



# **Health Financing Progress Assessment Report 2020**

Islamic Republic of Afghanistan

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## Abbreviations

ARTF	Afghanistan Reconstruction Trust Fund
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Center
CIT	Corporate Income Tax
CO/CI	Contracting Out / Contracting In
DBD	Development Budget Department
DCP3	Disease Control Priorities 3
DHIS2	District Health Information Software
DH	District Hospital
EPHS	Essential Package of Hospital Services
EMIS	Expenditure Management Information System
EU	European Union
GDP	Gross Domestic Product
GDPA	General Directorate of Pharmaceutical Affairs
GF	Global Fund
GFF	Global Financing Facility
GIRoA	Government of the Islamic Republic of Afghanistan
HEFD	Health Economics and Financing Directorate
HFPM	Health Financing Progress Matrix
HF	Health Financing
HFS	Health Financing System
HMIS	Health Management Information System
HSS	Health Systems Strengthening
HSR	Health Sector Resiliency
ICT	Information and Communication Technology
IRoA	Islamic Republic of Afghanistan
IPEHS	Integrated Package of Essential Health Services
JPPC	Joint Pooled Procurement Committee
MIP	Multiannual Indicative Programme
MoPH	Ministry of Public Health
MoF	Ministry of Finance
MoD	Ministry of Defence
MoI	Ministry of Interior
MoHE	Ministry of Higher Education
MOOC	Massive Open Online Courses
NCD	Non-Communicable Disease
NHC	National Health Centres
NGO	Non-governmental organization
NHA	National Health Account
NSA	National Security Council
OOP	Out of Pocket
PETS	Public Expenditure Tracking Survey
PIT	Personal Income Tax
PHC	Public Health Center
PFM	Public Finance Management
PMO	Performance Management Unit
RGSF	Revenue Generation Strategic Framework for Health Sector
SBC	State Building Contract
SDG	Sustainable Development Goal
SHC	Sub Health Center
SOP	Standard Operational Procedure
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
USD	United States Dollar
USAID	United States Agency for International Development
VAT	Value Added Tax
VHI	Voluntary Health Insurance
WBG	World Bank Group
WHO	World Health Organization
WTP	World Food Organization

## **A. Foreword**

The Health Financing Assessment is based on the MoPH Afghanistan's request to review the progress in implementation of health financing reforms following WHO health financing assessment methodology. The paper is targeted towards the policy makers in MoPH, MoF and other authorities involved in financing of health services both within government and donor agencies.

## **B. Acknowledgements**

Thanks are due to all in-country stakeholders who have contributed to the development of Health Financing Policy Options for Action in Afghanistan, specifically to the Health Economics and Financing Directorate (HEFD) and Policy and Planning in MoPH, MoF and WHO county office in Kabul, WHO EMRO in Cairo and WHO HQ in Geneva. We highly appreciate the valuable advice and technical support from the World Bank, USAID, EU and GFF in Afghanistan. Financial and technical support from the WHO Afghanistan is gratefully acknowledged.

## **C. About this report**

This report is the first assessment of the Ministry of Public Health (MoPH) using the Health Financing Progress Matrix (HFPM). The HFPM comprises a series of questions which reflect both established theory and global evidence about health financing reforms which matter, in other words reforms which have successfully resulted in progress towards UHC. The assessment takes an objective look at whether the way in which health financing is organized in Afghanistan is likely to result in progress towards UHC, and the changes or directions which would support progress. The HFPM captures the key elements of the health financing system and draws on existing analysis and documents. This report is prepared by WHO consultant Mr Dejan Loncar.

## **D. Objective**

The objective of the Health Financing Progress Assessment is to monitor in-country health financing functions and importantly to provide recommendations to facilitate direction and priorities for action. The aim is that the country assesses their current health situation including recent changes, with the use of the financing progress matrix, to capture progress over time. The findings from this assessment can be used to support evaluation and development of health strategies, policies and ongoing reforms.

## **E. Background**

While much progress has been made, Afghanistan is still a very fragile country with a lack of institutional capacities to manage resources, protecting property rights and providing security to citizens. Weak institutional capacities, poor economic development coupled with a fragile political and security situation create a vicious cycle that negatively affects any in-country development process. Afghanistan's health system has been steadily progressing since 2002 with increasing coverage of health services throughout the country. In 2018, a total of 3,135 health facilities were functional, which ensured access to almost 87% of the population within a two-hour distance (WHO). Despite remarkable progress in the improvement of health outcomes, there is a lot of space for enhancing effectiveness and quality of health care and improving the accessibility and affordability of health care to all citizens of Afghanistan. The main challenges of rebuilding Afghanistan's health care system include a lack of

security, low economic development and government investments in health, lack of appropriate infrastructure, difficult access to health care facilities, unsuitable hospital conditions, insufficient quality of care, and few trained health care workers. Health financing of Afghanistan has been characterized by very high OOP health spending, high donor dependence and low government health financing.

## **F. Methodology**

This health financing assessment follows WHO methodology for assessment of health financing functions and key areas. The health financing assessment team, was comprised of Health Economics and Financing Directorate (HEFD), WHO Afghanistan health financing specialist and a WHO health financing international consultant. The WHO team visited MoPH/HEFD in January 2020 with the objective to conduct a health financing diagnostic review, and support MoPH/HEFD in their efforts to improve health financing. The planned deliverables from this assignment are the WHO Health Financing Progress Report, Health Financing Policy Option Paper and an update of the Fiscal Space Analysis. With the support of the WHO Afghanistan country office and MoPH/HEFD the mission met relevant in-country stakeholders, reviewed the direction of health financing reforms and mapped out the exiting financial protection and social health protection arrangements in the country. The primary source of information was the repository of available literature compiled as part of the analysis. The valuable experts' opinions were obtained from numerous individual and focus group interviews of all relevant in-country and regional stakeholders. The findings from the WHO Health Financing Assessment were communicated and validated with the MoPH and other members of Health Financing Working Stakeholder Group.

## **G. Executive Summary**

Since 2002, substantial effort has been made to rebuild an almost devastated health-care system in Afghanistan, which resulted in remarkable progress in the development of a health care system and improving health's outcomes, especially child and maternal mortality. The backbone of Afghanistan's health system is the implementation of BPHS and EPHS that have significantly improved primary and secondary health care coverage and quality of health care. However, this healthcare module is highly dependent on international aid and Government of Islamic Republic of Afghanistan (GIROA) is still not able to take over full financial responsibility for this highly impactful programme. In addition, 75,5% of OOP health spending out of total health spending in 2017 is the biggest concern coupled with low socio-economic status of people of Afghanistan. Due to slow economic development, very high costs of public security and safety and other non-health related government priorities, the government share in health is very low and there appear to be no clear indications that this share will be increased. The MoPH and HEFD have been very proactive and maintain high readiness in the development of key evidence-based analyses and papers to boost health care development and most importantly implementation of health financing policies and reforms. However, in practice the progress has been very slow due to several factors such as: low prioritization of health, lack of legal and regulatory frameworks, insufficient quality of health care, shortage of well-trained and motivated health workforce, absence of an efficient pooling mechanism (e.g. social health insurance) to protect people of Afghanistan from catastrophic OOP health spending, lack of strategic purchasing and existence of inefficient fragmented purchasing, inefficient provider payment mechanisms in public and NGO provider payment mechanisms, lack of consensus between key in-country stakeholders about direction in health financing reforms and frequent delays in financial health flows.

The MoPH and MoF might consider forming a task force group to enable stronger synergies, development results and the enhancement of fiscal space through implementation of recommendations from Strategic Revenues Generation Framework. The health planning, budgeting and operative functions can be reinforced through the application of one health sector work plan and budget and all stakeholders' consensus about key policy reforms. The MoPH with all relevant in-country stakeholders needs to be focused on several key policy reforms to be implemented in a defined timeframe. Purchasing and provider payment functions can be meaningfully bettered in both

public and NGO health care provider sectors to incentivize human resources for health to strengthen quality and utilization of needed healthcare. The government should improve the efficiency of health spending through more strategic purchasing and implementation of public-private partnerships, mostly in regards to medicine and medical equipment.

## **Policy-making**

The policy-making process is highly transparent and inclusive. The policy making process has included all relevant in-country stakeholders. The MoPH and especially HEFD demonstrates high readiness to support the development and implementation of health financing policies and reforms with evidence based studies. Despite all efforts, it appears that progress in implementation of health financing reforms is very slow. In this regard, the MoPH is advised to proactively strengthen advocacy efforts and engage with donors to target and include relevant technical and top decision-making partners in MoF and parliament to support implementation of key health financing reforms that can be achieved in the short and medium time-frames. More specific recommendations are:

- Ensure consensus and buy-in of all key stakeholders (MoPH, MoF, WBG, WHO, USAID, EU, GFF, etc.) related to key health financing policy directions and support to one joint health plan and budget in MoPH to improve overall effectiveness and VfM.
- Support a stronger role of off budget programmes on MoPH strategy and policies which would bring more alignment between on and off budget with all relevant in-country stakeholders.
- Establish a high level committee which will discuss high level health financing priorities, oversee the implementation and results, coordinate decision making on the new health financing strategy 2019-23, monitor programme indicators and give recommendations on off and on budget allocations.
- Maintain high readiness of HEFD in terms of production of high level studies and evidence based papers to support health financing policy development
- Focus on policies that can be implemented in the short and medium term and maintain focus on longer term health financing policy perspective
- Ensure that health financing studies and policies are integrated into a wider health system perspective (e.g. nutrition).
- Improve advocacy and negotiation capacity of MoPH staff at all levels and especially HEFD to engage and implement advocacy efforts defined in Health Financing Strategy 2019-2023. Strengthen the capacities of HEFD staff with activities such as: technical capacity development, sufficient and sustainable funding and number of staff needed to maintain proactive role of HEFD in health financing policy development. The suggestion is to conduct a technical capacity assessment and make a capacity development plan for the HEFD. The MoPH should focus on building capacity in evidence informed advocacy and negotiation.
- Ensure support to the MoPH for the institutionalization of EMIS on primary, secondary and tertiary healthcare levels to support decision making process with real time health expenditure data

## **Revenue Raising**

The government spending on health is very low and despite extremely high OOP of total health spending at 75,5% registered in 2017 (NHA) at this moment there appear to be no clear indications that the government is willing to increase investments in the health sector. In these circumstances, the MoPH is encouraged to continue its advocacy efforts for increasing of government contributions to health and to be more focused on overcoming the barriers for generation of potential revenue from other revenue streams such as earmarked taxation, user fees and donor funding. More specific recommendations are:

- Afghanistan's response to the COVID-19 crisis was to invoke fiscal and monetary measures and reprogramming of existing expenditures towards the health care response. The situation has made policymakers rethink the existing budget allocations across sectors and within the health sector. These re-allocations ought to be seen with consideration of efficiency gains and considered as sources for potential increase of fiscal space of health and optimization of resource allocation within health sector.
- Support joint efforts on a technical level of MoPH/HEFD and MoF in the development of fiscal space and revenue raising analysis and studies to empower advocacy efforts on top MoF decision making level
- Reconsider the feasibility and focus on the barriers to revenue generation options defined in Strategic Revenues Generation Framework and Fiscal Space Analysis with top decision makers from MoF; map a few realistic options to be implemented in short and medium term and establish a work-plan supported by top government authorities. Look into other potential revenue generation sources from the government's budget in various scenarios such as absorption of security and public safety costs once the security situation improves in Afghanistan, through fiscal space analysis.
- Speed up the reforms that will provide predominant reliance on public compulsory funding sources, by designing a system that does not discriminate against the poor and gives financial autonomy to hospitals in order to maximize the efficiency of their resources.
- Strengthen practical implementation of advocacy efforts through engagement with relevant government institutions.
- Regularly update fiscal space for health analysis

## **Pooling**

Apart from the donor payments through ARTF to support the implementation of BPHS and EPHS that can be considered as some kind of prepayment mechanism, there is no pooling function such as social health insurance. However, the MoPH is working on the second phase which is a health insurance feasibility study. The MoPH is encouraged to continue to pave the way for successful implementation of health insurance schemes by removing existing barriers and strengthening data and evidence based analyses. More specific recommendations are:

- Revalidate and ensure in-country stakeholder consensus for implementation of health insurance schemes
- Strong continued engagement in the development of a mandatory national health insurance scheme is vital in order to progress towards universal coverage, which will encompass basic and essential services firstly for the formal sector with cross subsidization.
- It is very difficult to collect contributions for health insurance from the informal sector, which makes up a large piece of the total economy in Afghanistan.. Due to the size of the informal sector, the contributory system in Afghanistan should issue insurance policies to families rather than to individuals. Mandatory health insurance fund should be pooled at a national level to distribute funds more equitably and increase equality of access across regions, improve financial protection and decline informal payments.
- Strengthen the quality of health care through implementation of PPP and increased hospital financial autonomy. The small user fee charges in public health facilities that are directed to MoF increase administrative efforts and costs and doesn't incentivize utilization and quality of health care in public health services. The user fees should be managed by health facilities and if properly used it will serve to its primary objective to enhance quality of health services and rationalize use of medicines and health services
- Gather more information about: i) private provider's capacities and willingness to invest in health sector; ii) informal sector ability to pay for health insurance and iii) poor segment of the population.

