Islamic Republic of Afghanistan

Ministry of Public Health

General Directorate of Policy, Planning, and International Relations

Health Economics and Financing Directorate

Health Financing Strategy 2014 – 2018

January 2014

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FOREWORD

The development of the Health Financing Strategy 2014-2018 is a huge accomplishment for the Ministry of Public Health (MoPH) to move towards a more sustainable health system. The Afghanistan health system has made significant gains over the last decade. The dedication of Afghans and support of the international community to improve the health of the population have resulted in reductions in maternal and child mortality and infectious diseases. The need for a more strategic approach to maintaining and expanding these health gains while designing an Afghan system that is sustainable and suitable for the population is ever present now. We have embraced the international call to achieving universal health coverage for all as a mission in Afghanistan. This is an ambitious goal but a worthy goal to achieve for all women to have access to healthy deliveries; for all children to access life-saving immunizations; and for all families to access quality health services without the fear of impoverishment.

At a time when the country' s security is in transition, with limited resources, the MoPH is in a position to identify how to spend more efficiently and invest for the greatest impacts. This strategy outlines the strategic directions for the MoPH to increase capacity in health economics and financing; mobilize resources; promote aid effectiveness and efficiency of resource use in the health sector; reduce financial risks and barriers; strengthen resource tracking; and improve the purchasing mechanisms of health services.

Evidence has shown around the world that two of the largest barriers to achieving universal health coverage are the large amount of inefficiencies in the delivery of health services and the continued reliance of the health sector on household out of pocket payments. Raising funds through population prepayments has proven to decrease risk of financial ruin and increase efficiency and equity by providing services to a larger population. National wealth is not a prerequisite to universal health coverage – political commitment and sound policy decisions can fill the monetary gap and provide greater value for each Afghani. Only an Afghan solution will address the health financing needs of the country. The MoPH is excited and ready to take on the task of implementing this strategy and to own the process of delivering universal health coverage for all.

I would like to sincerely thank the Health Financing Working Group for efforts in developing this strategy, especially Ahmad Shah Salehi, Director of HEFD for his inputs and leading the entire process.

Sincerely,

Suraya Dalil, MD, MPH
Minister of Public Health
January 2014

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The development of Afghanistan' s Health Financing Strategy 2014-2018 has only been possible through the intensive efforts from many individuals and institutions.

We would like to take this opportunity to thank the members of the Health Financing Working Group for their continuous commitment over several months to identify the strategic directions and objectives of the MoPH in health financing. The participatory process allowed for greater stakeholder input and ownership. The working group members include (in alphabetical order, affiliations listed in Annex 2): Ahmad Shah Salehi, Christine Kim, Damon Brown, Dejan Ostojic, Genevieve Bussiere, Hedayatullah Saleh, Husnia Sadat, Jawad Mirzad, Jonathan Ruwe, Mir Islam Saeed, Miroslaw Manicki, Moazzem Hossain, Mohammad Saber Perdes, Molly Schaefer, Najibullah Safi, Noor Arzoie, Omarzaman Sayedi, Said Mohammad Karim Alawi, and Sefatullah Habib. We also thank all of the participants from the consultative workshop on the health financing strategy (a full list of participants and their affiliations is provided in Annex 3). We would also like to thank Khwaja Mir Ahad Saeed for translating the strategy into local language.

We would particularly like to thank Christine Kim from the USAID-funded Health Policy Project in Afghanistan for assisting the team with the preparation and finalization of this strategy document.

Sincerely,

Ahmad Shah Salehi, MD, MBA, MSc
Director of Health Economics and Financing
January 2014

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ACRONYMS

AHS	Afghanistan Household Survey
ANC	Ante Natal Care
ANPHA	Afghanistan National Public Health Association
BIA	Benefit Incidence Analysis
BPHS	Basic Package of Health Services
CBHI	Community Based Health Insurance
CCT	Conditional Cash Transfer
CIDA	Canadian International Development Agency
DSF	Demand-side Financing
EMIS	Expenditure Management Information System
EPHS	Essential Package of Health Services
GCMU	Grant & Contract Management Unit
GD	General Directorate
GDHR	General Directorate of Human Resources
GDP	Gross Domestic Product
GDPP	General Directorate of Policy and Planning
GIHS	Ghazanfar Institute of Health Sciences
GoIRA	Government of the Islamic Republic of Afghanistan
HCF	Health Care Financing
HEFD	Health Economics and Financing Directorate
HFs	Health Facilities
HMIS	Health Management Information System
HPIC	Health Partners International Of Canada
HPP	Health Policy Project
IP	International Procedures
ISAF	International Security Assistance Forces
KMU	Kabul Medical University
M&E	Monitoring and Evaluation
MoD	Ministry of Defense
MoF	Ministry of Finance
MoJ	Ministry of Justice
MoI	Ministry of Interior
MoLSAMD	Ministry of Labor, Social Affairs, Martyrs and Disabled

MoPH	Ministry of Public Health
MOPH-SM	Ministry of Public Health - Strengthening Mechanism
MSH	Management Science for Health
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NPP	National Priority Programs
NRVA	National Risk and Vulnerability Assessment
OOP	Out of Pocket
OPSC	Office of Private Sector Coordination
P4P	Pay for Performance
PETS	Public Expenditure Tracking Survey
PMF	Performance Management Framework
PPHO	Provincial Public Health Office
PPP	Public Private Partnership
RBF	Results Based Financing
RH	Reproductive Health
SMART	Specific, Measurable, Assignable, Realistic and Time related
SMARTER	Specific, Measurable, Assignable, Realistic, Time related, Evaluated and Reviewed
SOP	Standard Operation Procedure
SWAp	Sector-Wide Approach
TAG	Technical Advisory Group
THE	Total Health Expenditure
UN	United Nations
UNICEF	United Nations International Children' s Emergency Fund
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WHO	World Health Organization

GLOSSARY OF KEY TERMS

Allocative efficiency - A situation where healthcare resources are used to produce health outcome and distributed among the community. Allocative efficiency is achieved when resources are allocated so as to maximize the welfare of the community.

Catastrophic health expenditure - A situation where a household spends more than 30% of its income on health care, after paying for subsistence needs, e.g. food. It can be caused by catastrophic illness, either high cost but low frequency or by low cost and high frequency events.

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

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

> **Contracting-in** - In the Afghanistan health system, the MoPH manages and delivers services in a few provinces through the Ministry of Public Health Strengthening Mechanism (MoPH-SM). The provinces are contracted by the central MoPH similar to normal commercial contracts. The World Bank provides funds for this mechanism.
>
> **Contracting-out** –The delivery of health services in the majority of provinces and districts (other than MOPH-SM) have been contracted out to NGOs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Private health insurance - A health insurance scheme characterized by the following features: voluntary, managed outside the social security system with risk-rated or community-rated premiums, managed by an independent legal entity (an incorporation, organization, association or foundation) not by a state/quasi state body, operating for profit

or non-profit. Voluntary insurance to cover health care costs based on the individual' s level of risk.

