as follows:

Thailand: Public financing and a mix of public and private provision presently in contrast to a mix of public financing and out-of-pocket a decade ago with uncoordinated public and private provision. The change to complete public financing post-2002 has minimized out-of-pocket spending and regulation has reined in the private sector to the benefit of health care for the population as a whole. This has assured near universal access and equity.

Sri Lanka: Statist model of public finance and public provision. Public budgets are limited and hence the system is under stress. Primary care is universally accessible with reasonable equity but at higher levels of care, people experience inequities, wait lists, corruption, etc.

South Africa: Constitutionally primary health care is a right and reasonable access to primary care has been assured through public provision and financing. The impact of HIV/AIDS has hindered access, since it has not been adequately integrated under primary care due to resource constraints. Higher levels of care are insufficient in the public system and are only assured to those who are insured, those who are covered under the medical schemes because of their employment, or those who can afford it out-of-pocket. Again, there are significant inequities and lack of universal access to higher levels of care as a result.

8. TASK 4.5 ■ WHAT DOES MY GOVERNMENT COMMIT TO PROVIDE?
30 MINUTES

- **The aim of this task** is to provide participants an opportunity to compare their country context with others and to engage with the 3AQ: availability, accessibility, acceptability and quality.

- Provide participants with color-coded Post-It notes with their countries' names on them.

- Reveal a flipchart prepared in advance with a matrix like the following. Participants will find a copy of the in their Workbooks, under **TASK 4.5: WHAT DOES MY GOVERNMENT COMMIT TO PROVIDE?**

- Invite the participants to place their Post-It note on the matrix where they think their governments fall within the discussion of health systems financing. Then ask them to explain their choices.

MATRIX FOR MAPPING COUNTRIES' HEALTH SYSTEMS AND FINANCING
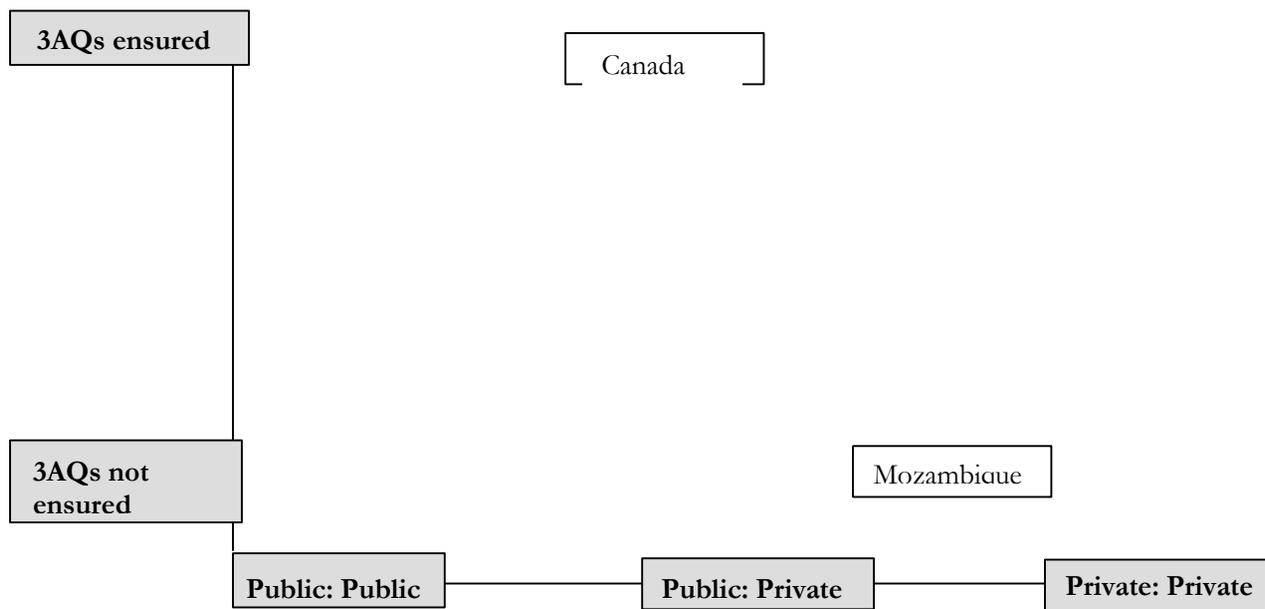
Add the following **examples** to the discussion:

- **Canada** has both committed to and provides universal access to health care. The Canadian health system is for the most part publicly funded and is mostly free at point of use. At the same time, most of the outpatient services are provided by private providers, pharmacies or other private entities, although most hospitals are public.

- **Mozambique** has committed to provide universal access to health care. However, due to the huge challenges and disparities within the Mozambican health system, in reality it has not achieved universal access. Despite reforms and investment in the public health system in Mozambique, about 40% of the population does not have access to these health services. In addition, there are only 3 doctors and 21 nurses for every 100,000 people in Mozambique, which means approximately 600 doctors for the entire country. Moreover there is a growing private

health care system in place, resulting in a parallel private health system existing servicing a small proportion of the population.

