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FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE: PEER-TO-PEER LEARNING WORKSHOP FINDING SOLUTIONS TO COMMON CHALLENGES ACCRA, GHANA | February 15-19, 2016 FINAL REPORT

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This publication was produced for review by the United States Agency for International Development.
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The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, $209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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| RTI International | Training Resources Group, Inc. (TRG)

I. CONTENTS

Financial Protection and Improved Access to Health Care: Peer-to-Peer Learning Workshop
Finding Solutions to Common Challenges
Accra, Ghana February 15-19, 2016
Final Report

1. Overview and Purpose:

Co-hosted by the U.S. Agency for International Development (USAID), the Ministry of Health and the National Health Insurance Authority (NHIA) of Ghana, and the World Health Organization (WHO), the *Financial Protection and Improved Access to Health Care peer-to-peer learning workshop: Finding Solutions to Common Challenges* was held in Accra, Ghana from February 15-19, 2016.

This five-day workshop was aimed at the following objectives:

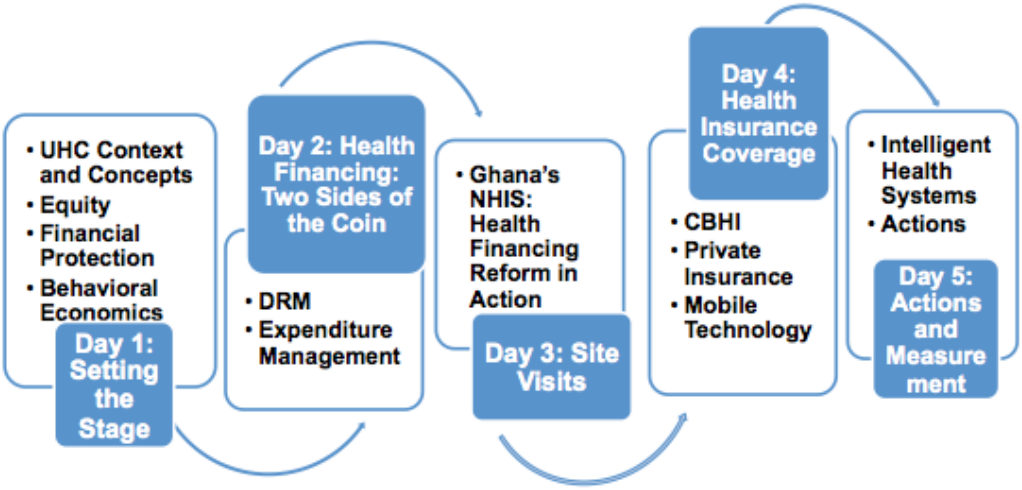
- Gaining a deeper understanding of how to grow and use financial resources to increase financial protection and improve equitable access to priority health services,
- Identifying concrete actions to take health financing and insurance programs to the next level,
- Strengthening partnerships and coordination across countries, within countries, and between partners.

The workshop brought together **167 participants from nine countries** (Benin, Cote D'Ivoire, Ethiopia, Ghana, Nigeria, Rwanda, Senegal, Togo, and Uganda). Each country delegation included a mix of government representatives from Ministries of Health (MOH), Ministries of Finance (MOF), and national health financing agencies, as well as USAID mission staff, WHO representatives, and various non-governmental organization (NGO) and private sector participants. Other participating partners included Bill & Melinda Gates Foundation, Joint Learning Network for Universal Health Coverage (JLN), World Bank Group, and the Mexico Ministry of Health. The participants list is included in Annex II.

The workshop provided a unique opportunity to bring together countries from across the continent to learn from each other in Ghana, a country with one of the most developed national health insurance schemes (NHIS) in Africa. Ghana is also at a pivotal moment, with an ongoing Technical Review of the scheme. Participants had the chance to visit a number of NHIA sites in Ghana to see how the system functions.

The workshop covered a range of key issues in health financing and service provision (see Figure 1). The workshop agenda is included in Annex I and overviews of each session are available in Annex III.

Figure 1. Agenda Schematic



Each session was centered on a particular topic, and structured to present a **state-of-the-art** technical framing, **delve deeply** into the experience of one or more countries, and open the floor for **cross-country discussion and exchange**. Throughout, the participatory design used a mix of interactive methods including roundtables, talk shows, and breakout sessions.