## **Purchasing and Provider Payment**

Despite the successful implementation of BPHS and EPHS there is still significant room for optimization and improvement of efficiency and effectiveness of BPHS and EPHS in public health facilities and NGOs. The existence of inefficiencies in purchasing and provider payments as well as constant delays in disbursement of health funds in implementation of BPHS and EPHS affect high OOP health spending, insufficient quality of care and lower utilization of needed health services in remote areas. These lessons are very important to be incorporated in the development and implementation of new IPEHS. More specific recommendations are:

- Conduct health effectiveness analyses to show impact of health financing strategies on health outcomes.
- After identification of low coverage of priority health interventions and poor areas, prioritize and strengthen the demand side of healthcare interventions through the cash transfer programs to ensure the access of the worse off to priority health services.
- HEFD should lead the study to identify, elaborate and address reasons of high OOP health spending.
- Through focused assessment identify and address inefficiencies in delivering BPHS and EPHS such as: lack of medicines, healthcare quality and health coverage in remote areas.
- Support purchaser provider split and the establishment of a single payer for health services under the government guaranteed beneficial package.
- A public-private partnership model should be considered for outsourcing of medicine supply and diagnostic services to the private health sector with negotiated and fixed prices of selected drugs.
- Increase the number of qualified healthcare providers with negotiated prices for less specialized services paid by OOP health spending to stimulate competition among health service providers from both public and private sectors to ensure financial viability quality and efficiency.
- Strengthen the implementation of strategic purchasing functions focusing on the reduction of fragmented purchasing and exploring economies of scale in the procurement of drugs and medical supplies
- Provide extended training for NGO providers of services related to the payment mechanism. The training needs to explain how low financial bids and consequently insufficient or delayed payments in the implementation phase can negatively impact performance and disincentivize health workers

## **Benefits and Entitlements**

The MoPH has developed IPEHS to address current health needs of the population. Several costing studies have been conducted to support the decision-making process. The implementation of IPEHS should be carefully planned to address potential challenges that a new IPEHS model can bring during the implementation phase such as: readiness of health facilities to implement a new health interventions defined in IPEHS (e.g. NCD health interventions), quality of healthcare of new interventions and availability of skilled, motivated and sufficient number of human resources for health to implement IPEHS healthcare interventions, costs of new healthcare services. More specific recommendations are:

- Support HEFD in conducting a health effectiveness analysis to assess effects of BPHS and EPHS on health outcomes (e.g. incidence) in one province and address how coverage and quality of services can be optimized.
- For the sustainability and effectiveness of the health services and optimum



design of the benefit package an understanding of the drivers of OOP is required, with regard to the urban and rural areas.

- Continue the development of IPEHS to address all weaknesses in the implementation of BPHS and EPHS. Due to a new scope of IPEHS, strengthen planning and piloting stage of implementation of IPEHS. The implementation of IPEHS should be carefully planned to address potential challenges that a new IPEHS model can bring during the implementation phase such as: readiness of health facilities to implement a new health interventions defined in IPEHS (e.g. NCD health interventions, etc.), quality of healthcare of new interventions, increased costs of new healthcare services and availability of skilled, motivated and sufficiently numbered human resources for health to implement IPEHS healthcare interventions.
- Update current IPEHS costing analysis and set up a system to regularly monitor and evaluate health expenditure growth due to implementation of IPEHS.

## **Public Financial Management (PFM)**

The MoPH has conducted three PETS so far. The last PETS was performed in 2019, with the scope of 2017-2018. The PETS has assessed just a part of PMF functions and addressed certain barriers such as: a long and timely budget process, inconsistency in budget and expenditure data between MoPH and NGOs, limited hospital autonomy and capacity in procurement processes, delays in procurement and unpredictability of expenditures that affects budget planning process. More specific recommendations are:

- Ensure that the budgeting process is inclusive and identify and mitigate reasons for lateness of the disbursement of funds; the last PETS indicates that NGOs have been included in the budget forming process, though more attention should be paid to this matter
- Make budget data more transparent
- MoPH, together with MoF, perform a PFM assessment in the health sector
- Strengthen EMIS to monitor tracking of health financing flows in real time Consider implementation of blockchain information technology placing the patient at the center of the health care and increasing the interoperability of health data.

## **Governance**

The MoPH is encouraged to establish technical and task force groups to work closely with the MoF. The advocacy papers developed by the MoPH are highly appreciated, but what may be perceived as missing is the proactive engagement on all levels towards other ministries and especially towards parliamentarians and media for materialization of targets defined in advocacy documents. The HEFD is a main gear for initiation and implementation of health financing reforms and needs more sustainable financial support. More specific recommendations are:

- Strengthen communication and inclusion of parliamentarians in key health financing debates
- It is recommended that a technical capacity assessment is conducted and subsequently a capacity development plan made for the HEFD unit.
- Ensure and strengthen HEFD staff with activities such as: technical capacity development, sufficient and sustainable funding and number of staff needed to maintain proactive role of HEFD in health financing policy development
- Maintain strong advocacy efforts

## H. Detailed Health Financing Progress Matrix assessment

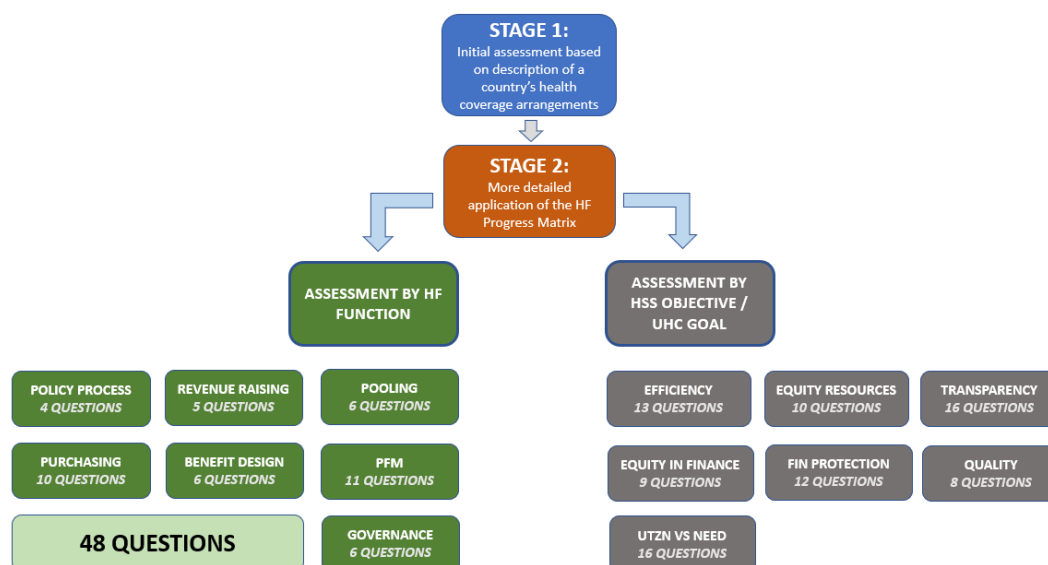
Over the past year WHO, together with its partners, has developed the Health Financing Progress Matrix that represents a set of questions, organized around several matrices, which in turn are based on the health financing functions of revenue raising, pooling, purchasing and benefit design. An additional matrix has been developed to assess the policy development process, public financial management, and governance issues in health financing in a country. The principles embedded in the Health Financing Progress Matrix are built around WHO's functional approach to health financing, and represent a set of evidence-informed hypotheses about the key attributes of health financing arrangements associated with progress towards UHC. WHO recommends applying the matrix in two stages: the first is an assessment and a descriptive overview of the different health coverage schemes in a country, outlining the key features of each. In the second stage, the questions of the matrix are completed.

The following provide the stages and details of financing using HFPM:

**Stage 1** overview of health coverage schemes: the first step of the HFPM assessment is to produce a description of the main health coverage schemes in IRoA. This allows the landscape to be mapped out, can identify areas of incoherence across the health systems in terms of benefit entitlements, the incentive environment for providers etc. and provides an important reference for Stage 2.

**Stage 2** detailed health financing system assessment: it is recommended particularly for the first baseline assessment to follow the functional approach to the HFPM assessment.

## Health Financing Progress Matrix



### Overview of health coverage schemes in Afghanistan

In the context of persistent insecurity and political tensions, slow economic development, weak public financing, and high dependence on donor aid, Afghanistan is among one of the most challenging countries to achieve universal health coverage (UHC) in. Despite many efforts to improve key elements underpinning UHC there is a lot of room for the achievement of an efficient and resilient health system; affordable

care and sufficient health financing; access to essential medicines and technologies; sufficient, skilled and motivated health workers; efficient and functional administrative and governance arrangements; and transparency in tracking progress and achieving equity.

The free provision of basic health services to all citizens of Afghanistan indicated in the Constitution was clarified. Primary healthcare is free for all citizens of Afghanistan. User fees have been introduced to cover healthcare costs on secondary and tertiary healthcare levels. The primary, secondary and tertiary healthcare coverage in Afghanistan has been provided through various types of health facilities on provincial, district and federal levels such as: health posts, sub-health centres, mobile health teams, basic health center, comprehensive health center, district hospital, provincial hospital, regional hospital and national hospital. The primary and secondary healthcare are provided by BPHS and EPHS on a provincial, district and federal level. The EPHS is limited to Provincial and Regional Hospitals. The tertiary healthcare level is provided by public hospitals. The Basic Package of Health Services (BPHS) in Afghanistan, launched in 2003, represents the approach taken by the Government to promote free universal coverage at the primary-health-care level across the entire country. The BPHS strategy emphasised priority access to the groups in greatest need, especially women, children, people with disabilities, and those living in extreme poverty. The Essential Package of Hospital Services (EPHS) has been introduced to provide a standardized package of hospital services at each level of hospital, guide the MOPH, private sector, nongovernmental organizations (NGOs) on how the hospital sector should be staffed, equipped in terms of materials and drugs, and promote a health referral system that integrates the BPHS with hospitals. A new IPEHS package will be introduced to better address population needs in terms of utilization of health services, quality and accessibility.

## MoPH's Policy Development Process

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*Q1.1 Has an in-depth diagnosis or assessment of your health financing system been conducted recently which examines the impact on health system performance along with the causes of performance problems?*

Despite many challenges faced, MoPH with other in-country stakeholders has managed to make certain progress and improve population and individual health outcomes. Quality and responsiveness of the Health System (HS), coverage and equity were mainly improved through the introduction of Basic Packages of Health Services (BPHS), Essential Packages of Hospital Services (EPHS) and contracting out to the NGO service delivery mechanism. However, there is still significant room for improvements in the areas of: revenue collection and PPP structural arrangements, pooling and financial protection, strategic purchasing, provision of healthcare services, provider payment mechanism to incentivize quality and coverage of healthcare, public financing management and productivity such as allocative and technical efficiency and labour productivity.