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

Results-based financing (RBF) - Transfer of money or material goods conditional on taking a measurable health related action or achieving a predetermined performance target. The synonym terms are: Pay for Performance (P4P), Output-Based Financing and Performance-based Contract

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

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

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

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

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

EXECUTIVE SUMMARY

This strategy outlines the second phase in health financing for the Afghanistan health sector covering the years 2014 to 2018. The 2009-2013 Health Care Financing Strategy aimed to respond to gaps in health financing and economics information in the country in order to move towards a more sustainable health system.

The development of this strategy is a joint achievement of the government, international development partners, and NGOs. Taking into consideration the limited resources available, the strategy represents the roadmap for addressing key financing questions such as how will the health system continue to be financed?; how can households be protected from the financial consequences of ill-health?; and how can resources be optimally used?

Six strategic directions were selected among a set of parameters to ensure their prioritization and alignment with the Ministry of Public Health. Linked to the 2012-2020 Health Financing Policy, this five-year strategy will continue to build on the successes of health financing in Afghanistan and serves as a guide for increasing the impact of investments to promote and sustain health. The six strategic directions include:

Strategic direction 1: Strengthen capacity of the Afghanistan health system at various levels in applied health economics and financing schemes

Strategic direction 2: Mobilize external and domestic financing for health

Strategic direction 3: Promote aid effectiveness, efficiency and equity of public spending, and eliminating wastage of resources

Strategic direction 4: Reduce financial risks and barriers to health access for the poor

Strategic direction 5: Support resource tracking mechanism

Strategic direction 6: Improve purchasing mechanisms

The strategy also provides an implementation framework with measureable results and indicators intended to track progress on policies and programs. Health financing activities rely on a diverse set of actors internal and external to the MoPH. Responsible entities and roles have been identified as well as mechanisms for coordination to ensure smooth implementation.

The MoPH is committed to advocating for the health sector' s needs and priorities, being a voice for the sick and most vulnerable, for great health equity for all.

1. INTRODUCTION

This strategy outlines the second phase in health financing for the Afghanistan health sector covering the years 2014 to 2018. The 2009-2013 Health Care Financing Strategy aimed to respond to gaps in health financing and economics information in the country in order to move towards a more sustainable health system. Many achievements have been made over the past five years to support greater evidence-based decisions in improving the efficiency of the health sector. Linked to the 2012-2020 Health Financing Policy, this five-year strategy will continue to build on the successes of health financing in Afghanistan and serves as a guide for increasing the impact of investments to promote and sustain health.

The development of this strategy is a joint achievement of the government, international development partners, and NGOs. Taking into consideration the limited resources available, the strategy represents the roadmap for addressing key financing questions such as how will the health system continue to be financed?; how can households be protected from the financial consequences of ill-health?; and how can resources be optimally used? Many countries are faced with responding to these questions as outlined in the World Health Report 2010. As Afghanistan transitions into a new chapter of more independence from international aid, the importance of improved country financing mechanisms for greater health care coverage cannot be undermined. The successful implementation of the 2014-2018 Health Financing Strategy will result in dramatic improvements in not only the health of the population, but also in the ability of the government to be a better steward of the health system.

1.1. Background and Context

Significant improvements have been made in the health sector of Afghanistan. Table 1 below shows general health statistics of the population specific to maternal and child health from the Afghanistan Household Survey (AHS) first conducted in 2006 and again in 2012. The Basic Package of Health Services (BPHS) has increased access to primary care services for the poor (1,2).Improvements are seen in the access to key maternal health services such as antenatal care and institutional deliveries. Despite these major accomplishments, challenges remain. For instance, full immunization coverage of children has not increased in the past half-decade regardless of the investments made in the Expanded Program on Immunization (EPI).Studies have shown improved quality of care in counseling and managing child illnesses but performance in health facilities overall remain suboptimal (3). Referral services across different health facility levels remain fragmented and threaten the quality of care continuum, particularly for children (4).

Table 1. Afghanistan Health Statistics

Indicator	AHS 2006	AHS 2012
Maternal Health		
% of women (12-49 years) that had at least 1 ANC visit from a skilled provider	32%	54%
% of women who delivered in an institution 2 years preceding the survey	15%	40.5%
% of women who used a skilled birth attendant	19%	47.4%
Child Health		
% of children 12-23 months who are fully immunized	27%	29.9%
% of infants 0-5 months exclusively breastfed 24 hours before the survey	83%	54.9%
% of infants 6-9 months who received complementary foods	28%	59.1%

While previously there were no health financing statistics on Afghanistan, the implementation of the National Health Accounts (NHA) in 2008/09 and 2011/12 has allowed for the tracking of expenditures in the health sector. Table 2 presents data from the National Health Accounts in 2008/09 and 2012. There has been an increase in overall health sector investments over the last three years by almost 32 percent – the total health expenditure (THE) per capita increased from US$42 to US$56. However, as a percentage of the GDP, the THE declined by two percent, with insignificant change in the contributions by the government as a percent of total government expenditure. Though the Out of pocket (OOP) expenditures or direct payments for health services by households decreased two percent in relative terms, in absolute terms, the OOP increased by US$ 312.8 million, remaining a significant burden on households.

Table 2. Afghanistan Health Financing Statistics

Indicator	NHA 2008/09	NHA 2011/12
Total health expenditure (THE)	USD 1,043,820,810	USD 1,500,975,945
THE per capita	USD 41.73	USD 55.59
THE as % of real GDP	10%	8%
Government health expenditure as % of total government expenditure	4%	4.2%
Total out of pocket expenditure as % of THE	75%	73%

1.2. Rationale

Several gaps have been identified in the health financing of Afghanistan' s health sector by the working group. A lack of capacity at both the central and provincial levels in applied health economics and financing as well as resource management impedes efficient and

effective decision-making. The high OOP expenditures by households coupled with the lack of protection mechanisms exacerbates the catastrophic costs of health care contributing to household poverty.

Limited domestic revenue and competing government priorities have resulted in low levels of public per capita health expenditure. Yet advocacy efforts have also been limited and ineffective on the regulatory environment related to domestic resource allocation for the health sector. Restrictive policies for smooth fund flow and execution further compounds the situation, seriously impacting the delivery of health services. At the same time, there is high dependence on external donor funds for the delivery of health services which are financed through competing mechanisms with weak aid coordination. Lastly, although public-private partnerships have been initiated, there is limited knowledge of the private sector and how it can better engage with the health system to improve coverage of quality services.

Aligned with the Health Financing Policy 2012-2020, this document will guide the Afghanistan health sector to strategically address major financing gaps for strengthening the health system to become more responsive to the health needs of the population.

2. PROGRESS, ACHIEVEMENTS, AND CHALLENGES

The 2009-2013 Health Care Financing Strategy was the first document in Afghanistan aimed at improving government resource allocation to the health sector; increasing capacity for health economics research; addressing health inequities due to high OOP; and improving efficiency in service delivery. The previous strategy provided a roadmap to developing a platform for health economics and financing evidence for informed decision making, and highlighted the need for greater efficiency in the delivery of public health services. The 2009-2013 strategy outlined several measures of progress, including process and outcome indicators. This section provides an overview of what has been achieved over the last five years, and the challenges in addressing some key health financing areas.