The workshop drew a much larger than expected group of participants, evidence that the health financing topic was of great interest and very timely for the nine participating countries. It also attracted a great deal of partner interest and support, including strong partnership with Ghana's NHIA and MOH, participation from WHO at the global, regional, and country levels, as well as collaboration with the Bill & Melinda Gates Foundation in support of Nigeria's strong participation.

The **country team approach** to workshop participation permitted frank team dialogues in a neutral setting. The inclusion of USAID field staff and WHO country staff helped to **build partnerships** and identify opportunities for support in follow-up to the workshop. The agenda allowed time for development partners to convene at both the beginning and the end of the workshop to discuss and determine how the meeting can help inform better coordination of technical assistance and financing in this space.

The meeting closed with **country commitments** of the key steps that they will undertake to move health financing reforms to the next level, an articulation of the partner support that will help them to go further faster, and the markers of progress and timeline that they will follow to track implementation.

1.1 Participant Feedback

Reflecting on the meeting, country participants and partners alike were pleased with this innovative opportunity to come together and learn about the implementation successes and challenges of other countries from both Anglophone and Francophone Africa. Participants described the workshop as **motivating, inspiring, and "electrifying."** When asked about the overall usefulness of the workshop in the participant evaluations, **93% of participants rated the workshop as very or highly useful** (summary of workshop evaluations available in Annex VII).The approach to working closely with USAID missions to seek country input on the agenda and design the sessions helped to ensure the workshop was **demand-driven**. Participants highly valued the **peer-to-peer learning** approach, with a **focus on implementation and governance challenges**, and **finding solutions to common problems**. They also appreciated the **world-class group of experts** the workshop attracted. Participants expressed that the workshop had helped them to identify a range of solutions and available resources to put their learnings into action, and move forward the universal health coverage (UHC) agenda in tangible ways on the ground.

> *""Having representatives from Parliament was one of the best aspects of the workshop, and it may have moved things at the political level in Nigeria."*
>
> - Nancy Lowenthal, USAID Nigeria

> *"The (Senegal) delegation believes that this workshop was an opportunity for them to visit several countries while remaining in a single country. The presentations made throughout this workshop offered a series of tools, concepts, experiences that the delegation intends to use in the process of elaboration of its strategy of financing health. So many doors are open to them to let them move forward"*
>
> - USAID Senegal Team

2 Key Challenges and Solutions Discussed

The meeting began with a priority-setting exercise focused on **"how-to" questions** about financial protection to identify key implementation challenges countries wanted to focus on (See figure 2 below). Resoundingly, countries identified **improving health system efficiency** as their top priority (21 responses), and **identifying the poor and reaching the informal sector** as their second (16 responses). Countries also articulated their top priorities for learning during the opening session, which helped to further orient and solidify the direction of discussions throughout the week.

Figure 2. Responses to country prioritization exercise

How to….	Responses	
Identify the poor and reach the informal sector?	16	*Nigeria, Ghana*
Incentivize positive behavior with provider payment?	4	*Rwanda, Nigeria*
Influence rational patient use of care?	1	
Align health reforms to public financial management systems?	6	*Nigeria, Uganda*
Improve efficiency, including pharmaceutical expenditures?	21	*Ghana, USAID Ghana, Benin, Ethiopia, Cote D'Ivoire, Rwanda, Nigeria, Uganda*
Make the case to increase general budget revenue for health?	8	*Uganda, Nigeria, Ghana*
Scale up CBHI to the national level?	1	*Ethiopia*
Leverage private health insurance to help improve access to care?	8	*Uganda, Ghana, Rwanda, WA Regional*
Use mobile payment to support UHC efforts?	3	*Nigeria*
Use data and systems to inform evidence based decisions?	2	*Uganda, Rwanda*

2.1 Finding Solutions to Common Challenges

Below is a list of ten key challenges and associated solutions that participants identified over the course of the week. Note, the order of challenges/solutions aligns with the workshop agenda, not with the relative priority placed on each challenge area.

Challenge 1: Addressing Inequities: High inequities in the health financing system are reflected in large out-of-pocket expenditures and catastrophic payments for health care that throw people back into poverty**.**

- Increase **pre-payment** (delink services from payment at point of care).
- In order to be pro-poor, include those who are unable to pay from the outset during the planning and implementation process.
    - **Mexico's Seguro Popular** was designed to increase financial protection and cover the poor, and has shown progress towards equity.
- National health insurance financed by taxes is a form of solidarity against financial risks for all population groups.
- If starting with community-based health insurance (CBHI), mobilize **public financing to subsidize the poor**.
- Progress in financial protection and access to care requires strong political will and changes in behaviors of providers and populations.