The Ministry of Public Health (MoPH) - Health Economics and Financing Directorate (HEFD) has developed a series of Health Financing (HF) studies, policy documents, strategies and rapid assessments. This rapid assessment was conducted as part of the MoPH effort to revise its five-year healthcare financing strategy 2019-2023. Most of HF activities of MoPH have been focused on evidence based analyses, policy and reform development, advocacy, capacity building and strengthening main HF area of work: revenue generation and pooling, purchasing, private-public partnership (PPP), provider payments and public finance management (PFM). However, the implementation of recommended policy options has been slowed due to several factors: a weak macro-economic situation and insufficient government investments in health, lack of political willingness to support HF reforms, inadequate law and regulatory environment, poor security levels and low institutional and technical in-country capacities. The MoPH/HEFD has developed the Health Financing Policy 2012-2018 and Health Financing Strategy 2019-2023 based on an assessment of the current health financing situation. Several evidence-based studies have analysed the efficiency and equity to inform decision makers about effects of current policies, ongoing reforms coupled with studies that presented various policy options and investment cases. The HEFD has conducted Basic Package of Health Services (BPHS) and District Hospital (DH) Efficiency Study to assess utilization, expenditures and efficiency of healthcare service provided. The National Health Account (NHA) has been conducted to estimate health financing data in 2011/12, 2014 and 2017 with a plan for another round of NHA to be conducted in 2020. The NHA in 2017 has disclosed some worrisome information about very high out-of-pocket (OOP) expenditures at 75.5 % of total health expenditure that has been addressed in several policy documents. HEFD has developed a MoPH revenue generation strategic framework and conducted fiscal space analysis to identify potential revenue sources and generate additional funds for health. In order to actively engage with relevant stakeholders on generation of revenue the MoPH developed its advocacy plan of action. MoPH for the first time developed a costed national strategy to identify how much is required to fully deliver the strategy and what are the financial gaps. The MoPH, with the support of the GFF Secretariat and its partners, is currently developing an investment case for Afghanistan to improve efficiency of current financing, increase donor financing and support advocacy effort through domestic resource mobilization. However, the health effectiveness analyses to show impact of HF strategies on health outcomes haven't been conducted yet.

*Q1.2 Is there an up-to-date policy statement related to health financing, which has been converted into relevant legal documents/government orders?*

The MoPH national health policy 2015-2020 highlights challenges associated with high OOP health spending that puts people at high risk of catastrophic health expenditures and inefficiency characterized by the low execution of available funds. The policy statement "The health financing and revenue generation policy of the Ministry of Public Health is to increase the efficiency and equity of public spending, improve financial risk protection and reduce dependence on international aid." clearly highlights the need to improve the health financial situation. Support to health financing is in the focus of the national health strategy under Strategic Area 2: Institutional Development. Despite all efforts, no adequate resources have been devoted to support building the MoPH capacity in health financing. Even though MoPH has developed several policy papers to stimulate top level policy makers to initiate adaptation of laws and legal frameworks, only limited progress has been made in this area: i) the "free" provision of health services and facilities to all citizens of Afghanistan indicated in the Constitution was clarified and specified in the health law. The "free" provision of primary health services and facilities to all citizens of Afghanistan indicated in the Constitution is still relevant; ii) the legal and regulatory framework has been adapted for application of user fees on secondary and tertiary health level; iii) significant progress has been made in legal and regulatory environment which allows purchasing of BPHS and EPHS on primary and secondary level from NGO providers; iv) a private-public partnership legal document has been signed by parliament to enable implementation of PPP. Apart from these successfully implemented legal adoptions, there are several policy initiatives that are waiting to be approved: i) adoption of law for implementation of earmarked taxation; ii) health insurance law and regulatory framework that are currently in the process of adoption in MoJ; iii) supportive legal and regulatory framework for full financial autonomy of health facilities. Although the legal framework has been adapted for the application of user fees in public health facilities on a secondary and tertiary healthcare level, all generated revenues from user fees according to current public expenditure and financial management law must be directed to a central MoF revenue account. Thus, the effect of user fees is more favourable for general revenue account of GIRoA than for health revenues. Inability of public health facilities to manage and benefit from user fees demotivates hospital healthcare providers to improve quality of healthcare. The tertiary health facilities have been credited with certain but not full financial autonomy. In addition, public hospitals still operate under the rigid line item budget which is inefficient and gives little leverage and incentives for the hospitals to improve quality of services and healthcare coverage. In order to achieve efficiency gains in hospital management, improve healthcare outputs and outcomes and benefit from the current reforms in health sector, the PFM needs to be improved to support hospital financial autonomy. The Health system resiliency (HSR) supported MoPH to start a user fees system in 28 tertiary and specialty hospitals in Kabul and provinces. As of March 2019, the user fees had generated more than 41 million AFS for MoPH.

*Q1.3 Does a system exist to routinely monitor health financing, and are data used to track progress (e.g. on expenditure patterns and financial protection) and to strengthen public accountability?*

The MoPH has started the production of NHA and several NHA exercises have been conducted to estimate health expenditures data. The evidence from NHA has been used in several policy documents to emphasise high OOP and analyse patterns of health expenditures by HF schemes and functions. The expenditure management information system (EMIS) has been employed to systematically monitor HF expenditure flow while HMIS is deployed to track health output data such as utilization of health service. The objective of EMIS is to enable the MoPH to routinely and in real time monitor health financing and expenditure data. An improved monitoring and tracking system has reduced the likelihood for corruption and delays

in payments and strengthened public accountability (MoPH RGSF, 2018). However, these systems can be improved as they still don't provide real time information. In December 2018, the MoPH conducted a Health Center Efficiency Study to make linkages and mapping between the expenditure management information system (EMIS) and health management information system (HMIS). The study findings suggest that there is room from improving the efficiency at both health primary health care facilities and at hospital level. The three PETS studies that were conducted in Afghanistan were performed to assess health expenditure flows and provide recommendations to strengthen public financing management and overall public accountability. The latest PETS was performed in 2019, which addresses certain bottlenecks in PFM. The comprehensive assessment of Health Information System (HIS) in Afghanistan was conducted in 2018 to address barriers and propose improvement in the system. There is a clear need for real time health expenditure information from EMIS from primary, secondary and tertiary levels.

*Q1.4 Are evaluation studies undertaken on a systematic basis to assess the implementation of specific health financing reforms and their consequences for policy objectives, and are findings used to inform the design & revision of health financing policies?*

The Health Center Efficiency Study in 2018 used healthcare utilization, human resource for health (HRH) and health expenditure data to examine the variation of performance of service delivery focusing on BPHS in Basic (BHC), Comprehensive (CHC) and Sub Health Centres (SHC) and identified factors in determining the efficiency to enhance the value for money in using MoPH resources. In total, 272 CHCs, 571 BHCs and 420 SHCs were included in the analysis. The study showed high average efficiency score for CHCs was 90%. However, the average efficiency scores for BHC and SHC were 78.7% and 73 %, respectively, suggesting that there is a room for potential efficiency gains. Similarly, the District Hospital Efficiency Study Analysis was conducted in 56 District Hospitals in 2018 to assess technical efficiency of District Hospitals. The result showed that assessed District Hospitals have high technical efficiency estimated in average at 0.95. Despite the progress in improving the overall health status, inequality and inequity of use of health care have been an increasing concern in Afghanistan. The Afghanistan Living Conditions Survey 2016/2017 data was reanalysed to assess status of equity in using health care services. Based on this study An Equity Analysis of Health Service Utilization in Afghanistan was done in 2019 to assess the use of inpatient and outpatient care by wealth status, marriage status, age group, gender, and education. To conclude, the assessments of specific segments of HF reforms have been conducted to improve healthcare settings in various health facilities. The practical implementation of these findings has been limited, however, it is expected that results from these studies will be incorporated in implementation of IPEHS.

In the past 15 years, there have been major health financing reforms in Afghanistan. These included: i) contracting out (CO) and contracting in (CI); ii) results based financing (RFB); and iii) introduction of the BPHS and EPHS. According to a study (Alonge O. et al.) that examined the distributive effect of different contracting types on primary health services provision between the poor and non-poor in rural Afghanistan, CO arrangement was effective in improving equity of health services provision. Under this arrangement, contractors were allowed to decide on how funds are allocated within a fixed lump sum with non-negotiable deliverables, and which was actively managed through an independent government agency. The available literature asserts that RBF can increase utilization of services and promote equity. Yet the evidence for RBF or Pay for Performance (P4P) is mixed. In the early stages of implementation, contracting for health came with a substantial increase in curative care use. Later on, the P4P did not improve the motivation of healthcare workers. It might have been due to the miscommunication of the intervention to the targeted healthcare workers. One study showed that the performance bonuses were not a part of neither the operational budget nor the salaries (Chashin C. et al.). A considerable body of evidence underpins the fact that the flow of money to health facility and the heterogeneity of the budget allocated to healthcare workers might have deprived workforce from receiving the

incentives they deserved. In 2010, HEFD worked jointly with consultants from EPOS Health Management in undertaking a cost efficiency study from the provinces of Jowzjan, Kapisa, Kunduz, Panjshir, Parwan, and Samangan to examine possible alternative directions in both financing and provision of the BPHS (ECORYS and EPOS Health Management, 2010). This study provided analyses of unit cost and utilization data of BPHS services and will further examine technical efficiency at the facility level as another means of exploring the impact of contracting “in or out” on outputs and resource allocation in the health sector.

## **Revenue raising**

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*Q2.1 What is your country’s approach to developing revenue raising policies and strategies, within an overall process of policy development and implementation planning for health financing?*

The macroeconomic situation in Afghanistan has been characterized by volatile fiscal sustainability and deteriorating investment confidence due to a poor security situation, with growth slowing to 1,8 % in 2018 (World Bank 2020), and low GDP per capita at 513 USD (IMF). There are a few additional factors that have been placing additional pressure on the health budget and health system in Afghanistan such as the poor security situation, increasing population growth and shortages of qualified human resources for health. The share of the government health budget from the central government budget was 4.2 % in 2019 (HFS 2019). The percentage of public health expenditure and domestic public health expenditure out of total health expenditure in 2017 was 5.1% and 2% respectively (NHA, HFS 2019). The 19.4% of total health expenditures and 58.3% of total government expenditure came from foreign financing (NHA 2017); The total health spending per capita in 2017 remains low at 81 USD where 75.5% of total health expenditures are OOP health expenditures and 10% of OOP health expenditures were incurred abroad; Household expenditures on medicines and diagnostics were estimated at 47% and 35% respectively in 2017. Health expenditure in 2017 pushes approximately 14% of households into poverty, with an overall poverty rate of 54% in the country. (NHA 2017). The MoPH continues to put strong advocacy efforts to increase government health allocation of at least 5% of GDP recommended by WHO and projected target of 6% of total health expenditures by 2023 from 2 % recorded in 2017 (HFS 2019). In Afghanistan, MoF is responsible for overall revenue collection and revenue is generated at three levels: national, provincial and local. National tax revenues are derived from two major taxes: personal income tax (PIT), corporate income tax (CIT) under centralized control of MoF. VAT tax does not exist in GIROA.