Develop capacity of the MoPH at central and provincial levels in applied Health Economics, Health Financing, and Resource Management: Three main health financing functions to be addressed include resource mobilization, development of risk pooling options, and the implementation and support of efficient resource allocation and purchasing of services. In order to first address these functions, capacity in health economics and financing at the MoPH level must be built and retained. The initial phase of building this capacity was to develop internal capacity within the Health Economics and Financing Directorate (HEFD) of the requisite skills and knowledge in health economics and financing. HEFD conducted a capacity gap assessment in 2010 which identified a clear and significant gap of trained health economists. The impact of this dearth of experts was evident, as HEFD staffs were unable to implement activities within their mandate without significant and continuous external technical assistance. Investments in building up a cadre of health economists in the MoPH were made to reduce Afghanistan's dependence on external technical support and external financing. Ten HEFD staffs were identified to attend a Master degree program in

Health Economics, of which seven graduated in 2013. Additionally, since 2009, HEFD staff participated in over 50 trainings on various research methods, budgeting, and management; conducted 27 health economics studies; and produced five policy documents related to health economics and financing.

Support to the mapping of health expenditures flows: A key information gap was the lack of health financing data related to expenditures in the health system. The National Health Accounts is a tool that over 50 developing countries have used it to track the flow of expenditures, highlighting resource spending and allocations. Key information from the NHA includes identifying who is providing health funds, where it is being spent, and on what types of health services. Afghanistan' s first NHA was produced in 2010 and housed in HEFD for institutionalizing the framework. A memorandum of understanding was signed with the Central Statistics Organization to include health expenditure questions in the National Risk and Vulnerability Assessment (NRVA) household survey. A NHA steering committee was established and efforts to include the NHA in public health higher education curriculum have been made. The Public Expenditure Tracking Survey (PETS) is another tool that developing countries have used to track the flow of funds from the source (Ministry of Financing) to the intermediary (Ministry of Public Health) to the health service provider (Hospitals, clinics). A pilot PETS is underway among National Hospitals in Kabul to track the flow of funds, and to assess delays and leakages. Thirdly, the Expenditure Management Information System (EMIS) is a database intended to improve financial reporting, expenditure tracking, and data access for economic analyses. The NHA, PETS, and EMIS are key resource tracking tools that enable the government to first understand where funds are allocated, then second, to make decisions for improving efficiency and spending more effectively.

Exploring Demand and Supply-Side Financing: Demand and supply side financing interventions aim to increase the demand of services or improve the quality of services by linking incentive payments to health workers with performance. Pilot programs assessing the demand or utilization of services have been implemented including a conditional cash transfer (CCT) program in 12 districts across four provinces of Afghanistan. The CCT program had three intervention arms where incentive payments to women were provided upon receipt of reproductive or child health services. The evaluation of the CCT program found that transportation was a major barrier to accessing services even with the incentive payment. Thus, a pilot mobile health (mHealth) program was designed and is currently being implemented to address the issue of transportation, related to the utilization of health services by women and children, using mobile phone technology. On the supply side, a results-based financing (RBF) project was piloted in 11 provinces (463 facilities) with intervention and control groups for improving the quality and quantity of services. Based on performance indicators, intervention facilities showed an 18 percent quality improvement in over control facilities.

Financial Sustainability, Revenue Collection, Inequity Reduction, and Advancing Risk Pooling Mechanisms. Domestic revenue generation continues to be a challenge for the government as traditional public sector financing such as taxes have proven difficult to collect. The MoPH has taken initial steps to move towards greater sustainability through increasing domestic

resources, however, legal constraints exist, particularly for the introduction of user fees. A Revenue Generation Strategic Framework and Advocacy Plan were developed which provide a series of options for raising domestic funds for health. The first Benefit Incidence Analysis (BIA) on the inequities and inequalities in the delivery of services was conducted which shed light on how to better target public spending to reach the very poor. A health insurance feasibility study is under preparation to introduce financial risk protection mechanisms in Afghanistan. Lastly, private health insurance regulations were drafted.

Support to Efficient Resource Use and Allocation: As mentioned, 27 health economics studies have been conducted since 2009. These studies include cost analysis studies of various health sector entities such as the BPHS, EPHS, National Hospitals, and the Kabul Medical University. Additionally, efficiency studies were conducted on district, provincial, and regional hospitals, as well as on contracting mechanisms of the health sector. These studies have added to the evidence-base for policy-makers. Findings from these studies continue to be promoted for greater use to improve the efficiency and delivery of health services.

Enhance Aid-Effectiveness in Healthcare Financing: An Aid Coordination Unit was established in 2012 which provides regular communication mechanisms among stakeholders. A feasibility study of the Sector Wide Approaches for the health sector was conducted to move towards harmonization and alignment of external funds. Regular coordination bodies were established and three health retreats were conducted to engage stakeholders annually. During the 2012 Health Retreat, a Partnership Agreement was signed, followed by the development of a Partnership Protocol for Health Sector Development.

Although much has been achieved, additional challenges and gaps related to the implementation of the 2009-2013 Health Care Financing Strategy were identified. These challenges and gaps include the following:

- Capacity in health economics and financing: overall MoPH-wide understanding of basic health economics and financing concepts remains limited, particularly in the areas of health insurance/risk pooling, provider payment mechanisms, and application of economic evaluation studies.
- Risk pooling/health insurance interventions addressing high out of pocket payments were not implemented due to the legal environment.
- Domestic revenue generation activities have been challenging to implement due to the political environment and current legal system. Efforts to introduce legislation on sin taxes (earmarked) have been made as well as continued dialogue with other key ministries (MoF, commerce, justice) and the parliament, however, this is a long term strategic direction that is influenced by many other actors in the public system.
- Aid effectiveness mechanisms
- Government contribution to health as part of the total budget

3. DEVELOPMENT OF THE 2014-2018 HEALTH FINANCING STRATEGY

Figure 1. Group work discussion at the Consultative Workshop 2013

The development of the 2014-2018 Health Financing Strategy relied on the participation of various stakeholders within the MoPH as well as external partners. A working group was established in April 2013 with a clear terms of reference (Annex 1) agreed upon by all participants. Over a period of three months, the working group met bi-weekly to discuss the timeline of implementation, achievements of the last strategy, and components of the new strategy (strategic directions, objectives, and interventions). A consultative workshop with a larger group of stakeholders was conducted in September 2013 to present the working group' s draft strategic framework and obtain feedback and consensus on the directions, objectives, interventions, and monitoring and evaluation plan for the strategy. The strategic framework presented in this document incorporates the feedback and opinions shared from 62 participants who attended the consultative workshop. The consultative workshop facilitated the discussion of several major challenges facing the health financing environment in Afghanistan. Therefore, the strategy aims to reflect the dynamic financing situation and needs of the country by focusing on prioritized areas of the health sector identified by the working group participants. It is well acknowledged that not all functions of health financing or issues facing the country will be comprehensively addressed here. Working towards universal health care coverage within a sustainable health system is a long-term goal that requires long-term financial investment, planning, and commitment. Furthermore, many factors external to the control of the MoPH continue to pose as barriers to achieving more domestic resources to health. Such factors include the existing legal framework, limitations of the current tax base, and differing beliefs of purchasing and payment mechanisms appropriate for Afghanistan. The MoPH is committed to advocating for the health sector' s needs and priorities, being a voice for the sick and most vulnerable, for great health equity for all.