- Mechanisms at a national level need to be in place to regulate health insurance system in order to improve financial protection and reduce fragmentation.
- Implement processes to **measure and track out-of-pocket spending**.

Challenge 2: Expanding Fiscal Space: Economic transition in many African economies will create fiscal space and will enable them to spend more for health. However, in many cases policymakers (e.g., Parliamentarians and/or MOF) may be reluctant to allocate additional resources to health.

- Apply **behavioral economics principles** to influence policymaker behaviors, build political will, and generate commitment (e.g., analysis of impact of price on use of services or analyzing policymaker receptivity to different messages).
    - Ghana's political leaders showed that **engagement of policymakers** in health system development can make the path to UHC smoother and faster.
- **Make case to MOF** by showing results through the use of resources and positioning health as an important economic investment.
- Funding for implementation of health reforms should be domestic, and external resources can serve as catalytic support to help reforms get started.

Challenge 3: Reducing Health Financing Gap for UHC: The funding gap is large to attain UHC. It is difficult to reduce the gap by only mobilizing additional domestic sources.

- Need to focus on **both sides of the coin**—**mobilizing domestic resources** through regular revenues and innovations must be used in tandem with measures to **manage expenditures and increase efficiency** to help improve value for money of existing funds.
    - Uganda's experience with adopting measures to improve efficiency showed the importance of focusing on the expenditure management side of the coin while continuing to seek additional funding for health.
- Focus on bringing the general budget for health -- the backbone of domestic country financing – in line with country priorities and expected results.
- Improved **MOH/MOF dialogue** is crucial to improving systemic alignment.

Challenge 4: Mobilizing and Allocating Domestic Resources: While expanded fiscal space should allow countries to allocate larger resources to health; how resources are allocated will be critical for achieving health and financial protection goals.

- If **allocated equitably** and **managed efficiently**, more resources can translate into reduced out-of-pocket spending and expanded coverage.
- Budget analysis and donor funding need to align with the priorities of the country – to make decisions clearer for MOF.

- The total envelope going to health including other sectors should be considered for realistic expectations and inter-linkages of health with other sectors.
- **Earmarking** can be an easy sell, and resonate with the public - however, strong management is needed to ensure expenditure does not exceed revenue and meets public health needs.
- **Data are critical** to understanding what is working and what is not to decide on allocation and use of resources and customize the services according to the demand.
- Domestic revenue mechanisms like **Value Added Tax** and social security contributions provide more than 90% of funding for the Ghana NHIS.

Challenge 5: Increasing Efficiency: About 30-40% of health expenditures are wasted. Increasing efficiency and getting more **value for money** are low-hanging fruit and essential for increasing fiscal space and reducing the health financing gap for UHC. Managing health expenditures is equally, if not more important, than generating new resources.

- Improve **strategic purchasing** of services through provider payment reforms (e.g., capitation payments in Ghana and performance-based financing (PBF) in Rwanda and Senegal).
- Strengthen **financial management** systems to improve budgeting and execution (e.g., health sector piloting public financial management reforms in the DRC, including improved budget formulation according to health sector priorities, capacity-building for expenditure management, streamlining procurement, integrated financial reporting platform, and PBF).
- Use **data and technology**- establishment of intelligent health system- to monitor provider payment and financial management reforms.

Challenge 6: Rationalizing the use of drugs: Pharmaceuticals are the largest source of inefficiency. Overuse and misuse from drug benefits can overwhelm health insurance program finances.

- Conduct **costing analysis** before offering to finance drugs.
- Do not over-promise the drug benefit coverage (start small).
- Fast-response **information technology (IT) systems** can assemble data and improve management of adherence, availability and quality, and reduce fraud.
- Apply IT tools (e.g., mobile technology) to fully adjudicate eligibility and payments before issuing drugs to patients.
- Develop a review process for new drugs using **health technology assessment** tools.
- Introduce **price regulations** for pharmaceuticals (e.g., Namibia and South Africa), and **prescribing practices** (e.g., South Korea).