In attempt to raise revenues MoPH/HEFD has developed several policy papers and strategic frameworks:

- “Health Financing Policy 2012-2020” focused on the generation of domestic resources for health through taxation and prepayment mechanisms;
- Policy brief statement 2016-4 “Revenue collection and management - A Challenge to the Afghan Government” outlined revenue collection challenges and proposed various policy options;
- “Introducing Earmarked Taxes for Health in Afghanistan” developed in October 2017, to elaborate experience of other countries in the introduction of earmarked taxes, recommended acceleration of implementation of earmarked taxes and estimated potential financial gains and price elasticity from earmarked tobacco, vehicles and fuel taxes. It appears that despite all efforts of MoPH/HEFD, there appears to be no intention by the MoF to create the legal environment and earmark any of proposed taxation for Health;
- The “MoPH Revenue Generation Strategic Framework for the Health Sector (RGSF)” was developed in November 2018 to back up the “National Health Strategy 2016-2020”. The RGSF outlined strategic frameworks for raising

revenues and set up very ambitious targets;

- “Rapid Assessment of Health Care Financing in Afghanistan” developed in Dec 2018 to assess HF functions and provide performance evaluation of HF Strategy 2014-2018. The assessment has identified that out of 50 activities under 6 strategic directions and 16 relevant strategic objectives, 22 were successfully completed (44%) while the rest were in progress or not initiated at all. Many of incomplete activities and objectives from this strategy are still relevant and are incorporated in HFS 2019-2023;
- Health Financing Strategy 2019-2023 developed in 2019 outlined Strategic Directions and Objectives and promoted efficiency gains in each Strategic Objective including performance monitoring framework with baseline and targets.

The MoPH/HEFD has been working in parallel on all critical areas and has managed to maintain a high level of readiness to support the government in policy health reforms. In addition, the importance of revenue raising and increased fiscal space for health to reduce very high OOP have been strongly emphasised in both HF Strategies 2014-2018 and 2019-2023. The MoPH has been exploring commonly used and innovative mechanisms for revenue raising through: an increase of the share of health from central government revenue by giving higher priority to health in government budgeting; implement earmarked taxation for health; increase predictability of financing, maintain current and even raise additional external funding; apply progressive user fees; increase of absorption capacities; maximize the use of existing resources - efficiency gains; implement VAT; tobacco taxation and utilize Zakat and Takaful funding. The introduction of a value-added tax (VAT) has been postponed because government authorities and the IMF are working to strengthen revenue administration and governance before introducing it.

However, it appears that the MoPH needs more support and political willingness from top decision makers to benefit from proposed revenue generation schemes. During the HFA in-country group stakeholder meeting a few promising strategies were discussed. It was concluded that the MoPH/HEFD should pave the way from policy development to action by including parliamentarians in lobbying and advocating, strengthen collaboration between the MoPH and the MoF on various technical levels to enable mutual understanding and effective advocacy effort on higher level, proactively implement advocacy action plan and integrate HF policy development with other health system components. There is a need to improve advocacy and negotiation capacities at all levels of the MoPH, especially at the HEFD. HEFD should remain the institution behind all health financing efforts, and its capacity should be sustained and strengthened. The Afghanistan London conference paper “Realizing Self Reliance” (MoPH, 2014) provides evidence that Afghanistan is proposing short term solutions to ensure its financial sustainability. The Health Sector Resiliency (HSR) project is project supports the Government of Afghanistan to foster a stronger and increasingly self-reliant health system. One of its objectives is to support the MoPH to implement the World Bank-funded System Enhancement for Health Action in Transition (SEHAT) and sub sequent (SEHATMANDI) initiatives. As such HSR advocates for the MoPH to MoPH to advocate and implement strategies to increase the health budget (health facility user fees and possible tobacco tax), HSR developed user fees guidelines as well as a user fees exemption guideline to alleviate financial hardship. The guidelines will enable MoPH to properly implement a user fees system. However, user fees have been previously shown to have limited beneficial effects due to centralization of these funds to MoF, thus, if this strategy were to be implemented, caution need to be taken in to account. The Health Financing Strategy provides clear directions toward strengthening of main health financing functions and areas of work that are pre-requisite for improvement of quality, accessibility and affordability of health care and health system strengthening efforts initiated by donors.



*Q2.2 To what extent does health financing in your country rely on public/compulsory funding sources (e.g. taxation/public revenues, including mandatory contributions for national/social health insurance)?*

According to the Afghanistan Public Finance and Management Law, the central government revenue is collected and pooled into a single government account managed exclusively by the MoF. In such circumstances, coupled with a lack of political willingness to put into action the increase of government investment in health, there is limited space for manoeuvre for the MoPH to increase health revenue and benefit from various pooling options. The Afghanistan Reconstruction and Trust Fund (ARTF) is a multi-donor trust fund through which the donors' nondiscretionary funds for health are being channelled, via the MOF. The health financing of IRoA has been characterized by very high OOP spending, high donor dependence and low public government health financing. Since the public financing management is not well aligned with the goals of health financing, the shift from out of pocket expenditure to compulsory sources of funding has been very slow. From this perspective, moving forward, there are no clear indications as to when and if a health insurance scheme or earmarked taxation will be implemented. The MoPH has developed its revenue generation strategic framework identifying new sources of revenue that could be earmarked for health. According to the recent revision to the strategy, around USD 112 million can be generated should the strategic framework be fully implemented. The MoPH identified areas of weakness related to increasing revenues for health and implementing the health financing reform. However, MoPH staff charged with the budget negotiation often do not possess the required negotiation and advocacy skills. In addition, managing relations with the MoF and other stakeholders with strong potential to influence policies, including the parliament and cabinet remains a challenge. Therefore, among other suggestions, we recommend WHO to help the ministries of health including Afghanistan MoPH with courses on the above topics and any other skills helping the health financing experts to operate with the highest efficiency. MOOC, face to face and other tested and effective mediums would be highly welcome.

*Q2.3 To what extent is public funding for health in your country predictable over a period of years?*

The public financing in IRoA is highly dependent on donor funding. Since the donor funding is around 78 % out of government plus donor financing (OOP health spending excluded) to the health sector (NHA 2017), its predictability depends on how well the MoPH priorities are aligned with those of the donors. In this context, it is very important to align donors and government goals and visions in health sectors and develop one budget and work plan for health. In addition, inflation and the unfavourable exchange rate of USD to Afghani negatively impacted domestic public health budget. In the short term, public domestic health financing is relatively stable with some fluctuation, but still extremely low. However, in the medium and long term there is high unpredictability of public health funding. The GIRoA has very limited space for manoeuvre to support health allocation from government revenues due to low economic development and government priorities such as security and public safety. An improved security situation in Afghanistan would provide more opportunity for domestic public health funding to grow through increased general revenue and decreased share of security costs in the government revenues. The National defence and security and public order and safety consumed 41.6% of government budget in 2019 and it is projected that 41.8 % government budget will be used in 2020 to cover these costs. One of the promising revenue raising strategies of the MoPH is to develop various scenarios to absorb part of the security costs, once the peace agreement is reached in Afghanistan. The Investment case, Return on Investments studies and Fiscal Space Analysis can help the MoPH to present these options to the MoF and increase the currently very low contribution of government to the Health Sector. To conclude, it seems that the present allocation of GIRoA budgets will stay constant without any clear indication

that the share of government spending to health will increased. Due to the very fragile situation in the country it would be useful to have a certain amount of reserve funding in the account earmarked for health to serve as a buffer in case of fiscal shocks. ODA received per capita in Afghanistan is 102 USD in 2018 (World bank 2020). Afghanistan is one of the world's largest recipients of international aid, however, International assistance for health is expected to be reduced.

*Q2.4 To what extent is the flow of public funds stable, as a result of regular execution i.e. timely release of funds in line with approved health budgets?*

The government budgets are released on a quarterly basis, based on approved funding from the MoF, where budgets for salaries are typically released on time. The longest delay in the processing of funds happens in the beginning of the project when funds need to be transferred from the donor to GIROA's special accounts. Depending upon the approved budget there is evidence generated through PETS 2014 that there are some delays in budget releases to health facilities on secondary and tertiary levels. The PETS 2019 reported that national hospitals experienced very long procurement times of up to almost two months on average. Interviews with key informants of the study suggested very long delays in the receipt of medicines and supplies in hospitals and BPHS services which is a main reason of high OOP spending on medicines. In addition, budgets for contracting out NGO providers for BPHS and EPHS can often experience delays. As the PETS 2019 states, the main reporting challenge was with the delays in the approval of budget. It appears that due to unavailability of data, PETS 2019 haven't been able to quantify delays from MoF and MoPH to NGOs. The key informants of the study reported delays specifically during budget approval by the Parliament, which have then overflowed to delaying payments at the beginning of the fiscal year, delays in the ability of the MoPH and NGOs to procure supplies and medicine on time and delays in salaries for health workers. Further delays were reported when the MoPH makes a budget request to the MoF and the forms are not completed properly. Delays for salaries were between one and five months. Delays in payments to NGOs were also mainly at the start of the fiscal year. Based on the communication we had with our account colleagues, it takes some time at the beginning of the project until the fund is transferred from the donor to the government of Afghanistan's special accounts. Afterwards, the payments get more regular depending on the approved budget. Chances for delay and irregularities also exist when transferring funds from the government accounts to the NGO providers and contractors. The problems vary depending on whether the development budget is discretionary or nondiscretionary in nature with more chances for delay or fund shortage when the project is under a discretionary funding arrangement. Shortage of funds was mainly an issue at the MoF level, which led to delays in the budget chain down to the hospital level. There is a communication gap between the MoF and MoPH.

*Q2.5 To what extent are the different revenue sources raised in a progressive way (i.e. based on capacity to pay), and hence promote equity in the way the health system is funded?*

Despite the strong advocacy efforts of MoPH to implement Health Financing Strategies and reduce the very high OOP health spending, this still hasn't materialized. In circumstances of low ability to pay for health services, an already high share of OOP health spending and low reliance on public revenues support when accessing private healthcare facilities, we consider that revenues raised are medium to highly regressive and inequitable. The Equity Analysis of Health Service Utilization report has been published that to address substantial inequality in using inpatient and outpatient care in Afghanistan. According to the Afghanistan Health Survey 2018, only 59% of the women are assisted by SBA in their deliveries, and only 61% of children are immunized with Penta-3. There are substantial inequities in service utilization across urban/rural areas, wealth quintiles and level of

education. The Afghanistan Health Survey 2018 shows that main drivers of out-patient health care are: drugs and supply, transportation and diagnostics, retrospectively, 39.5 %, 10.5 % and 5.9 % of total health expenditures. In in-patient health care settings, these costs are: 42.4%, 13.5% and 7.2%. To support revenue raising in progressive way MoPH should work more closely with relevant stakeholders on introduction of social health insurance, introduction of earmarked funds from goods with negative externality on health and bringing more donor off budget funding on budget to improve efficiency in financing. In addition, as suggested in MoPH Fiscal Space Analysis 2016, GIRA should reprioritise health budget.

## **Pooling Revenues**

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*Q3.1 Please summarize the key characteristics of the different health coverage arrangements in your country.*

There are various funding pools from which the government finances, purchases and provides services to the people of Afghanistan. Ministry of Interior, Ministry of Defence, National Security Agency, Ministry of Higher Education, Afghanistan Red Crescent Society and Ministry of Public Health each have an individual share in the government budget. The Ministry of Public Health receives funding from the MoF from two sources: development and ordinary budget. The development budget finances the Basic Package of Health Services and Essential Package of Hospital Services through contracting out arrangements with NGOs in 31 provinces and contracting in (the MoPH SM) in 3 provinces and a network of hospitals under the MoPH Hospital Reform Project. Under the contracting out model, the MoPH plays its stewardship role including design of benefit packages, target setting and performance management, while the delivery of services is fully the responsibility of contracted NGOs. Under the MoPH SM contracting arrangement the MoF provides financing (both donor and domestic revenue), while the provincial MoPH performs both service delivery and monitoring and evaluation. The hospital reform is another arrangement the MoPH has made for delivery of hospital services in the provinces. There are also off budget projects financed directly by the donors. In order to strengthen planning and budgeting processes, benefits from efficiency gains and improve overall effectiveness of health programmes, the MoPH, together with in-country stakeholders, has initiated the creation of off budget mapping, an initiative to develop a joint plan of action and align and coordinate donor and government investment in health.