Figure 2. Participants from the Consultative Workshop 2013

4. HEALTH FINANCING STRATEGY COMPONENTS

The Health Financing Policy 2012-2020 outlines the following key policy priorities for which this strategy aims to move forward:

- Identifying ways to mobilize domestic resources through taxation and prepayment mechanisms to provide defined health care
- Increasing the efficiency and equity of public spending through different mechanisms
- including public-private partnerships and better targeting of beneficiaries of public funding
- Improving risk pooling through health financing schemes including social health insurance
- Securing more sustainable external funding for defined functions

4.1. Vision

Health for all Afghans

4.2. Mission

The MoPH will implement health financing arrangements to increase total finances available for the health system and contribute positively to:

- Expanding population access to health care
- Improving the quality of services
- Appropriate utilization of health care services
- Pooling of the financial risk of illness
- Improving predictability of funding streams
- Greater community participation in and ownership of the health system

4.3. Goal

Rapid movement toward universal health coverage through raising sufficient funds and improving efficiency and equity.

4.4. Core Values and Principles

This strategy has been developed considering the following principles:

- Ensuring access
- Improving quality
- Enhancing equity
- Attaining sustainability
- Promoting accountability and transparency
- Generating efficiency
- Advancing simplicity
- Results-oriented culture

5. STRATEGIC DIRECTIONS

Each strategic direction and objective was selected among a set of parameters to ensure their prioritization and alignment with the Ministry of Public Health. The proposed criteria for the selection of strategic directions and objectives are as follows:

- Relevant to Afghanistan health system
- Alignment with National Health Policy and 5 year Strategic Plan
- Alignment with National Priority Program (NPP)
- Alignment with Health Financing Policy
- Measurable – can be measured with SMARTER indicators
- Addresses sustainability related to financing mechanisms
- Understandable – everyone agrees and understands the importance
- Feasible and time bound
- Can contribute at least to two of the following themes: efficiency, equity, effectiveness, access, transparency, accountability, system development

5.1. Strategic direction 1: Strengthen capacity of the Afghanistan health system in applied health economics and financing schemes

Building capacity of the MoPH in health economics and financing schemes is critical for achieving the objectives of this strategy. Although significant capacity gains have been made in the past five years through support for master degree programs in health economics, short course trainings, technical assistance embedded with capacity strengthening programs, and on-the-job learning, support in the three core health financing functions of collecting resources, pooling risk, and purchasing services is still needed. Resource collection or revenue mobilization involves the ability to generate resources for under-funded priorities, improve financial management, and increasing overall government contribution to the health sector. Risk pooling includes the implementation of health insurance schemes in order to ensure financial protection against the risk of ill health – no one should become poor as a result of illness and using health care services. The purchasing of services enables health services to be provided to individuals. Understanding these specific functions by broader health system actors will facilitate longer-term goals of health financing reform.

5.1.1. Strategic Objective 1.2: Build organizational and institutional capacity at the central level in collecting resources, pooling risks, and purchasing services

Priority Interventions:

- Advocate for integration of a health economics module into the curriculum of KMU, Ghazanfar Institute of Health Science (GIHS), and private medical universities
- Conduct desk reviews to understand practices in institutional capacity building in health financing in other countries in the region
- Identify appropriate trainings in health financing functions for relevant government entities (MoPH, MoJ, MoLSAMD, MoF, etc)

5.2. Strategic Direction 2: Mobilize external and domestic financing for health

The immediate need is for increasing the total share of the government' s budget to the health sector, without replacing external financing. This is the first step in going from 4.2 percent to 8 percent of the government contribution to health, while preventing any shocks to the health system due to any reduction of external funds. Greater advocacy and knowledge-sharing on the need for more government contribution for health as well as the need to maintain current levels of external financing is important. For future long-term sustainability of the health system, it is well recognized that a gradual shift from donor funding to increased government funding for health is needed. It is important that this transition occurs gradually so as not to affect the current levels of quality and quantity of health services. However, Afghanistan' s ability to generate domestic revenues remains limited. Maintaining current levels of external funds is necessary to support this important long-term goal of transition. The Revenue Generation Strategy should be implemented as it identifies opportunities for generating resources through taxation, user fees, and health insurance, as well as ways to improve the efficiency resource use and financial management. Lastly, in order to move forward in improving the quality, efficiency, and purchasing of secondary and tertiary hospital services, a national price list should be developed and introduced.

5.2.1. Strategic Objective 2.1: Develop sound mechanisms to ensure stronger government commitment to the health sector

Priority Interventions:

- Advocate for earmarked funds to the health sector (ie: mining, long term)
- Strengthen partnerships with MoI, MoF, MoD, Parliament, and MoJ
- Advocate for increased government contribution to the health sector
- Conduct a literature review on increased government spending to health in developing countries and develop policy briefs for advocacy efforts

5.2.2. Strategic Objective 2.2: Implement the Revenue Generation Strategy for more domestic resources

Priority Interventions:

- Advocate for the introduction of earmarked taxes and tariffs for tobacco, fuel, vehicle smog/car, sales, and airlines
- Advocate for introduction of pre-payments/co-payments in secondary and tertiary hospitals

5.2.3. Strategic Objective 2.3: Develop a national price list for a number of health services at secondary and tertiary level hospitals

Priority Interventions:

- Establish a committee to price a package of services at secondary and tertiary level hospitals
- Identify costs per service and determine prices (as well as any co-payments)

5.2.4. Strategic Objective 2.4: Maintain current support of donors and advocate for more resources

Priority Interventions:

- Advocate for continued donor funding for the health sector
- Advocate for more donor resources for gap areas, based on results of financial gap analysis

5.3. Strategic Direction 3: Promote aid effectiveness, efficiency and equity of public spending, and eliminating waste

The availability of limited resources and decreasing donor commitments to Afghanistan requires more stringent policy decisions on the efficient allocation and use of funds. Greater health economics evidence through economic evaluations, cost analysis, and a mid-term expenditure framework is needed to support evidence-based decisions in the health sector. The application of these evidences will help to identify ways to improve allocative and technical efficiency in the delivery of health services. While advocating for greater domestic resources to health, it is important for the MoPH to show efficient and effective use of existing funds. To further reach this goal, improved harmonization and alignment among development partners and line ministries, as adopted in the Paris Declaration, is an imperative process for supporting MoPH priorities; ensuring continued quality and availability of health services; and increasing the government capacity to plan, budget, manage, and implement health programs.