Challenge 7: Focusing on Communities: Sustainable CBHI can be a pathway to UHC and help cover poor, rural and informal sectors.

- Countries can determine the path most suited to them and learn from the experiences of Rwanda, Ethiopia and Senegal.

- If the country has CBHI, seek more than just community contributions: important to seek **government subsidies for the poor**, **enlarge the risk pool**, and integrate CBHI with other prepaid schemes.
    - Rwanda's example of moving CBHI to the Rwanda Social Security Board (RSSB), under the MOF, illustrates an example of efforts to improve CBHI management through a single pool and separate the functions of purchaser and provider.
- If the country does not already have CBHI, begin with the national model, and start pro-poor UHC scheme from the beginning.

Challenge 8: Expanding Public-Private Partnership: Large scope for private health insurance to complement government-sponsored UHC programs (e.g., increasing access to populations and promoting efficiency and viability of health insurance schemes) but limited progress thus far.

- Create **enabling environment** for engagement between public and private stakeholders.
- Establish appropriate regulatory framework and government oversight.
- Ensure that private health insurance solutions ***complement*, rather than compete** with, UHC initiatives (e.g., Nigeria's experience of private health insurance as a government partner to promote innovation, efficiency, and viability of government-sponsored programs).

Challenge 9: Using Mobile Technology: Mobile technology can improve efficiency of health systems and expand outreach of insurance for the poor, as illustrated by examples from Ghana, Nigeria and Rwanda.

- Governments need to get involved. Private mobile insurance can **complement** government sponsored health insurance, but this requires oversight/coordination.
- Adopt **mobile-enabled insurance and savings solutions** to deliver simple "mass" private health insurance (e.g., MTiba Mobile Health Wallet for insurance pre-payment in Kenya, Orange's mobile money partnership with CBHI in Mali).
- Improve **interoperability** across mobile network operators for accelerated expansion of mobile solutions, and address signal coverage gaps.
- Explore use of satellite technology to provide platform for coordination**.**

Challenge 10: Developing intelligent Health System: Evaluation and monitoring are prerequisites for successful reforms. Establishment of data collection and data use are critical and lie at the heart of **evidence-based decision-making**.

- **Operational research** and leveraging **big data** are important complements to global UHC measurement framework.
- Global frameworks should not get in the way of countries designing measurement and data systems that reflect their needs. Thinking about data integration from the start is important, by creating coding and ways for different data sources to speak to one another.
- Ghana's multi-stakeholder working group to develop an evidence-based **dashboard** for the NHIS helped to ensure that priority indicators were actionable and based on available data.

The NHIS also created a standing technical committee on operations research to examine key actionable research issues.

- Ethiopia's health data management system has evolved from "family folders" to a well-integrated health management information system **(HMIS)** that includes a system of red, yellow or green "flags" to indicate performance at the federal level.

3. Next Steps

3.1 Country Commitments

The meeting concluded with a commitment from each country of the key steps that they will undertake to move health financing reforms to the next level, an articulation of the needed partner support, and the markers of progress and timeline that they will follow to track implementation. Country commitments were publicly documented during the report-outs and will be circulated separately to partners for follow up and assistance. A summary table of each country's commitments is included in Annex V.

3.2 Partner Meetings

The agenda allowed time for partners to convene at both the beginning and the end of the workshop to discuss and determine how the meeting can help inform better coordination of technical assistance and financing in this space. Partners resolved to exchange information on plans at least quarterly, and USAID agreed to organize the first set of plans, with other agencies such as WHO or the World Bank, eventually taking over future coordination. A report on the partner meetings is included in Annex VI.