*Q3.2 What is your country's approach to arrangements for pooling revenues, within the overall process of policy development and implementation planning for health financing?*

In the most recent Health Financing Strategies (HFS) 2014-2018 and HFS 2019-2023, the Ministry of Public Health has encouraged transition from fragmented pooling to mitigate health system inefficacy and reduction of high level OOPs through the introduction of a prepayment arrangement. The Afghanistan Reconstruction Trust Fund (ARTF) administered by the World Bank is a pool of funds from several donors to be potentially used as support funding for the development of prepayment mechanisms. This has been deemed as a good start for the establishment of large-scale pools. The MoPH has recently joined the core Global Financing Facility (GFF) initiative. The main purposes of this initiative are improving technical and allocative efficiency, better alignment of off budget donor support, increasing domestic revenue generation, and improving predictability of donor funding. The MoPH has developed a health insurance law with the intention of

establishing social health insurance, while keeping options open for the introduction of private health insurance. However, due to lengthy procedures this law hasn't been approved yet. In addition, there is a certain reserve and lack of consensus between in-country stakeholders (e.g World Bank) for the implementation of health insurance at this moment. The MoPH has finalized the first phase of health insurance feasibility study assessing stakeholder interest, policy options and capacity to operate health insurance. In collaboration with the USAID financed HSR Project, HEFD has conducted the second phase of the health insurance feasibility study with the focus on key design features of health insurance such as benefit packages and premiums. The project has supported the MoPH to conduct work on WTP study analysis and actuarial analyses. The MoPH is currently carefully analysing the options and recommendations and deciding on a future course of action regarding the development of health insurance. The implementation of relevant health insurance premiums might be a challenge in the context of Afghanistan due to the very low ability to pay of the people of IRoA, a large informal sector and low government public health spending per capita. Still, the MoPH is facing certain barriers in the process of development of health insurance such as: inadequate laws and regulations, unstable political support, insufficient health care quality, low affordability and lack of identification of poor segment of population and targeted subsidization.

*Q3.3 To what extent are there limits to the re-distributional capacity of prepaid funds in your country, which arise from health financing institutional arrangements?*

According to GIRoA's constitutional law, primary healthcare is free for all persons with citizenship of IRoA. Primary health care is delivered through BPHS and EPHS, through ARTF, which demonstrate certain redistributive capacities. Thus, funding allocated to both BPHS and EPHS are pro-poor in utilization without any prepayment mechanism. The private health sector has grown very rapidly over the past one and half decades, with most of the providers administering primary healthcare, as well as other levels of care. The payment to private healthcare is made privately out of pocket at the point of service. Since OOP health spending is the biggest source of health financing, coupled with significant donor contribution to cover BPHS and EPHS and very low domestic public investments in health, the space for manoeuvre for any redistribution capacities is very limited. Social health insurance as a prepayment mechanism does not exist in Afghanistan. However, donor payment through ARTF can be considered a prepayment mechanism, but with very limited redistribution capacity. Furthermore, the government also provides financial support to other ministries to deliver health services and hence create small fragmented pools with limited redistribution and risk bearing capacities. Finally, off budget donor support directly contracted with international organizations, usually covers high indirect cost, reducing the amount of direct funds for services delivery and creates additional barriers to improving efficiency and pro-poor targeting. In order to strengthen the redistribution capacities, the MoPH has been working on various strategies to raise the revenues for health and establish health insurance mechanisms. To conclude, the prepayment mechanism is limited and focused on donor support through ARTF.

*Q3.4 To what extent are there measures, related to benefit design, provider payment, or non-financial underlying systems, that address problems arising from fragmented pool?*

There is a minor number of fragmented underfunded pools that are based on tax revenue and prepayment mechanisms, that do not leave room for redistribution. The main financing pool is limited to donor support through ARTF. This major pool, provided by Sehatmandi project, supports delivery BPHS and EPHS as two explicit packages that the government provides to its citizens. The new IPEHS has been designed from integration of BPHS and EPHS in the light of DCP3 recommended priorities for low income countries to address challenges with the growing new burden of diseases such as NCDs and injuries. The IPEHS consists of an expanded list of health services to address NCDs and injuries and other essential health services. The IPEHS has been already developed, still not in use, to replace BPHS and EPHS and better address population needs in terms of utilization, healthcare quality and affordability. Both BPHS and EPHS providers are paid on a performance basis, a lump sum payment schedule in exchange for achieving certain target outputs and outcome indicators. The MoPH, in collaboration with the World Bank, has developed payments to the NGOs on a lump sum and on a fee for service basis for the provision of targeted services low in utilization. A third party is established to carefully measure performance against targets and verify the NGOs performance reports provided through self-reported Health Management Information System (HMIS). The Performance Management SOP of - Sehatmandi project and ToR - Third Party Monitoring and Evaluation for the Sehatmandi Project developed by MoPH provides detailed instructions both for providers and the client.

*Q3.5 To what extent are different revenue sources and funding streams organized in a complementary manner, for the purpose of financing a benefit package for the entire population.*

The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) are aimed to cover the whole population especially those in the rural and underserved areas. There are also a number of hospitals at the national level, each providing secondary and tertiary services to the people who access them. The ARTF is a funding pool to finance delivery of BPHS and EPHS under 31 provincial contracts with NGOs and in three Ministry of Public Health Strengthening Mechanism (MoPH-SM) provinces where the MoPH delivers services. Part of the finances for the MoPH-SM provinces comes from the GIROA domestic revenues. The hospital reform project, financed from the government development budget, finances and manages around 11 regional and provincial hospitals which are not financed by Sehatmandi project. Apart from this, a number of health facilities in insecure areas have been supported from humanitarian aid by the off-budget donors and technical partners. GAVI and TGF provides funding for TB, Malaria and HIV/AIDS and for health systems strengthening (HSS). Donor financing is welcome and appreciated by the Government, however, there is an urgency to be focused on insufficient domestic finances. The government allocations to national and specialty hospitals are made from the ordinary budget. Off budget technical support is also being provided to the health facilities staff of targeted provinces to ensure that services delivered are of sufficient quality and to be effective. These technical support projects are designed jointly by the MoPH and donors and financed by off budget donors aiming to complement the BPHS and EPHS as well as provide support to the national hospitals for quality improvement including provision of on the job training to doctors and nurses as well as some needed supplies.

*Q3.6 To what extent are voluntary health insurance (VHI) arrangements a source of inequity, creating potentially harmful spill over effects for the wider health system?*

Since health insurance is in the development stage in Afghanistan, private voluntary health insurance is not yet a common risk pooling scheme. There are some isolated cases of national or international organizations that insure their staff with private health insurance but the scope, packages and premiums are not analysed. There is no study or evidence of inequities resulting from voluntary health insurance arrangements.

*Q3.7 To what extent are fund flows incoherent and duplicative, limiting the potential to use the government budget and donor funds effectively?*

The health financing flows in Afghanistan come from donors, government or households to cover healthcare on primary, secondary and tertiary levels. The incoherence in pooling might come with multiple pools within the public sector and outside the public sector offering the same services through BPHS and EPHS. Part of the donor funding is spent off budget through direct contracts between the donors and service providers, which can be a source of incoherency. The Health Center Efficiency Study in 2018 was conducted to assess the variation of performance of service delivery, but the study didn't separate health services financed by donor and government budgets. Since it is very difficult to make a clear separation between various interventions financed from the on budget and off budget, it is hard to assess whether resources are being put to their most effective use. Multiple management costs are certainly a cause of inefficiency if not incoherence. In order to mitigate any inefficiency, the MoPH with in-country stakeholders has initiated the creation of off budget mapping, an initiative to develop a joint plan of action and align and coordinate donor and government investment in health. In addition, the MoPH is tracking off budget resources to make sure they are spent to expand the coverage of basic and essential health services and reduce inequity and inefficiency. The Afghanistan Reconstruction Trust Fund is an instrumental financial instrument to support GIRA in international development efforts. This action will continue the EU support to the health sector in Afghanistan. It is aligned with the Afghanistan Multiannual Indicative Programme 2014-2020 as well as with the new European Consensus on Development, the Afghanistan National Peace and Development Framework (ANPDF) and the current National Health and Nutrition Strategy. It is strongly linked with two main National Priority Programmes (NPPs), namely Citizens' Charter and Women Economic Empowerment. In combination with the State Building Contract (SBC), particularly SBC II envisaging a stronger focus on service delivery, this action will contribute to advancing EU-Afghanistan policy dialogue on a priority area. It is also designed to prepare the Government of Afghanistan for possible future Health Sector Budget Support. The action envisages a combination of on-budget support for the provision of health services across the country, through the Afghanistan Reconstruction Trust Fund (ARTF), and off- budget/direct management support for key reforms and capacity building, including human resource development. It includes the following components:

1) On-budget/ARTF - Support implementation of SEHATMANDI

In line with the EU global strategy for aid effectiveness, a large part of this action will be channelled through the WB/ARTF. It will support the implementation of SEHATMANDI (Healthy) - the new operation continuing the "System Enhancement Health Action in Transition" (SEHAT). SEHATMANDI's components are: a) Improving service delivery and performance management; b) Health system strengthening through reforms and innovations; c) Strengthening community engagement.

2) Off-budget - Progressive handover to the Ministry of Public Health (MoPH) of current off-budget direct management projects

The EU will continue to support the expansion and improvement of health services to vulnerable group through training of Psychosocial Counsellors, Physiotherapists,

Orthopaedic Technicians and specific cadre for nutrition, thus complementing SEHATMANDI (which includes provision of services in these areas but not training of specialists). The action will also focus on strengthening the capacity of the MoPH and other institutions to train the mentioned staff categories, oversee their incorporation in the health sector, and provide post-training supportive supervision. This approach will not only reduce the gap between needs and staff availability but also enhance sustainability through Government ownership. The EU's direct management support for the training of various health professionals will be gradually phased out. A national disability survey is also planned, in close coordination with Central Statistical Office (CSO). Grants/calls for proposals are envisaged. A Technical Cooperation program will strengthen the stewardship functions of the MoPH and complement SEHATMANDI and the off-budget projects mentioned above. It will be designed to fill capacity gaps and provide support in areas where there is not enough expertise inside the MoPH. Particular attention will be given to the MoPH-Ministry of Finance (MoF) relationship and public finance management (preparing for possible future sector budget support). A service contract/call for tender is envisaged.

## **Purchasing and Provider Payment**

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*Q4.1 To what extent do fund allocations to lower-level purchasers e.g. local governments, and/or payment rates to providers, reflect population health needs?*

Health services purchasing decisions are taken centrally. The high OOP at 75.5% of total health expenditures in 2017 indicates that health allocation to BPHS and EPHS is either not sufficient or there have been certain inefficiencies in the utilization of health services. The people of Afghanistan directly purchase medicine, supplies and diagnostics from the private sector due to shortages in public health facilities, especially the national hospitals. NHA 2017 has estimated that OOP health spending for medicines and diagnostics was at 47% and 35% respectively. PETS 2019 exercise has indicated that delays in budget disbursement to health facilities directly caused shortages in medicines. The Health Center Efficiency Study in 2018 showed that efficiency scores for BHC (78.7%) and SHC (73 %) can be improved for potential efficiency gains. Apart from this, Afghanistan is facing a triple burden of disease and due to growing NCDs and population growth, the current packages do not adequately address the population urgent needs, however, the current allocations to some extent address mother and child health services. The new IPEHS benefit package will replace BPHS and EPHS to address these gaps and improve overall effectiveness of healthcare. Since the local governments do not provide services, the amount allocated to them in the form of annual operations budget each year is for their salaries and operational costs. Finally, all purchases take place at the central level and only small procurements related to goods needed in provincial offices take place in provinces. Therefore, a decentralized healthcare services purchase decision is not applicable in context of Afghanistan.