5.3.1. Strategic Objective 3.1: To increase collection and use of health economics and financial data for evidence-based decision making

Priority Interventions:

- Develop mid-term expenditure framework (MTEF) based on MOPH priorities
- Produce economic analysis for decision and policymaking
- Set up mechanisms for the follow-up and use of data and information produced as well as the provision of feedback

5.3.2. Strategic Objective 3.2: Improve efficiency in the health sector

Priority Interventions:

- Identify ways to improve allocative efficiency in staffing, procurement, HFs size, higher education (short term and long term), administrative, network of health facilities based on morbidity and mortality
- Analyze the efficiency and equity of BPHS facilities, EPHS and national hospitals and distribution of pharmaceuticals

5.3.3. Strategic Objective 3.3: Improve harmonization and alignment among development partners and line ministries

Priority Interventions:

- Liaise/advocate with donors to ensure predictability of aid
- Consolidate and align implementation of development initiatives
- Assess new coordination mechanisms
- Advocate for greater health sector-on-budget support and enhance government mechanisms for response

5.4. Strategic Direction 4: Reduce financial risks and barriers to health access for the poor

Afghanistan is in the nascent stages of introducing social protection mechanisms such as health insurance schemes and equity funds. The results of the health insurance feasibility study conducted in 2014 will help to identify a mix of financing mechanisms that are feasible within the country' s context. This strategy aims to introduce a coherent and appropriate mix of risk pooling mechanisms to achieve universal coverage. Possible mechanisms include community based health insurance, social health insurance, user fees with fee-exemptions for the poor, and health equity funds.

5.4.1. Strategic Objective 4.1: Pilot and introduce health insurance schemes (community based health insurance, social health insurance)

Priority Interventions:

- Implement health insurance feasibility study roadmap
- Develop capacity in health insurance
- Coordinate with relevant government insurance bodies
- Develop insurance benefit package and implement the pilot schemes
- Pilot health insurance schemes and evaluate

5.4.2. Strategic Objective 4.2: Develop mechanisms for protecting the poor from catastrophic health expenditures

Priority Interventions:

- Assess the degree of catastrophic health spending and identify health care financial barriers
- Develop and apply exemption policies for welfare patients
- Create standard exemption tools for assessing household poverty level at the point of service
- Design and pilot voucher schemes for the poor
- Establish institutional capacity and design and pilot a health equity fund
- Design, pilot and expand a community health fund for transportation for the poor
- Coordinate with other stakeholders to reduce the access barriers

5.5. Strategic Direction 5: Support resource tracking mechanisms

Resource tracking provides important information to monitor the flow of funds in the health system. Many health system actors, governments and development partners alike, rely on health expenditure data to understand how much funds are in the health sector, who manages it, and whether it reaches the destination it' s intended to serve; to assess the performance of health policies and programs over time; and to guide decision-making. Resource tracking mechanisms include the National Health Accounts, Expenditure Management Information System, and the Public Expenditure Tracking Survey. Despite the importance of the data provided through these systems, resource tracking is often difficult to implement due to its dependence on external funding and technical assistance. As the MoPH strengthens its capacity in resource tracking mechanisms, these mechanisms will be absorbed into the framework of the MoPH and institutionalized with little external assistance for routine production and evidence-based decisions.

5.5.1. Strategic Objective 5.1: Institutionalize National Health Accounts (NHA)

Priority Interventions:

- To develop a NHA guideline to standardize the process
- Implement NHA systematically every two years
- Expand subaccount to include maternal, child health and disease programs

5.5.2. Strategic Objective 5.2: Institutionalize Expenditure Management Information System (EMIS)

Priority Interventions:

- Develop EMIS guideline/manual
- Implement EMIS
- Assess feasibility for Integrating EMIS into MoPH data warehouse

5.5.3. Strategic Objective 5.3: Regularly track the flow of funds

Priority Interventions:

- Implement PETS throughout the Health Sector

5.6. Strategic Direction 6: Improve purchasing mechanisms

Many different mechanisms for purchasing services exist. In Afghanistan, services are purchased by capitation or contracted to a provider for delivering a certain amount of care, fee-for-service, and incentive-based performance system. As the MoPH begins to leverage the private health sector, more support and investment in public-private partnerships (PPP) is needed. Demand and supply-side financing interventions such as results-based financing (RBF), conditional cash transfers, and mobile health will continue to be piloted and implemented to improve key health indicators and address barriers to accessing services. In order to begin introducing user fees and risk pooling mechanisms, provider payment mechanisms must be studied and improved to ensure that all funds are effectively used and leveraged for quality health services.

5.6.1. Strategic Objective 6.1: Support the private sector and public-private partnerships

Priority Interventions:

- Establish legal and administrative frameworks for PPPs in the health sector
- Introduce an investment promotion strategy
- Initiate hospital PPPs

5.6.2. Strategic Objective 6.2: Strengthen Demand and Supply-side Financing initiatives

Priority Interventions:

- Pilot different demand and supply-side financing initiatives
- Scale up of RBF intervention at national level
- Scale up m-health intervention

5.6.3. Strategic Objective 6.3: Continue supporting contracting mechanisms based on evidence

Priority Interventions:

- Conduct a study on payment mechanisms in Afghanistan for hospitals and primary care facilities, and providers
- Improve contracting mechanisms based on study results

6. DESIRED RESULTS AND OUTCOMES FOR 2018

Major results and outcomes have been identified to ensure successful implementation of the health financing strategy. These are organized by three phases of implementation. The first two phases are two years each in duration, with the last phase implemented over a one year period.

Phase 1 (2014-2015)

- ✓ Health insurance feasibility study provides risk protection options and roadmap for implementation
- ✓ Financial gaps identified and action plan developed
- ✓ Advocacy for domestic revenue generation implemented
- ✓ mHealth project is evaluated and scaled up based on results
- ✓ Risk protection mechanisms piloted
- ✓ User fees introduced with pilot of health equity funds in tertiary hospitals
- ✓ The 3rd NHA estimates include Reproductive Health and Child Health subaccounts
- ✓ EMIS tested and the manual developed
- ✓ RBF expanded under SEHAT
- ✓ Price list developed
- ✓ Health economics curriculum introduced into KMU public health course
- ✓ MTEF developed

Phase 2 (2016-2017)

- ✓ The 4thNHA estimates include Reproductive Health, Child Health, and other disease subaccounts
- ✓ Advocacy for domestic revenue generation implemented
- ✓ Implement the roadmap proposed and developed by the health insurance feasibility study
- ✓ Risk protection mechanisms and equity fund evaluated and scaled-up
- ✓ Public-private partnerships are strengthened through the establishment of a legal and administrative framework
- ✓ EMIS is fully institutionalized
- ✓ Health economics curriculum incorporated into GIHS curriculum

Phase 3 (2018)

- ✓ Implement the roadmap proposed and developed by the health insurance feasibility study
- ✓ PPP Hospitals established
- ✓ Utilization and quality of health services significantly improved in RBF facilities
- ✓ Revenue to health sector increased through tobacco tax funds

7. MEASURING PERFORMANCE: MONITORING IMPLEMENTATION OF THE HEALTH FINANCING STRATEGY 2014-2018

The monitoring and evaluation mechanisms for this strategic plan should be integrated with existing M&E functions and systems. There are several sources of M&E data that are needed to measure progress, which include: HMIS and surveillance data for health outputs, household survey data, expenditure data from NHA and EMIS, as well as any other necessary budgetary and costing data. Data should be cross-checked and verified through monitoring visits for programs, as well as through the production of studies, reports, meeting minutes, etc.