Annex I. Workshop Agenda

At-a-glance Agenda

Sunday Day 0-FEB 14		Monday Day 1-FEB 15		Tuesday Day 2-FEB 16		Wednesday Day 3-FEB 17		Thursday Day 4-FEB 18		Friday Day 5-FEB 19	
Arrivals		8:00am - 9:00am	I. Registration Meet and Greet with Coffee (8:30am - 9:00am)	8:00am - 8:05am	I. Prayers	8:00am - 8:05am	I. Prayers	8:00am - 8:05am	I. Prayers	8:00am - 8:05am	I. Prayers
		9:00am - 9:05am	II. Prayers	8:05am - 9:45am	II. Health Financing for UHC: "Two Sides of the Coin"	II. Site Visits Full Day, with early morning departures (to be announced)		8:05am - 9:15am	II. Debriefing and Reflections from the Site Visits: NHIS: Connecting the Past and Present	8:05am - 9:45am	II. "Intelligent Health Systems"
		9:05am - 9:30am	III. Opening Session	*Coffee Break 9:45am – 10:15am*				9:15am - 10:30am	Community-Based Health Insurance – Lessons, Challenges, and Opportunities	9:45am - 10:15am	III. Country work sessions
		9:30am - 10:30am	IV. Icebreaker, with Coffee Service	10:15am - 12:00pm	III. How to Mobilize Domestic Resources for Health			*Coffee Break 10:30am – 11:00am*		*Coffee Break 10:15am – 10:45am*	
		10:30am - 12:00pm	V. Setting the Stage					11:00am - 12:30pm	The Role of Private Health Insurance in UHC	10:45am - 12:00pm	IV. Generating ideas for future learning and action
		Lunch 12:00pm - 1:00pm		*Lunch 12:00pm - 1:00pm*				*Lunch and Learn 12:30pm - 1:30pm*		12:00pm - 12:30pm	V. Closing Brief closing remarks by USAID, NHIA, WHO, and Gates
		1:00pm - 2:30pm	VI. Financial Protection and Access to Care: In Theory and Practice	1:00pm - 2:30pm	IV. Expenditure Management: How to Increase Efficiency and Value for Money			1:30pm - 3:00pm	V. Mobile Facilitated Insurance Products and Solutions	*Closing Lunch 12:30pm – 1:30pm*	
2:00pm - 4:00pm	I. All Session Chairs, Presenters, and Coordinators - Prep Meeting	*Coffee Break 2:30pm – 3:00pm*		2:30pm - 3:30pm	V. Spotlight on Pharmaceuticals			*Coffee Break 3:00pm – 3:30pm*			
4:00pm - 5:00pm	II. Focused Prep Sessions for Day 1 Chairs, Presenters, and Coordinators	3:00pm - 4:30pm	VII. Commitment Generation and Behavioral Economics: Redistribution and Solidarity	*Coffee Break 3:30pm – 4:00 pm*				3:30pm - 4:30pm	VI. Country work session		
5:00pm - 6:00pm	III. Development Partners (USAID, WHO, Gates) Collaboration Meeting	4:30pm - 4:45pm	VIII. Daily Wrap-Up	4:00pm - 4:45pm	VI. Country Work Session			4:30pm - 5:00pm	VII. Daily Wrap-up		
Dinner on own		5:00pm - 6:00pm	IX. Focused Prep Session for Day 2 Chairs, Presenters, and Coordinators	4:45pm - 5:15pm	VII. Daily Wrap-Up and Overview of Field Visit Plans			5:00pm - 5:30pm	VIII. Focused prep session for Day 5 Chairs, Presenters, and Coordinators		
				5:15pm - 6:15pm	VIII. Senegal Health Financing Strategy Work Session IX. Focused Prep Session for Day 4 Chairs, Speakers, and Coordinators			5:30pm - 6:30pm	IX. Development Partners (USAID, WHO, Gates) Collaboration Meeting		

Annotated Agenda

Workshop Objectives

1. ***Deepen knowledge and understanding*** of practical health financing concepts and promising solutions to common challenges, focusing on how to grow and use financial resources to increase financial protection, improve equitable access to priority health services, and achieve financial sustainability in a UHC context.
2. ***Identify specific actions*** that countries can take to effectively balance revenue mobilization and expenditure management, drawing on the knowledge and peer relationships built over the course of the workshop.
3. ***Strengthen partnership*** between USAID missions, WHO, and partner Governments, and amongst Government partners, on health financing, identifying technical priorities, knowledge gaps, and needs for future support and continued learning.