*Q4.2 To what extent are provider payments harmonized across schemes/revenue sources, and across public and private sectors, to ensure coherent incentives for providers.*

Purchasing of health services is fragmented. GIRA provides primary and secondary BPHS and EPHS healthcare service through ARTF, where 31 provinces are funded by donors and 3 provinces by public health funds. The content of BPHS and EPHS packages have been designed to address health needs of population of Afghanistan in various health settings: Health Posts, Basic Health Centre, Comprehensive Health Centre, District Hospital, Provincial Hospital, Regional Hospital and Specialized Hospitals. There is no co-payment mechanism for self-referred patients who bypass the primary health services. For those who visits secondary and tertiary healthcare facilities a small fee is being charged. The

provider payment mechanisms vary, based on revenue sources. The payments in all publicly financed hospitals which provide healthcare are based on line items, with the majority of public funding allocated to salaries of the staff in hospitals and MoPH. This salary allocation of public funding explains the high financial implementation rate of public funding in national hospitals. The contracted BPHS and EPHS providers are paid on lump sum and performance based payment for achieving priority indicators. Thus, the harmonization of provider payments is only partially implemented for incentive creation for the BPHS and EPHS providers. The payment to the private sector is based on a fee for service at the point of delivery in the form of direct out of pocket spending by Afghanistan citizens. Since the private sector is not properly regulated, there is incentive for suppliers to induce demand. The MoPH is working on a PPP legal and regulatory framework which has been signed recently by parliament and awaiting presidential approval. In addition, the private provider licencing and accreditation process is currently under development. The payment levels are substantially different for public and private sector providers. The salaries received in the public sector vary by province, by 'grade' and facility type, but they are typically substantially lower than the salaries received in the private sector. The different payment levels and payment types create contradictory incentives for doctors to refer patients to their own private facilities for treatment and/or follow up.

*Q4.3 To what extent do provider payment methods and purchasing in general, promote quality of care, and care coordination across specialties and different levels of care?*

The method of purchasing and provider payments adopted by MoPH for NGOs to provide BPHS and EPHS has some elements of strategic purchasing: the BPHS and EPHS packages are still relevant for many healthcare interventions although MoPH is working on the adaption of the new IPEHS to address new population needs for health care; the list of services contained in the packages are characterized by high cost effectiveness; there is a clear target set for the providers who are paid by lump sum and performance based payment for the targets met and regular monitoring and evaluation of service delivery is performed by a third party. However, the purchasing function is still fragmented which leads to inefficiencies in the system. To be able to enhance efficiency gains in purchasing, using economy of scale, and increase overall health programme efficiency, the fragmentation of purchasing should be significantly reduced. Purchasing of medicine is very fragmented and that might be a cause of high OOP health spending on medicines. It appears that NGOs have certain challenges to understand the provider payment method based on a combination of lump sum and targets met. Thus, the MoPH is currently developing an SOP to better address these challenges. The valuable lessons learned from the implementation of BPHS and EPHS will be used to improve the introduction of IPEHS. In public hospitals, the only payment arrangement is line items including salaries, investment and supplies. The rigid and insufficient payments do not include any incentives for improved quality and coordination of care. Moreover, the salaries are low and capital investments and supplies underfunded and obviously not sufficient to cover population needs. NHA 2017 has showed that these gaps have been mostly covered by OOP health spending. In the private sector, the predominant purchasing mechanism is user fee for service which might incentivise quality of care to some extent. There is a lack of information about the still unregulated private sector. There are no additional financial inducements or payment systems to incentivise the improved quality or improved coordination of healthcare in the private sector.

Delivery of the BPHS is supported by three donors in all of Afghanistan's 34 provinces: The World Bank finances 11 provinces and Kabul City; the United States Agency for International Development (USAID) finances 13 provinces; and the European Commission (EC) finances 10 provinces. The delivery of the BPHS is the core that drives Performance Based Financing (PBF) in Afghanistan. MOPH decided to contract out the delivery of the BPHS to NGOs in 2002, except in the three provinces where the MOPH implemented the BPHS (MOPH-SM). Contracts supported by the European Commission (EC) and the United States Agency for International Development (USAID) are cost-reimbursement contracts against



budgeted line items, although if deliverables outlined in contracts supported by USAID are not met, payment can be withheld. EC contracts do not include any type of monetary or nonmonetary performance-based incentive.

*Q4.4 To what extent do purchasing contracts specify quality of care requirements, including the availability and appropriateness of care, and then monitor/enforce these on a regular basis?*

The contracts granted to NGOs to deliver BPHS and EPHS explicitly define the target indications for the healthcare services that need to be delivered, level of coverage for those services and required healthcare quality of services delivered. The third party is contracted out and in charge of verifying the NGOs performance and approving performance based payments. Though public hospitals also provide services of varying quality, these requirements are not explicit. The public health facilities receive an annual allocation based on a ceiling the MoF fixes. In the majority of cases, the public hospitals and MoPH do not have any decision-making role. There is less coordination between the hospitals operated by the MoPH and those by the MoD, MoI, NSA, and MoHE.

*Q4.5 To what extent do provider payment methods promote efficiency in resource allocation e.g. reduce over- or under provision of services, and manage expenditure*

The current payment methods to NGOs to provide BPHS and EPHS are made on a lump sum basis incentivized by performance payment. The NGOs are obliged to provide a pre-defined set of health services, however the inefficiencies in deliverance might come as NGOs can provide services in areas with easy access to reduce cost rather than increasing use of health services by those residing in remote and underserved areas. The area where providers have the leverage is the lump sum part of the budget for BPHS and EPHS based on which they compete to get contract. The lowest, target and cap of performance are decided on by the MoPH and the donor, as well as the rate of payment for each priority indicator. In addition, the selection process of providers is very competitive and the incentive exists for providers to under-bid. The majority of payments to NGOs are taking place on a pay for performance basis and therefore improve efficiency. The lump sum budget they offer, if lower, does not provide room for better supply of the health facilities required for quality improvement and efficiency gain. Hence, despite the strong effect on cost containment, the risk remains for under provision of healthcare services, over provision on another set of health services and the transfer of the financial risk to consumer. This can explain some of the possible reasons for the MoPH's inability to reduce out of pocket expenditure. Despite the continuous growth in total health expenditure over the past years, the public health expenditure does not seem to have increased remarkably. Payment to government financed hospitals are taking place mostly on a line item budget basis with no incentive on hospitals' decision to perform efficiently. There are no blended incentives to prevent under provision of health services. In the private sector, payment is dominated by a fee for service at the point of delivery, which is certainly a cause for both inefficiency and inequity. There are no explicit structures and incentives in place to regulate the private sector behaviour and therefore prevent or reduce over-provision of services. In addition, there is a lack of clarity regarding the payment mechanism to NGOs that produces high inefficiency in healthcare delivery. It appears that the NGOs cannot cover salaries and essential operational costs, that affect high OOP health spending while planned funds are left unspent.

There are many results-based financing projects in Afghanistan. Although the performance payments were authorized quarterly upon verification, significant lags existed between the time of authorization and disbursement of bonuses to frontline health workers (Dale E, 2014). There was also no standard approach for distributing the performance bonuses among health workers within a health facility (Dale E,

2014). Health facilities managers distributed the performance bonuses in one of three ways: equal bonuses to all staff members; bonuses proportional to health worker salaries; and bonuses based on the direct contributions of the individual health workers to services that triggered the P4P payments. There were initial concerns about the small size of the performance bonus; however, these concerns were promptly addressed by raising the amount of payment per unit service (Engineer et al. 2016)

*Q4.6 To what extent are patient encounter forms standardized across the health system and used to review and assess activity across the population?*

The health insurance pooling mechanism doesn't exist in IRoA to require the encountered forms. Thus, the payments are not processed based on any patient encounter form. The contracted NGOs provide BPHS and EPHS healthcare reports on the number of patients they have visited and how they achieved target and quality performance indicators. The MoPH makes payments based on the NGOs performance reports verified by the third party and their payment claims.

*Q4.7 To what extent do provider payments cover only a portion of total costs, or cover total costs including salary, recurrent expenditures etc.*

The provider payments to NGOs to manage health facilities cover all costs including salary and recurrent expenditures. In the public sector, all costs including medicine supplies and doctors' fees should have been paid by public funds. In practice, due to a lack of medicine supplies and long patient wait time for diagnostic services, the citizens of IRoA pay these expenditures to the private sector from OOP. Opportunity costs such as the non-medical costs like travel, lost productivity costs are covered by patients or their facilities in the form of OOP. In public health facilities on a secondary health care level, the user fees are introduced to cover a part of the costs for improving quality of hospitals services, but due to restrictions in public expenditure and financial management law, all revenues have been submitted to the MoF central account which has yet not returned to the hospitals to be spent for the reason they are collected. In the private sector, all costs are covered by a fee for services and revenues are obtained from the patients or their families.

The Hospital Management Task Force (HMTF), at the Ministry of Public Health is advocating the idea of Limited and Progressive Autonomy (LPA) in National Hospitals. The first step in this process includes the availability of discretionary funds for the independent use of the hospital to achieve modest improvements through small or petty cash purchases of needed equipment, supplies, or repairs.

*Q4.8 To what extent are providers given financial autonomy, and held accountable, to an extent which is realistic and in line with their capacities?*

The NGO providers have more financial autonomy than hospitals to allocate the financial funds toward the population needs, benefit from efficiency gains within mandated contract and enhance a profit based on performance rating. They have their financial audit. In the public sector, after a short pilot period of hospital autonomy the hospitals are again centralized. The hospital has a right to procure goods which don't include medicines. The hospital user fees collected on a secondary and tertiary health care level must be directed to MoF. The Financial audit of the hospitals takes place by the MoPH internal audit department as well as the MoF and other related entities within the government. However, to improve efficiency and effectiveness of health care, the MoPH advocates for hospital autonomy to use collected user fees. The hospital reform project manages around

ten hospitals in provinces with differing degrees of autonomy. The autonomy also exists in the hospitals managed by the NGOs. Afghanistan's use of RBF to increase access and equity in health services utilisation provides useful learnings for other countries exploring options for contracting providers, as well as those reflecting on their own experiences. Future Health Systems partners' collaboration with the Afghanistan Government helped to facilitate embedded research and evaluation to test and guide the implementation of several policy initiatives, generating important knowledge to strengthen and adapt strategies.

*Q4.9 To what extent is provider accreditation or selective contracting established, functioning, and used for purchasing?*

Under Sehatmandi project the NGO service providers submit their bids with price for the lump sum element. The service providers need to decide what level of performance they can achieve on the 11 key services and what costs will be incurred. The NGOs contracted to deliver BPHS and EPHS services need to pass through a competitive recruitment process. The selection process includes technical and financial assessment of service providers' offer. The NGOs providers are motivated to offer lower bids to get the contract to deliver BPHS and EPHS, which in turn might produce a deficit in the NGOs' budget to deliver agreed health services and cause an increase in OOP health spending, lower quality and selection for delivery of health services in a more convenient and easily accessed location leaving behind the population in rural areas. In addition, the MoPH is in the process of developing accreditation and licencing mechanisms for hospitals to improve the quality of healthcare and pave the way towards the implementation of health insurance. The MoPH has developed Sehatmandi SOP Performance Management to outline a key mechanism for contracting management of providers, how performance will be assessed, provider payment method and procedures for tracking, monitoring and evaluation of performance. The MoPH is working on the development of accreditation and licencing functions that will be responsible for PPP provider licencing and accreditation.

*Q4.10 To what extent is purchasing and payment for pharmaceuticals implemented to promote efficient medicines use (e.g. generics rather than originator) and to improve financial protection for patients?*

Ideally, the General Directorate of Pharmaceutical Affairs (GDPA) in Afghanistan would be fully functional. It is the MoPH's responsibility to ensure that the financing of medicine supply is fairly shared between the Government and consumers and that price control is maintained and wastage reduced (Afghanistan National Medicines Policy 2014-2019). However, NHA 2017 has showed very high OOP at 75.5 % and specifically the share of OOP on medicines at 47%. As hospitals don't have the autonomy to purchase pharmaceuticals and this function is highly centralized, frequent delays are reported in the disbursement of medicines from government to hospitals. This resulted in patients buying medicine and supplies out of pocket from the private market, when they visit public hospitals. There have been discussions on pooled procurement of pharmaceuticals, however, this function is still fragmented and highly inefficient, affecting negatively the affordability and accessibility of citizens of IROA to pharmaceuticals. Based on the Afghanistan National Medicines Policy 2014-2019, health workers, including doctors and pharmacists, will be encouraged to explain the acceptability and cost benefits of generic products to patients. There is apparently a lot of room for improvement in this area, as high OOP spending on medicines clearly shows that government's central purchasing function is inefficient. In addition, there is not enough information about the local market in terms of good pricing and quality of pharmaceuticals. It would be beneficial for population of IROA that the MoPH puts more focus on achieving efficiency gains in this area of work and focus first on medicines to reduce purchasing fragmentation which will significantly reduce OOP and improve the quality of pharmaceuticals. In addition, enhancing PPP can bring

certain improvements in terms of supply, quality of medicines and affordability (e.g. the public sector can negotiate prices of selected medicines with private suppliers of medicines using economies of scale and therefore reduce OOP spending).