Monitoring functions will principally be the responsibility of GD Policy and Planning (HEFD as well as the Aid Coordination Unit). However, requisite data should be provided by all relevant stakeholders. The Performance Management Framework (PMF) below proposes a set of indicators for which to assess progress towards achieving the goal of the Health Financing Strategy, the six strategic directions, and each strategic objective. This PMF was initially drafted by participants in the consultative workshop to ensure that proposed indicators for measurement followed the SMART framework and were agreed on by the larger group.

Table 3. Performance Management Framework

Strategic Direction	Indicators	Baseline	Target	Means of Verification
Strategic Goal: Rapid movement toward universal health coverage through raising sufficient funds and improving efficiency and equity.				
SD1: Strengthen capacity of the Afghanistan Health System in applied health economics and financing schemes				
SO1.2: *Build organizational and institutional capacity at the central level in collecting resources, pooling risks, and purchasing services*	- Health Economics Module included in KMU and GIHS - Desk review conducted - Coordination mechanism among the department exists - Number of SOPs developed	- NA - NA - NA - # of SOPs	- Module included in KMU and GIHS - TBD	- Module exists - Review report - Available SOPs
SD2: Mobilize external and domestic financing for health				
SO2.1: *Develop sound mechanisms to ensure stronger government commitment to the health sector*	- Increased per capita government expenditure from US$1.5 (out of $42) to US$5 by 2016 - Health Finance MoU signed between MOI, MOF, MOD, Parliament, and MOJ	- US$1.5 - No MoU	- US$5 - MoU signed	- NHA report - MoU

Strategic Direction	Indicators	Baseline	Target	Means of Verification
	- One budget execution assessment conducted	- 0	- 1	- Assessment report
SO2.2: *Implement the Revenue Generation Strategy for more domestic resources*	- 100% of revenue raised by new taxes is earmarked to the health sector by MoF - Advocacy conducted for introduction of co-payments	- 0% - NA	- 100% - Materials developed and used	- MoF reports - Advocacy materials, advocacy plan
SO2.3: *Develop a national price list for a number of health services at secondary and tertiary level hospitals*	- One committee for pricing a package of services established - 25 services priced in the first year for secondary and tertiary hospitals by epidemiological profile of the country	- No committee - 0 services priced	- Committee established - 25 services priced	- Meeting minutes - Price list
SO2.4: *Maintain current support of donors and advocate for more resources*	- Should be aligned with SD3 activities	- NA	- NA	- NA
SD3: Promote aid effectiveness, and efficiency and equity of public spending and eliminating waste				
SO3.1: *To increase collection and use of health economics and financial data for evidence-based decision making*	- MTEF developed - # of cost benefit studies conducted - # of mechanisms established	- None - 01 - Current mechanisms (M&E, HMIS and surveys)	- By Dec. 2016 - 6 more studies - EMIS	- -MTEF document - Study reports - EMIS report and data
SO3.2: *Improve efficiency in the health sector*	- # of allocative efficiency studies conducted - # of efficiency and equity analysis studies	- None - 3	- 3 - 6 total	- Study reports presented and follow-up
SO3.3: *Improve harmonization and alignment among development partners and line ministries*	- # of yearly predicted budget - Annual MoPH retreat conducted - # of assessments conducted - # of inter-ministerial and strategic steering meetings conducted	- SEHAT - 9 - NA - NA	- 3 - 3 - 1 - 9	- Reports - Reports and workshop - Assessment report - Meeting minutes
SD4: Reduce financial risks and barriers to health access for the poor				
SO4.1:P*ilot and introduce health insurance schemes*	- Feasibility study roadmap implemented - Number of sessions to all levels conducted on health insurance	- NA	- TBD based on feasibility study results	- Feasibility study final report

Strategic Direction	Indicators	Baseline	Target	Means of Verification
(community based health insurance, social health insurance)	(governmental and non-governmental organizations) - The unit of coordination established - Insurance benefit package of services developed - Pilot study implemented			
SO4.2: *Develop mechanisms for protecting the poor from catastrophic health expenditures*	- Feasibility study conducted - Number of financial barriers identified - Policies developed and applied - Tools developed - Number of capacity building sessions - Organization to manage health equity fund established - Policies developed and health equity fund established - Effective coordination mechanisms established - % increase in hospital revenues from user fees - # of people enrolled in pilot health insurance schemes	- NA	- TBD	- Study reports and interviews
SD5: Support resource tracking mechanisms				
SO5.1: *Institutionalize National Health Accounts (NHA)*	- Availability of guideline	- NA	- NHA guideline available	- MoPH documents
	- NHA Report includes child and reproductive health subaccounts	- Two reports available	- Three NHA Reports	- MoPH documents
	- NHA Report includes RH, child, and disease subaccounts	- RH, child, disease subaccounts included	- NHA Report includes child health, RH, disease subaccounts	- MoPH documents
SO5.2: *Institutionalize Expenditure Management Information System (EMIS)*	- Availability of guideline/manuals	- NA	- EMIS guideline/manuals available	- MoPH documents
	- EMIS Implemented	- NA	- Implementation of EMIS	- MoPH documents
	- Feasibility report for Integrating EMIS into MoPH data warehouse available	- NA	- Feasibility assessment for Integrating EMIS into MoPH data	- MoPH documents

Strategic Direction	Indicators	Baseline	Target	Means of Verification
			warehouse	
SO5.3: *Regularly track the flow of funds*	- PETS completed	- 0	- 1 PETS conducted	- Final PETS report
SD6: Improve purchasing mechanisms				
SO6.1: *Support the private sector and public-private partnerships*	- # of laws, regulations, policies, guidelines and rules of procedures developed	- Procurement Law, draft PPP Regulation and PPP Management Manual	- Amended Procurement Law, Approved PPP Regulation and Rules of Procedure and PPP Manual	- Cabinet and Parliament approvals of the Procurement Law and PPP Regulation issued in the official gazette
	- Developed investment strategy	- 0	- 5 years IP strategy in health sector developed and implemented	- Final and approved investment promotion strategy
	- # of operational PPP hospitals	- 0	- 3	- PPP contracts
SO6.2: *Strengthen Demand and Supply-side Financing initiatives*	- Pilot initiatives conducted	- NA	- Completion of pilots	- Final approved pilot study reports
	- RBF performance indicators	- Implementer household survey and BSCs	- RBF national implementation	- HMIS verification and final project report
	- Household , health post and facility indicators for mHealth	- Baseline survey	- Dependent on evaluation	- mHealth final finding
SO6.3: *Continue supporting contracting mechanisms based on evidence*	- Area identified for improvement	- Contracted services	- Expansion of successful modalities	- Evaluation report for identified area

8. DATA USE AND POLICY IMPLICATIONS

Data of the highest quality should be the focus with utilization at all different levels of the health system. The quality of data will be ensured through indicators that are routinely measured as well as verification of data. Utilization and application of data and information are priorities for the MoPH in order to streamline and consolidate information to measure performance and better inform interventions and their impact on the population. Appropriate reporting mechanisms should be designed and implemented at each level of the health system to ensure information flow and access in a timely manner. Dissemination of information to different audiences – from policy makers to health facilities – is essential to facilitating evidence-based decision making. The following matrix provides an approach for obtaining the highest quality and use of data.