Sunday, Feb. 14

I. All Session Chairs, Presenters, and Coordinators – Prep Meeting	2:00pm – 4:00pm
II. Focused Preparation Sessions for Day 1 Chairs, Presenters, and Coordinators	4:00pm – 5:00pm
III. Development Partners (USAID, WHO, Gates) Collaboration Meeting	5:00pm – 6:00pm

Day 1: Monday, Feb. 15

The UHC Context: Increasing Financial Protection and Access to Services in Mixed (Public/Private) Health Systems

I. Registration ○ **Meet and Greet with Coffee (8:30am – 9:00am)**	8:00am – 9:00am
II. Prayers	9:00am – 9:05am
III. Opening Session **Chair: Akua Kwateng-Addo, USAID/Ghana Mission** **Welcome Remarks** ○ ***Megan Rhodes, USAID/Washington*** (4 minutes)	9:05am – 9:30am

Day 1: Monday, Feb. 15

The UHC Context: Increasing Financial Protection and Access to Services in Mixed (Public/Private) Health Systems

○ ***U.S. Ambassador to Ghana, Robert Jackson*** (4 minutes) ○ ***Honorable Minister of Health of Ghana***, ***Alex Segbefia*** (7 minutes) **Objectives and Expectations**(10 minutes) ***Ishrat Husain, USAID/Washington and Amanda Folsom, Results for Development (R4D)/HFG***	
IV. Icebreaker, with Coffee Service Objectives of the Icebreaker: ○ Meet other participants ○ Identify priority UHC-related implementation topics that participants hope to focus on during the week. Session Format: The Icebreaker will be structured as an interactive voting exercise.	9:30am – 10:30am
V. Setting the Stage: **Chair: Honorable Minister of Health of Ghana, Alex Segbefia** **Keynote: Economic Transitions in Health and UHC in Africa** (25 minutes) ***Ariel Pablos-Mendez, Assistant Administrator for Global Health, USAID/Washington*** **Covering the Poor and Ensuring More Equitable Health Financing** (20 minutes) ***Abdo Yazbeck, Lead Health Economist, World Bank*** **Overview of Ghana's National Health Insurance Scheme** (20 minutes) ***Nathaniel Otoo, Acting CEO, National Health Insurance Authority (NHIA) Ghana***	10:30am – 12:00pm

Day 1: Monday, Feb. 15

The UHC Context: Increasing Financial Protection and Access to Services in Mixed (Public/Private) Health Systems

Session Objectives: ○ Discuss latest developments in UHC and economic transitions in health ○ Learn about Ghana's national health financing strategy and implementation of the National Health Insurance Scheme ○ Consider how health financing can be a powerful tool for improving equity Session Format: Plenary remarks followed by 25 minutes of participant discussion ***Session Coordinator: Rubama Ahmed***	
Lunch *12:00pm – 1:00pm*	
VI. Financial Protection and Access to Care: In Theory and Practice **Chair: Nathaniel Otoo, Acting CEO, NHIA, Ghana** Session Objectives: ○ Understand concepts of financial protection and access to care, including how to they are defined, implemented, and measured ○ Identify practical strategies for increasing and sustaining financial protection and access to services, such as use of public funds for extending financial protection (subsidies, waivers, vouchers, insurance) or engaging private providers to expand access Session Format: State of the art (15 minutes): ○ ***Laurent Musango, WHO AFRO*** ○ Concepts and practical strategies for increasing and sustaining financial protection and access to care	1:00 pm – 2:30pm

Day 1: Monday, Feb. 15

The UHC Context: Increasing Financial Protection and Access to Services in Mixed (Public/Private) Health Systems

Spotlight country (30 minutes): Mexico ○ ***Adolfo Martinez Valle, Mexico Ministry of Health*** ○ An interactive "fishbowl" interview by Ghana Discussion (45 minutes): ○ Interactive Q&A in plenary (40 minutes) ○ Brief closing reflections from Benin, by ***Evelyne Akinocho, Benin Ministry of Health*** (5 minutes) ***Session Coordinator: Bob Emrey***	
Coffee Break *2:30pm – 3:00pm*	
VII. Commitment Generation and Behavioral Economics: Redistribution and Solidarity **Chair: Dr. Francis Ukwuije, Federal Ministry of Health, Nigeria** Session Objectives: ○ Learn about the principles of behavioral economics and their application in the real-world implementation of health systems reform for UHC ○ Better understand how countries have generated commitment and built solidarity to ensure coverage of the poor and to distribute/redistribute limited resources, at the provider and population levels Session Format**:** State of the art (15 minutes): ○ ***Abdo Yazbeck, World Bank*** ○ Introduction to behavioral economics and application in UHC Spotlight country (20 minutes): Ghana ○ Behavioral economics in action in Ghana, by ***Christine Papai, Innovations in Poverty Action (IPA) – Ghana*** (5 minutes) ○ Ghana's roll-out of new provider payment system, , by ***Professor Irene***	3:00pm – 4:30pm