Assessment of the feasibility of a Pooled Procurement Option for Public Sector Supply Chain System under the WB-led ARTF/SEHAT Project was conducted. USAID procured and supplied medicines to the BPHS/EPHS implementing NGOs in the 13 USAID-supported provinces via its Partnership Contracts for Health (PCH) activity, which ended on June 30, 2015. The requested task aims to evaluate options to strengthen the security and availability of quality-assured medicines after USAID ends its role as a direct procurement agent. On August 07, 2016, Afghanistan President Ashraf Ghani approved a critical strategy paper on implementing a pooled procurement mechanism (PPM) for essential medicines and health products. Afghanistan's Joint Pooled Procurement Committee (JPPC) developed the paper with technical and financial support from the USAID-funded Strengthening Pharmaceutical Systems (SPS) project. The JPPC is comprised of the Office of the President; the Ministries of Public Health, Defence, and Interior; the National Procurement Authority; and the Combined Security Transition Command – Afghanistan. In Afghanistan, performance bonuses to health workers were provided centrally through contracted NGOs who in turn delivered these payments to health facilities as additional funds to their operational budget (Engineer et al. 2016). Some health workers were in fact not aware that performance bonuses were included as part of their health facility operational budget and monthly salaries (Engineer et al. 2016). The managing NGOs also had significant autonomy in deciding how the performance bonus was spent and distributed among their employees (Engineer et al. 2016). Given the way incentives were transmitted to health facilities and the heterogeneity in allocating bonuses, it is possible that some individual health workers who deserve the rewards and whose extrinsic motivation is critical for improving health services performance at a facility may not have received any bonus (Dale 2014).

## **Benefits and Entitlements**

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Q5.1 When addressing the following questions, refer to the overview from Step 1 which summarizes the key characteristics of the different health coverage arrangements in your country.

The MoPH is currently working on an investment plan which relies on domestic resources gathered through taxation, alongside the support provided by the donors. While developing the BPHS, the MOPH worked within a framework of specific objectives to: include basic services that would have the greatest impact on the major health problems, with these services constituting a standardized package of basic services that would form the core of service delivery provided in all primary health care facilities; ensure the quality of services provided; include services that would be cost-effective in addressing the problems faced by many people; extend coverage of the population that had access to these services in an equitable manner for both rural and urban populations; provide a foundation for the new health system for Afghanistan focused on community-based health care. (BPHS for Afghanistan, 2015). Explicit BPHS funding under Sehatmandi and off-budgets such as vaccines and nutrition supplements are insufficient to cover all costs. The National Risk and Vulnerability Assessment 2012 is a report that provides sufficient level of details to identify that some expenditures, mostly medicines, were paid by OOP health spending after patients visited BPHS and EPHS facilities. The IPEHS package has been designed and costed to replace BPHS and EPHS to improve utilization of needed health interventions, quality, access to healthcare and hopefully reduce the high OOP health spending and provide better financial protection. All the characteristics of BSPH and EPHS are outlined in the documents developed by USAID and MoPH. Detailed information on the basic benefit package in the document Integrated Package of Essential Health Services 2019.

*Q5.2 To what extent are benefit decisions and revisions made in a transparent way, based on a clearly-defined process, and agreed criteria e.g. cost-effectiveness, financial protection, budget impact?*

According to the National Health Accounts 2017 (NHA) just 7.9% of Afghanistan's total health expenditures occur at the hospital level (public and private hospitals). The development and revision of benefit packages are undertaken in participation with stakeholders. All the suggested interventions have the aim of expanding to the entire population, having the poor especially in mind, with enlarging primary and secondary care to protect people from financial catastrophes and advancing equity. The list of services contained in the packages are characterized by high cost effectiveness. The Health Center Efficiency Analyses for BPHS and District Hospitals have been conducted to assess how efficiently the current health facilities were operating and better understand where resource gaps exist and how more cost-efficient services can be delivered. Finding out such information is vital to making informed recommendations for health care reforms and introduction of IPEHS. The healthcare services introduced in BPHS, EPHS and IPEHS are fully costed. This will also be useful in the implementation of the Hospital Sector Strategy, whose goal it is to increase hospital autonomy with regards to their resources, as well as to improve the quality of its services. In order to lessen the extent of financial costs coming directly out of pocket, the MoPH is planning on instituting social health insurance.

*Q5.3 To what extent do benefits entitlements explicitly reflect population health needs?*

The current BPHS and EPHS packages have been demarcated by the prevailing and urgent health requirements of the population. The MoPH wants not only to expand the coverage of services offered by these packages, but to additionally increase the range of services by raising the coverage of NCD services and injuries. The BPHS has seven key elements: 1) maternal and new-born care, 2) child health and immunization, 3) public nutrition, 4) communicable disease treatment and control, 5) mental health, 6) disability and rehabilitation services, and 7) regular supply of essential drugs. Afghanistan's health system has been steadily progressing since 2002 with increasing coverage of health services throughout the country. In 2018, a total of 3,135 health facilities were functional, which ensured access to almost 87% of the population within a two-hour distance (WHO). The population of Afghanistan that lacks access to BPHS predominantly lives in the most remote rural areas. EPHS, which was developed in 2005, is a secondary care-based complement of BPHS. The EPHS lays a foundation for standard services package for each hospital level, provides staffing guidelines for hospitals, and promotes a referral system to integrate BPHS facilities with hospitals. It establishes that all hospitals with EPHS have four clinical functions: medicine, surgery, paediatrics and obstetrics, and gynaecology. The main aim of the MoPH is that the entire population of Afghanistan has access to both BPHS and EPHS. A new IPEHS package, which is developed from integration of BPHS and EPHS, will be introduced to better address population needs in terms of utilization of health services, quality and accessibility.

*Q5.4 To what extent do benefits prioritize priority population groups e.g. for improved use of high priority services and financial protection?*

Services offered by the BPHS and EPHS have a strong accent on meeting the needs of women and children, and provide them with critical services. The BPHS health facilities provide free of charge services to the population that access health facilities. The MoPH has implemented a conditional cash programmes as demand

driven intervention to supports the women who deliver at the health facilities, increases coverage and speeds up progress towards achieving the goals of UHC as reflected in the SDGs. Due to a huge informal sector, the main barrier to the implementation of social programmes to support populations living below poverty line is that there is no clear methodology to identify the poor segment of the population.

*Q5.5 To what extent are population entitlements and obligations explicitly defined and understood by people?*

Designed in 2003, the Basic Package of Health Services has been the cornerstone in the foundation of Afghanistan's health system. Health indicators in Afghanistan were extremely poor due to the decades of conflict, and the aim of BPHS was to give access to healthcare to the majority of the population. Since the introduction of BPHS and EPHS, the Afghani people are aware that the government offers free services for its people at public health facilities. Even though this is the case, there is a wide network of private sector facilities working in the country which operate on a user fee basis. Thus, regardless of the provision of free services at the point of use in public health facilities, the level of OOP health spending does not improve in the country.

*Q5.6 To what extent are benefits aligned with provider payment, to ensure that they are delivered and that there is financial protection for patients?*

Payments for hospitals are made on a fixed budget basis, and the payment to BPHS and EPHS providers are on a bulk (lump sum) payment schedule and for the priority health services as a fee for services. The goal is to notably enhance financial protection against the risk of ill health and improve equity. The total estimated costs of the BPHS, including all costs at facility, NGO, MoPH, and off-budget levels, are USD \$241,746,483 (13,537,803,048 Afs) in 2014 and USD \$237,479,993 (13,536,359,601Afs) in 2015. Furthermore, the total cost per capita is USD \$9.32 (531 Afs), apportioned as USD \$6.47 (facility level), \$1.51 (NGO level), USD \$0.17 (MoPH level), and USD \$1.17 (off-budget level) (Assessment of the Referral System and Costing of the Basic Package of Health Services (BPHS) in Afghanistan 2016).

*Q5.7 To what extent are benefits, including cost-sharing for patients, aligned with revenues, to ensure adequate funding for approved benefit entitlements?*

The MoPH has implemented user fees for the provision of secondary and tertiary services at hospitals. Even though the fee amount is noticeably low, arrangements are made to ensure that the poorest populations are not denied care due to their lack of funds. The \$61 annual OOP expenditure per capita (NHA 2017) could be used as an upper-bound baseline price for a comprehensive insurance package with no user fees, and access to private sector healthcare. Though, this amount may be considered high for people living in rural Afghanistan, given the country's wealth distribution: 68% of the wealthiest quintile lives in urban areas. As Afghanistan's low Gini coefficient of 27.8 indicates, the Afghan's ability to pay for healthcare in various wealth quintiles does not differ by large degrees. An option might be to offer premium waivers for the neediest users, if the enrolment of wealthier users is adequately high. However, if a health facility implements a waiver policy, the health facility needs to ensure that they will be compensated for the loss of revenue due to exempting patients. Otherwise, the waiver policy can create deficit in a health facility and demotivate health faculty staff to provide high quality health services.

## **Public Financial Management (PFM)**

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*Q6.1 Has an in-depth diagnosis/ assessment of health-sector specific PFM bottlenecks been recently conducted e.g. within last 3 years?*

GIRoA's Public Finance and Expenditures Law outlines key PMF legal and regulative framework and procedures. The MoPH has developed Sehatmandi SOP Performance Management to outline a key mechanism for contracting management of providers; how performance will be assessed; provider payment method and procedures for tracking, monitoring and evaluation of performance. The SOP has defined minimum standards for utilization and equity of health care services and human resources for health. The MoPH has conducted a Public Expenditures Tracking Survey 2019 for the period 2017-2018 to assess the flow of expenditures, potential barriers and inefficiency, and deal with a part of PFM functions. The key findings from the survey have shown the following: the system of budget preparation, procedure, and allocation needs improvement and the use of public funds can be more transparent and efficient; NGOs and NHCs are extending their already insufficient budgets to meet the requirements of their clients; differences in approaches and systems to tracking budgets internally at the MoF, MoPH, and NGOs creates barriers to effective use of this information when units are not defined similarly; delays in payments to NGOs, salaries, and procurement of drugs and supplies significantly hamper the provision of quality services and negatively affect health worker morale. The MoF has been commencing reforms in the budget process, incorporating capacity building workshops to improve the development of budgets to be realistic and project-based.

*Q6.2 Capacity of MOH staff to understand (new) PFM rules and apply these to the health sector budgetary process.*

MoPH has established a Performance Management Unit (PMO) focusing on Sehatmandi Performance Management functions and performance implementation plans within public sector. There is a lack of staff capacity to assess PFM functions within MoPH and there is not enough funding for PFM training. We recommend that PMF related training is provided for staff to understand PFM functions, and with a fully operational EMIS, this would result in better tracking of health financial flows. Thus, they would register the lateness in the disbursement of funds and prevent delays. There is a critical shortage of PFM knowledge in the department. In addition, a fully functional EMIS would significantly improve technical capacities of MoPH to monitor health financial flows. The Multiannual Indicative Programme (MIP) which is aligned with EU support to the health sector in Afghanistan action document for EU support to health and nutrition services for the Afghan population - SEHATMANDI includes an off-budget component of progressive handover to the Ministry of Public Health (MoPH) of current off-budget direct management projects. The action will also focus on strengthening the capacity of the MoPH and other institutions to train the mentioned staff categories, oversee their incorporation in the health sector, and provide post- training supportive supervision. A Technical Cooperation program will strengthen the stewardship functions of the MoPH and complement SEHATMANDI and the off-budget projects mentioned above. It will be designed to fill capacity gaps and provide support in areas where there is not enough expertise inside the MoPH. Particular attention will be given to the MoPH and MoF relationship and public finance management (preparing for possible future sector budget support). A service contract/call for tender is envisaged. Special emphasis should be put on financial management at MoPH, to ensure effective contributions from MoF and effective budget mobilisation by MoPH, especially in view of the implementation of the current State Building Contract and potentially future Sector Budget Support.