Table 4. Data Quality and Use

Area	Approach	Recommended Frequency
Improving data quality	Indicators for measurement: • Completeness • Timeliness • Accuracy • Data security • Ethical considerations • Data analysis • Acceptance • Cross check of data	Monthly; Quarterly
Ensuring verification of data	• Routine data checks at central and provincial levels, including facilities and communities	Quarterly
Establishing methods for reporting	• Progress reports • Data reports	Daily; Weekly; Monthly; Quarterly; Annually
Establishing methods for dissemination	• Policy briefs • Online system • Published papers • Workshops	Weekly; Monthly; Quarterly; Annually

Dissemination of results and sharing of data to appropriate stakeholders is important for the widest impact at both policy and service delivery/program implementation levels. For instance, health facility cost data are not only useful for the MoPH at the central policy level, but are also useful for facility managers to make day to day decisions in resource use and allocation. All study reports, advocacy documents, and program evaluations will be adapted to the appropriate audience for the greatest uptake of relevant information and its application.

9. ASSUMPTIONS AND RISKS

The implementation of the Health Financing Strategy 2014-2018 will face several risks and challenges due to the rapidly changing environment of the country. Five main anticipated risks are described below with mitigating actions for best managing these potential areas of concern.

1. *Stakeholder support:* Leadership for implementing the health financing strategy and support from all stakeholders is necessary. Without stakeholder consensus on the approach and design of financing mechanisms, the strategy will have difficulty during implementation and runs the risk of fragmentation and inefficient use of health sector resources. Addressing the limitations of the existing legal framework for revenue generation activities can become highly controversial. Thus, strong leadership and facilitation for consensus throughout the process are essential.
2. *Political instability:* The year 2014 poses many new opportunities and potential challenges for Afghanistan. With the pending presidential elections, many changes are anticipated given the political environment. This has implications on a number of health financing objectives, particularly related to revenue generation. Advocacy efforts should remain targeted and focused, meanwhile considering this period as a potential opportunity to raise health financing issues at the forefront of a new administration' s agenda as well as to the public.
3. *Funding:* The changing donor climate and priorities of the Government of the Islamic Republic of Afghanistan (GIRoA) may affect the funds available to dedicate to the implementation of the strategy. Strong coordination and advocacy across major financial stakeholders must be a continuous process to successfully implement the proposed interventions for longer-term impact on sustainability.
4. *Security:* The fluid security situation of Afghanistan remains a risk for implementing new programs, such as the proposed pilot interventions on health insurance, as well as for the ongoing delivery of quality health services. The withdrawal of troops in 2014 may affect the stability in which these programs are implemented. The security situation will be closely monitored, particularly in pilot-provinces, to assess the impact of security on the program' s success. Provinces varying in security climates will be selected for the pilot-phase to assess the feasibility of scale-up in differing environments reflective of the country. Overall security threats to the equity, quality, and efficiency of health services will also be monitored.
5. *Brain Drain:* Addressing the health economics and financing needs of the country required intensive investments in human resources from training a cadre of health economists to continued on-the-job capacity building efforts. Government investment in human resources in developing countries often risk 'brain drain' or loss of qualified skilled workers internally to other international agencies and NGOs, or externally to other countries. Efforts to mitigate the frequent loss of highly qualified staff will be made through appropriate incentives and motivational support, but cannot be guaranteed.

10. RESPONSIBLE DEPARTMENTS FOR IMPLEMENTATION

Table 5 indicates strategic directions along with the responsible department within MoPH for the advancement and implementation of each component. Improvement of Health Financing is not the responsibility of one department or unit within the Ministry. It requires collaboration and coordination across different program units and departments to come together and develop systems and processes.

Table 5. HCF Strategic Directions and Responsible Departments

SD	Strategic Directions	Responsible departments
1	Strengthen capacity of the Afghanistan Health System at various levels in applied health economics and financing schemes	HEFD
2	Mobilize external and domestic financing for health	HEFD, GDPP, Public Relation
3	Promote aid effectiveness, and efficiency and equity of public spending and eliminating waste	HEFD, GDPP (Aid Coordination Unit), GDHR, Procurement Department, Public Relation
4	Reduce financial risks and barriers to health access for the poor	HEFD
5	Support resource tracking mechanisms	HEFD, HMIS, Finance Department
6	Improve purchasing mechanisms	HEFD , GCMU, OPSC – PPP Unit, GDHR

11. COORDINATION MECHANISMS

To institutionalize the activities of health care financing within the MoPH, it is critical for the Ministry to further establish formal coordination mechanisms with the various directorates, units, at the level of the MoPH leadership and with other Ministries in GIRoA as well as Development Partners. The following provides a brief overview of proposed coordination mechanisms, including routine coordination mechanisms within the Ministry of Public Health.

11.1. Existing Coordination Mechanisms within MoPH

- Health Financing Task Force
- NHA Steering Committee
- Hospital Management Task Force
- Health Insurance Task Force
- PPP Task Force
- MoPH Health Sub-Committee, TAG, and Executive Board

11.2. External Coordination Mechanisms

The implementation of the Health Care Financing Reforms (e.g., Financial Autonomy at Hospital Level or taxation etc.) will imply strong cooperation and formal dialogue with the MoF. The MoF and MoPH have already developed regular working relationships through program budgeting activities. Strong linkages with the Ministry of Commerce are also necessary for implementation of revenue generation activities. The Revenue Generation Task Force is a mechanism that represents the interests of these various stakeholders specifically for increasing domestic resources to health. Additionally, a MoU with the Central Statistics Office ensures coordination on data collection activities through the NRVA, however, coordination mechanisms to ensure communication channels are regularly used have yet to be formalized.

12. ANNEXES

Annex 1: Terms of Reference for Health Financing Strategy 2014-2018 Working Group

Terms of Reference
Health Care Financing Strategy 2014-2018
Afghanistan Ministry of Public Health (MoPH)
April 23, 2014

I. Background

Afghanistan continues to increase its domestic revenue, though it is still also heavily dependent on external aid. At present, external assistance is estimated to represent more than 85% of total public spending on health. On the other hand the flow of such aid is unstable and difficult to predict. The alignment and compliance of external aid with government policy and strategy is challenging. Additionally, capacity in health economics research and costing analysis is limited. It is evident that there is a need for improving efficiency as well as the flow of financial data in the health sector.

The implementation of a fully developed HCF strategy 2009-2013 guided the MoPH and both public and private sectors to establish greater resource efficiency in the provision of health services, deliver cost-effective health interventions at all levels in the health services system, and to conduct evidence-based health policy decision-making at all levels.

Therefore, there is need of having a health care financing (HCF) and sustainability strategy 2014-2018 in light of Health Financing Policy 2012-2020 in order to identify key health financing schemes for further improvement of the health system.

II. Goal of the Health Financing Strategy, 2014-2018 development Committee

To develop a Health Financing Strategy, 2014 -2018 based on the Health Financing Policy, 2012-2020.