- **Sweden** has a health care system completely financed by tax revenues and provision of all services by the state. There is no private sector and all citizens have full access to health care without exceptions. All doctors and nurses are employees and receive a salary. Access is universal and highly equitable.

- The **United States** follows a market model where most of health care is left to the individual through a predominant mechanism of financing through private insurance. Most of those in regular employment would have employers contributing to the premiums. Most provisioning is in the private sector. Public finance is about 40% of all health care, but it is targeted to the two schemes of Medicare (for elderly) and Medicaid (for poor). Despite this, nearly 50 million people in the U.S. do not have adequate access to health care

- **Brazil** is a country in transition, rapidly moving towards universal access and equity. The country's social insurance expansion and state coverage for the non-working has helped the Brazilian health system to achieve near universal access and reduced out-of-pocket spending.

MANAGEMENT OF HEALTH SYSTEM FINANCING

Duration of session: 2 hours, 20 minutes

STRUCTURE OF THE SESSION

9. **FACILITATOR INPUT AND BRAINSTORM:** The Components of Health Systems

    20 minutes

10. **TASK 4.6** ■ Financing in Centralized and Decentralized Health Systems

    20 minutes

11. (*Optional*) **ENERGIZER:** Debate – Centralized or Decentralized   15 minutes

12. **FACILITATOR INPUT:** Donor Financing in Health   25 minutes

13. **TASK 4.7** ■ Accessing Health in Polarus   60 minutes

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9. FACILITATOR INPUT AND BRAINSTORM ■ KEY COMPONENTS OF HEALTH SYSTEMS   20 MINUTES

- This input amounts to an introduction to the next session. Introduce the topic by asking participants to brainstorm in plenary what they consider to be the key components that make up a health system and the bearing of each of these components on access to health care.

- If necessary, start the discussion by using personnel as an example.

- **Have the ten components written up on colored cards before you start (See Reading 4.5 for the list of components).** As participants call out their ideas, place the corresponding cards up on a sheet of flipchart paper. Should the participants leave out any of the components out, add them yourself and explain why they are important.

- Inform the participants that they can make notes in their Workbooks. They will also find a summary of this discussion in **READING 4.5: KEY COMPONENTS OF HEALTH SYSTEMS**.

10. TASK 4.6 ■ FINANCING OF HEALTH CARE IN CENTRALIZED AND DECENTRALIZED HEALTH SYSTEMS   20 MINUTES

- Explain that government health systems are structured with different degrees of centralization of control and financing. In order to work with the health budget and bring about change related to that budget, it is essential to know where the funding in the budget comes from—from the

central government, from local revenue or from some mix–and who is responsible for expenditures and on what.

- **Show the slide in the PPT file Module 4 – Example of Financing Health Care in Sudan.** (This shows the health financing system as of 2009.) Explain what it says, which is essentially:

  - The Federal Ministry of Finance provides funding to the Federal Ministry of Health, which in turn provides funding to State Ministries of Health (for specific programs, such as immunization). The State Ministries of Finance also provide the State Ministries of Health with funding. The SMoHs in turn provide funding to the Health Offices in their Localities.

  - Individuals in communities pay fees to use the primary health clinics and these fees, in turn, are revenue for the Health Offices in the Localities.

  - Individuals in communities pay fees to use State or rural hospitals, and these fees are revenue for the State Ministries of Health.

  - The Federal Government runs teaching and specialized hospitals. The Federal MoH funds those hospitals. When individuals use those hospitals, they have to pay fees, and the latter, in turn, are revenue for the Federal MoH.

  - International institutions, such as UNICEF, provide funding directly to the Federal Ministry of Health for earmarked programs. This funding is directed by the FMoH to State MoHs as appropriate.

  - Some individuals (generally wealthier individuals) have private health insurance.

- Provide each country group with a sheet of flip chart paper. Ask them to discuss among themselves the sources of funding for primary, secondary and tertiary care in the country, and the flow of funds to those different levels from different sources. Once they have reached consensus on these issues, they should illustrate their findings on the flip chart paper.

- Ask two groups to present their charts. Ask where others see similarities and differences from the system in their countries. Direct participants to question 1 of **TASK 4.6 ▪ FINANCING OF HEALTH CARE IN CENTRALIZED AND DECENTRALIZED HEALTH SYSTEMS** in their Workbooks.

- Participants should then turn to question 2 in TASK 4.7. They should read the text in the box, discuss among themselves what the obligations of different levels of government mean for how the health care system is financed.

- The central issues that should come out are that 1) the central government should ensure that sub-national governments responsible for provision of health services have adequate funding to

meet their obligations with regard to 3AQ; 2) sub-national governments should be giving adequate priority within their own budgets to financing of the health system; 3) the sub-national governments should not be discriminating, intentionally or otherwise, in the way that they finance the health system; and 4) the central government should ensure that the way the health system is financed is such as to ensure that people in different provinces, states or localities are able to enjoy the 3AQ on an equal, non-discriminatory basis (in other words, the central government should ensure that poorer states are provided added funds necessary to be able to provide services on a par with the health systems in richer states).