*Q6.3 A multiyear budgetary process exists and is being implemented effectively.*

The preparation of the GIROA budget is based on multi-year national development and security programmes, and an economic framework covering the budget for at least 2 coming years. GIROA has developed an operational, development and consolidated multi-year budget 2018-2023 by ministries supported by regular Mid Term (Year) Expenditure Framework. The government health budget consists of ordinary (operational) and development budget, where the ordinary budget covers mostly staff salaries of MoPH and Public Hospitals and the development budget finances BPHS and EPHS health facilities. Both the 2014 and 2019 PETS confirm that the budgetary process is not fully inclusive, despite certain efforts being made.

*Q6.4 Extent to which annual health budget allocations are aligned with health sector priorities (level, structure, nature/focus).*

Afghanistan's health financing is characterized by a heavy dependence on donor financing and OOP health spending. The public health level of spending is low and not focused on health sector priorities, as most of the funding is allocated to staff costs. The MoPH has developed the National Costed Health Strategy 2016-2020 which outlines the resources required across the main health priorities such as: governance, institutional development, public health, health services, human resources for health and information management. A comparison of the resources required and the resources available for achieving the strategy goals highlighted a remarkable gap, the MoPH has very limited discretionary funding to support the health strategic priorities and depends on priorities and support from multilateral and bilateral assistance. Most of the national hospitals do not have resources to properly operate, therefore, this drives some of the OOP health spending when Afghanistan's citizens access secondary and tertiary services. The health budget alignment in Afghanistan was carried out to map on and off budget. The objective of this resource mapping exercise is to support ongoing planning, budgeting process and PMF.

*Q6.5 Extent to which the budget process is consultative, transparent, and a mid-term budget review and adjustment process is established.*

The key findings from PETS 2014 has showed that the budget development process is highly centralized, participation of concerned stakeholders is very low and there is a lack of proper planning and inaccuracy of estimated needs during the budget process. The PETS 2019 study states that the system of budget preparation, request, approval, and allocation needs enhancement and the use of public funds can be more transparent and efficient to meet the health needs of the people. The MoPH asks for budget requirements for other programs and projects from project staff and based on these discussions, the budget is drafted and sent to the MoF. This process has been described as somewhat problematic as it is not established on needs, evidence, and is widely understood to promote the continued use of inaccurate historical budgets. This results in mid-year review and alterations as there is often a preference to under budget due to concerns of the budget execution rate or over budget to roll over unspent budget (funds are returned to the MoF). This unrealistic planning and budgeting practice was cited as a reason behind the low utilization of the appropriated budget. According to the latest PETS report 2019, on-budget spending is estimated to US\$135 per citizen, of which merely US\$8 per capita is for health. Appropriations for health have increased as a result of increases in the development budget, but, recurrent budget has remained low and consistent. The MoPH performs better among the ministries in the execution of its operating budget (92%) and development budget (62%). In 2018, the government has altered its approach to fiscal planning by reducing the overestimation of the program and project budgets, with more accurate estimates



in order to accomplish higher rates of budget execution and quality expenditure. These reforms were carried into the following year. The focus was on bettering the timeliness and responsiveness of the budget process by including the Parliament and donors at an early stage. With the purpose of promoting transparency and accountability, the civil society and Parliament are more strongly engaged in prioritizing the budget, as those priorities are developed. In 2019, National Hospitals again converted to semi-autonomy, though the procurement of medicines still remains centralized with the MoPH's Procurement Department.

*Q6.6 Extent to which fiscal transfers are designed and implemented to improve equity in resource distribution in the health sector.*

The MoF has a centralized role in the collection and redistribution of revenues. There are four main fiscal transfers – from the MoF to the MoPH and from the MoPH to public health facilities. In addition, donors transfer funds to ARTF and these funds are transferred directly from MoF/ARFT to contracted NGOs to support BPHS and EPHS. Primary health care is free of charge for all citizens of Afghanistan. Fiscal transfers to support BPHS and EPHS through NGOs or public health facilities packages are designed to support health care needs of the poor population. In that sense, we can conclude that they are improving equity of health care. Significant exposure of citizens of Afghanistan to high OOP health spending brings a big equity concern. Small user fees are designed to be charged on secondary and tertiary level of health care at the point of service use to support health care delivery. However, these fees aren't managed by health facilities as they need to be returned to MoF and therefore don't serve their initial purpose. In addition, there are health care indirect costs that might place an additional burden on already high OOP spending.

*Q6.7 Extent to which the health budget rules allow for flexibility in spending.*

The flexibility of health spending in the public sector is limited. The budget allocation to public hospitals is based on line-item budgeting and thus public hospitals have very limited autonomy and room for manoeuvre to redistribute allocated financial resources. However, contracted NGOs facilities, funded by the development budget to deliver BPSH and ESPH, have a more flexible budget which allows for a flexible structure and execution.

*Q6.8 Flexibility in resource use is provided at/ delegated to the right level.*

The responsibility for budget allocation mainly stays with the Ministry of Finance. The MoPH is responsible for the health ordinary (operational) budget. Contracted out NGO providers can manage their budget according to a signed contract while the manager of a public hospital must mainly follow the predefined line-item budget.

*Q6.9 Budget discipline policies to control spending are in place (e.g. cash management, compliance with procurement rules) and implemented effectively.*

The hospitals are audited by the internal audit department of the MoPH and the MoF and the high audit office of the government. The contracted NGO providers' performances are assessed based on contractual agreement and Performance Management SOP for Sehatmandi project. They are also audited by independent auditors as per the NGO policies. The government managed health facilities are bound to comply with the PFM rule procurement law and procedures.

*Q6.10 Extent to which information systems are in place to both meet financial accountability needs and to monitor health sector performance*

The NGOs contracted to deliver healthcare through the Sehatmandi project have been reporting using pre-defined forms and SOP procedures. There are HMIS and EMIS that are planned to support MoPH in the monitoring of financial and health sector output and performance indicators. However, these systems are not able to provide real-time information. With the establishment of DHIS2 and establishment of Web Based EMIS in the future, reporting will be much improved. The national and sub-national levels, applying best practices in health governance and accountability. HSR also supports the MoPH to implement the World Bank-funded System Enhancement for Health Action in Transition (SEHAT) and subsequent (SEHATMANDI) initiatives. This initiative will Upgrade Afghanistan's Health Management Information System to create a national data warehouse and enhance the culture of data use. HSR supported MoPH to start a user fees system in 28 tertiary and specialty hospitals in Kabul and provinces. As of March 2019, the user fees had generated more than 41 million AFS for MoPH. Of the outcomes included: HSR developed a Human Resource Management Information System (HMIS) data base on all public health sector personnel information, a significant step in improving accountability, transparency, and efficiency and reducing the risks of ghost workers and wasted resources.

*Q6.11 Extent to which multiple fund flows, budget structure and PFM rules are aligned with strategic purchasing.*

The purchasing function of health financing in MoPH is fragmented. The BPHS and EPHS health programmes funded by development budget have some elements of strategic purchasing such as: performance based provider payment, mix of providers and benefit packages designed to meet population needs, utilization of cost effective and targeted health interventions. Under the current PFM law, line-item budget is the most suitable payment arrangement, therefore, it does not support strategic purchasing. Payment reforms under the Sehatmandi project were possible only because this specific case operates under the donor rules and law. A greater interaction between MOF and MoPH is needed to ensure that there is alignment in budget preparation and fund flows. WHO support could be viewed as creating an enabling environment to foster dialogue between MOF and MOH, following the provided document and existing future directions of fostering a good dialog could bring about change.

## **Governance**

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*Q7.1 Extent to which roles and responsibilities (related to health financing goals and performance in revenue raising, pooling, purchasing, benefits, etc.) are clearly defined and divided across governing institutions in health financing.*

The health financing roles and responsibilities across governing institutions are clearly defined. The MoF is responsible for revenue raising and pooling while the MoPH is responsible for purchasing, health services delivery and design of healthcare benefit packages. Other ministries are involved in health provision including purchasing and health services delivery of healthcare services. The MoPH has its own source of revenue which is directly channelled from a government account in the MoF, from the budget of GIRoA. However, this funding is very limited

and earmarked for staff wages of the MoPH and public hospitals that provide public health services. The MoF also pools the funds from ARTF for provision of BPHS and EPHS funded by donors.

*Q7.2 Extent to which governing institutions in health financing have adequate capacity, including human resources (technical and managerial capacity) and ICT?*

The MoF has sufficient human resources with good capacities to execute budgeting and accounting procedures. The HEFD, despite technical capacity of its existing staff, requires additional human resources in order to properly exercise all its roles and responsibilities. Implementation of the current HFS 2019-2023 requires additional resources to be provided. The ICT for financial reporting has been improved, but still requires enhancing their use of ICT. The expenditure tracking systems is still not in real time and needs certain improvements. The culture of data use needs to be improved and promoted. It is recommended that a technical capacity assessment and subsequently capacity development plan are made for the HEFD unit.

*Q7.3 Extent to which accountability mechanisms for purchaser/financing agencies, including autonomy and governing board of purchaser, rewards/sanctions, etc. are in place to ensure that health financing policy supports progress towards sector goals, and funds are used effectively for priority populations, programmes, and services.*

The purchasing of BPHS and EPHS healthcare services from NGO providers are strictly designed to ensure VfM and high effectiveness of health programmes. The MoPH, in collaboration with other key in-country partners, agreed on a list of priority indicators against which the project progress is being assessed. In order to ensure that all health facilities are resourced to provide good, basic services at all times, service providers are requested to maintain a set of minimum standards and ensure quality of health care. The third-party provides independent verification of the 11 Key Services which is required for payments to be approved. They also verify the minimum standards and complete the balance score cards. To ensure that all allotments are processed and disbursed on time to the NGO provider accounts, the MoPH organized a development budget unit that consists of highly skilled financial managers and accountants to support the PFM functions. In addition, the organization's accounts are annually audited by independent accountants and the MoF and recommendations for improvement are made accordingly. There are several hospitals that are paid out of the ordinary budget of government of Afghanistan using the fixed budget line item that does not allow sufficient flexibility in terms of spending. Most of the hospitals have governing boards including hospital community boards. The hospitals' expenditures are not only audited by the internal audit department of the MoPH but also by the MoF and the high audit office of the government.

*Q7.4 Extent to which the use of funds or performance of national health care purchasing agency or health budget reported to the public (e.g., annual report)?*

The contracted NGOs submit quarterly expenditures reports verified by a third-party to the MoPH for final verification and through the MoPH to the Ministry of Finance. The Public expenditure tracking survey has been completed in December 2019, and will be publicly made available. Public annual reporting is not common in IRoA.

*Q7.5 Extent to which MoF, MoH, and national purchasing e.g. health insurance organization is engaged in the health financing policy process.*

The MoPH, donors and technical partners are involved in the health financing policy and strategy development process. There is no health insurance organization in IRoA. The development of HF policies is transparent and inclusive. The process of development of HF policies should include MoF technical staff. This will enable better understanding of technical issues between MoF and MoPH departments.

*Q7.6 Extent to which policy-making process for health financing is transparent and participative.*

However, even though efforts have been put in place to make the policy making process for HF development highly transparent and participatory, it has proven difficult to ensure effective participation of all stakeholders.

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