III. Objectives of the Health Financing Strategy 2014-2018 Development Committee

1. To review the current Health Financing Strategy, 2009-2013 and identify areas where actions have not yet been taken/completed;
2. To provide expert opinions (literature review) and recommendations on the new proposed areas to be included in the new health financing strategy in line with the health financing policy 2020; and
3. To provide new ideas to the MoPH on how to implement the proposed areas in the future.

IV. Activities

1. Developing a timeline for the WG;
2. Reviewing the Health Financing Strategy 2009-2013;
3. Reviewing current activities and their implementation progress;
4. Providing expert opinions on the new proposed areas to be included in the new strategy for 2014-2018;
5. Developing health financing strategy 2014-2018;
6. Developing an action plan for the implementation; and
7. Costing of the new health financing strategy.

V. Members

1.	HEFD	Dr. Ahmad Shah Salehi (Chair)
2.	ANPHA	(Representative)
3.	ANPHI	Dr. Khwaja Mir Islam Saeed
4.	CIDA	Ms. Genevieve Bussiere
5.	Deputy Minister Office	Dr. Jawad Mirzad
6.	EPOS	Mr. Dejan Ostejic, Dr. Miroslaw Manicki
7.	EU	Dr. Sefatullah Habib
8.	FGGO-HPP	Dr. Omarzaman Sayedi, Ms. Christine Kim
9.	GCMU	(Representative)
10.	GDCM	Dr. Hidayatullah Al-Noor
11.	GDPM	Dr. Parwiz
12.	GDPP	Dr. Noor Ahmad Arzoie
13.	HEFD	Dr. Husnia Sadat, Dr. Mohammad Saber Perdes
14.	HPIC	Dr. Nasratullah Rasa
15.	Ministry of Economy	(Representative)
16.	MoF	(Representative of Treasury and Tax Administration Dept.)
17.	MSH	Dr. Newbrander, Dr. Hedayatullah Saleh
18.	Private Sector	(Representative)
19.	Private Sector Coordination Office	Dr. Sayed Mohammad Shafi Sadat
20.	UNICEF	Dr. Sayed Moazzam Hossain
21.	USAID	Dr. Ibrahim Maroof, Ms. Lisa Childs, Ms. Catherine Fischer
22.	WB	Dr. Ghulam Dastgir Sayed
23.	WHO	Dr. Najibullah Safi

VI. Meeting Venue:

1. MoPH/HEFD

VII. Timing:

Twice a month on Tuesdays, 2.00 – 4.00pm. The schedule will be adjusted for the period of Ramadan.

VIII. Secretariat:

Health Economics and Financing Directorate and Ms. Christine Kim (HPP).

Annex 2: Health Financing Strategy Working Group Members

SN	Name	Affiliation
24.	Ahmad Shah Salehi (Chair)	MoPH/HEFD
25.	Khwaja Mir Islam Saeed	ANPHI
26.	Genevieve Bussiere	CIDA
27.	Dejan Ostojic	EPOS
28.	Miroslaw Manicki	EPOS
29.	Sefatullah Habib	EU
30.	Christine Kim	FGGO/HPP
31.	Omarzaman Sayedi	FGGO/HPP
32.	Damon Brown	ISAF
33.	Jonathan Ruwe	ISAF
34.	Molly Schaefer	ISAF
35.	Jawad Mirzad	MoPH/DM
36.	Noor Ahmad Arzoie	MoPH/GDPP
37.	Husnia Sadat	MoPH/HEFD
38.	Mohammad Saber Perdes	MoPH/HEFD
39.	Hedayatullah Saleh	MSH
40.	Sayed Moazzem Hossain	UNICEF
41.	Najibullah Safi	WHO

Annex 3: Consultative Workshop List of Participants

Health Financing Strategy Consultative Workshop, September 3, 2013 MOPH Staff List		
#	Name	Organization
1.	Najia Tariq	MoPH/ Deputy Minister
2.	Mohammad Hafiz Rasooli	MoPH/APHI
3.	Jawad Mirzad	MoPH/DM
4.	Wahidullah Zaheer	MoPH/GCMU-HSS
5.	Massoud Mehrzad	MoPH/GCMU-PCH
6.	Zahidullah Rassouli	MoPH/GCMU-PGC
7.	Mohammad Hassan	MoPH/GCMU-PPA
8.	Nazir Heidarzad	MoPH/GDPA
9.	Noor Ahmad Arzoie	MoPH/GDPP
10.	Kemya Aziz	MoPH/GIHS
11.	Sher Shah Amin	MoPH/GPP
12.	Abo Ismael Foshanji	MoPH/HEFD
13.	Ahmad Reshad Osmani	MoPH/HEFD
14.	Ahmad Shah Salehi	MoPH/HEFD
15.	Ajmal Behzad	MoPH/HEFD
16.	Emal Masood	MoPH/HEFD
17.	Faridoon Joyenda	MoPH/HEFD
18.	Husnia Sadat	MoPH/HEFD
19.	Kaleemullah Niazi	MoPH/HEFD
20.	Khwaja Mir Ahad Saeed	MoPH/HEFD
21.	Mir Najmuddin Hashimi	MoPH/HEFD
22.	Mohammad Fahim Ahmadi	MoPH/HEFD
23.	Mohammad Saber Perdes	MoPH/HEFD
24.	Mohammad Samim Soroush	MoPH/HEFD
25.	Mohammad Younus Zawoli	MoPH/HEFD

26.	Najibullah Hoshang	MoPH/HEFD
27.	Qiamuddin Sabawoon	MoPH/HEFD
28.	Saifuddin Hemat	MoPH/HEFD
29.	Said Mohammad Karim Alawi	MoPH/HEFD
30.	Shuhrat Munir	MoPH/HEFD
31.	Sayed Yaqoob Azimi	MoPH/HMIS
32.	Ahmad Jawad Osmani	MoPH/IR
33.	Ibne Amin Khalid	MoPH/M&E
34.	Abdul Hakim Aziz	MoPH/PHD
35.	Khan Mohammad Zamani	MoPH/PPP
36.	Karima Mayar	MoPH/Quality Assurance Department
37.	Sadia Ayobi	MoPH/RHD
OUTSIDE MOPH/NATIONAL		
38.	Momen Mansour	MoF
39.	Esmail Ahady	MoF
40.	Saifuddin	MoE
EXTERNAL PARTNERS		
41.	Genevieve Bussiere	CIDA
42.	Dejan Ostejic	EPOS/EU
43.	Jordi Benages	EPOS/EU
44.	Norio Kasahara	EPOS/EU
45.	Carmen Lloveres	EU
46.	Fazel Mohammad Zameer	EU
47.	Sefatullah Habib	EU
48.	Nasratullah Rasa	HPIC
49.	Omarzaman Sayedi	HPP
50.	Wu Zeng	HPP
51.	Christine Kim	HPP/HEFD
52.	Jonathan Ruwe	ISAF
53.	Molly Schaefer	ISAF
54.	Hedayatullah Saleh	MSH
55.	Mohammad Khakerah Rashidi	MSH
56.	Mubrak Shah Mubarak	MSH
57.	Nasreen Khan	UNICEF
58.	Sayed Moazzam Hossain	UNICEF
59.	Mirwais Amiri	URC
60.	Mirwais Rahimzai	URC