- Depending on the time taken brainstorming the components of the health systems, proceed to the following debate as an energizer:

11. (OPTIONAL) ENERGIZER ■ DEBATE: CENTRALIZATION VS. DECENTRALIZATION   15 MINUTES

- Divide the participants into two groups. One group will be in favor of a health system that is managed through a decentralized framework while the other group is in favor of a health system that is managed through a centralized framework.

- Ask the groups to allocate one spokesperson to put forward the advantages their group's case.

- Allow the spokesperson 1 minute each to present their case.

- Ask the facilitators in the room to take a vote or alternatively select a committee from the participants who will vote.

- **The key aim of this energizer** is to get the participants thinking about the discussions taking place within the health sector with regard to the advantages and disadvantages of a centralized or decentralized managed health system.

12. FACILITATOR INPUT AND DISCUSSION ■ DONOR FINANCING IN HEALTH   20 MINUTES

- Lead a discussion on the implications of donor financing of health systems on the provision of health care. Involve the participants in the discussion by posing a number of open questions to draw on their experience and for them to share their country contexts.

- Begin with questions such as:

    - *Who are the main donors towards health funding in your country?*

    - *What impact has donor funding of health care had in your country in terms of 3AQ?*

- In facilitating this discussion, draw the participants attention to some of the ways in which donor financing takes place and the dilemmas it raises, for example:
  - Conditionalities, fungibility – donors invest, countries disinvest;
  - Unpredictability and volatility;
  - Fragmentation/distortions of policy;
  - Verticalization of programs;
  - Donor accountability; and
  - Corruption.

- You can also draw the participants' attention to the Paris Declaration on Aid Effectiveness,[1] which commits signatories to five principles:
  1. Ownership: Partner countries exercise effective leadership over their development policies and strategies, and coordinate development actions.
  2. Alignment: Donors base their overall support on partner countries' national development strategies, institutions, and procedures.
  3. Harmonization: Donors' actions are more harmonized, transparent, and collectively effective.
  4. Managing for results: Managing resources and improving decision-making for results.
  5. Mutual accountability: Donors and partners are accountable for development results.

- Draw the discussion to a close with another open question to the participants: *What would you consider to be some of the key budget implications of donor financing on your government's approach to health care financing and provision?*

- Let participants know that they can find information on this topic in their Workbooks in **READING 4.6 ■ DONOR FINANCING IN HEALTH**.

13. TASK 4.7 ■ ACCESSING HEALTH CARE IN SUNRISE STATE, POLARUS
60 MINUTES

- Ask participants to gather in their Polarus groups and allocate a health system issue to each group. Note that these are national issues, not limited to Sunrise State:

  Issue 1: Availability of doctors and nurses for the public health facilities in Polarus

  Issue 2: Access to HIV/AIDS treatment in Polarus

  Issue 3: Decentralized management and decision making for public health facilities in Polarus

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[1]   http://www.oecd.org/dac/aideffectiveness/34428351.pdf

Issue 4: Social health insurance in Polarus

- Refer participants to **TASK 4.7 ■ ACCESSING HEALTH CARE IN SUNRISE STATE, POLARUS** in their Workbooks. They are to discuss the challenges related to the issue assigned to their group and consider what can be changed to improve people's access to their right to health.

- Each group should record their analysis in a grid like this one on a sheet of flipchart paper:

GRID FOR ANALYSIS OF SPECIFIC HEALTH ISSUES IN POLARUS

Key challenges relating to the issue	What should be changed?	Who is responsible for this change?	What will be the 3AQ impact?	What will be the budget implications?
1.				
2.				
3.				

- After 40 minutes, ask the participants to post their chart on the wall, and take a gallery walk to look at all of the groups' outputs.

- Clarify any questions that participants may have. Allow about 20 minutes for the gallery walk and discussion.

MODEL ANSWER

Issue Description: Availability of doctors and nurses in public health facilities:

- What is the doctor-population ratio in Polarus?
- What is the nurse-doctor ratio?
- What proportion of doctors and nurses are in the private sector and public sector?
- What is the extent of migration of doctors and nurses (brain drain)?

Key challenges relating to this issue	What should be changed?	Who is responsible for this change?	What will be the 3AQ impact?	What will be the budget implications?
1. Low doctor: population ratio in Polarus	a) Payment levels and working facilities b) Policy on licensing of doctors being linked to compulsory public service for few years	Ministry of health, ministry of finance and ministry of justice	Greater availability and accessibility of doctors will attract more patients to the public health system and strengthen people's confidence in them	Increased allocations for salary component of the budget
2. Out migration of doctors and/or spatial distribution of doctors across the country	Legislation relating to professional migration, licensing of doctors, compulsory public service, better salaries and facilities	Ministry of health and ministry of justice	Better availability, accessibility and quality of doctors, especially specialists, improved credibility of the public health care facilities	More allocations for doctor salaries, costs of recruitment of more doctors