Day 1: Monday, Feb. 15

The UHC Context: Increasing Financial Protection and Access to Services in Mixed (Public/Private) Health Systems

Agyepong, University of Ghana School of Public Health (7 minutes) ○ Improving health care quality in Ghana, ***Daniel Kojo-Arhinful, Noguchi Memorial Institute for Medical Research*** (7 minutes) <u>Discussion (55 minutes):</u> ○ Participants will divide in small groups to exchange their experiences with implementing health financing reforms, including how they have generated policy commitments and motivated changes in provider or population behaviors. ***Session Coordinator: Ishrat Husain***	
VIII. Daily Wrap-Up	4:30pm – 4:45pm
IX. Focused Prep Session for Day 2 Chairs, Presenters, and Coordinators	5:00pm – 6:00pm

Day 2: Tuesday, Feb. 16

Raising Resources for Health and Managing Expenditures to Increase Equity

I. Prayers	8:00am – 8:05am
II. Health Financing for UHC: "Two Sides of the Coin" **Chair: Cheikh Mbengue, Senegal** <u>Session Objectives</u>: ○ Highlight the need for both DRM and expenditure management as "two sides of the coin" that will be required for countries to create fiscal space for health and sustainably achieve UHC. ○ Share policy tools and tips for encouraging a more productive dialogue between Ministries of Health (MoH) and Ministries of Finance (MoF), fostering alignment between health financing and public financial management systems and goals.	8:05am – 9:45am

Day 2: Tuesday, Feb. 16

Raising Resources for Health and Managing Expenditures to Increase Equity

Session Format: State of the art (20 minutes): ○ ***Joe Kutzin, WHO*** ○ Introduction to emerging WHO-World Bank guidance on the macroeconomic, fiscal, and public financial management context for informing dialogue between Ministries of Health and Ministries of Finance in support of UHC ○ How countries can strike a balance between revenue mobilization and expenditure management (the "two sides of the coin") Spotlight countries (30 minutes): ○ Roundtable dialogue between mix of representatives from Ministries of Finance and Ministries of Health • ***Olivia Nassuna, Uganda MoF and Sarah Byakika, Uganda MoH*** • ***Marie Lattroh, Cote d'Ivoire MoF and Ghislaine Kouakou-Kouadio, Cote d'Ivoire MoH*** • ***Joy Kemirembe Mulisa, Gasabo District Community-Based Program, Rwanda, Michael Karangwa, USAID/Rwanda*** Discussion (45 minutes): ○ Plenary discussion of practical policy solutions and tools and tips for encouraging a more productive dialogue ***Session Coordinator: Danielle Bloom***	
Coffee Break *9:45am – 10:15am*	
III. How to Mobilize Domestic Resources for Health **Chair: Atakelti Abrha, General Director, Ethiopian Health Insurance Agency** Session Objectives: ○ Raise awareness of global experiences on domestic resource mobilization (DRM) for health and country transitions from donor assistance. ○ Understand the menu of DRM options available to countries and the link between mobilizing new resources and how these resources are pooled	10:15am – 12:00pm

Day 2: Tuesday, Feb. 16

Raising Resources for Health and Managing Expenditures to Increase Equity

and spent to promote efficiency and equity. ○ Identify specific actions countries can take to mobilize domestic resources for health, drawing on the specific implementation and governance experiences in Ghana and other countries in Africa. Session Format: State of the art (15 minutes) ○ ***Bob Fryatt, Director of USAID Health Financing and Governance Project and Susna De, Bill & Melinda Gates Foundation*** ○ Latent developments and review of the global experience, including range of DRM options available to countries • Overview of global earmarking study, by ***Danielle Bloom, R4D*** Spotlight country (30 minutes): ○ Perspectives on Ghana's experience with Value-Added Tax (VAT)/Social Security and National Insurance Trust (SSNIT) contributions • ***Hon. Kwaku Agyeman-Manu, Member of Parliament (MP) from Dormaa Central and Chair of Public Account Committee*** • ***Hon. Joseph Yieleh Chireh, MP for Wa West and former Minister of Health*** Discussion (60 minutes): ○ Participants to select country DRM tables according to their interest. ○ Country tables will include: **Ethiopia** (***Zelalem Abebe Segahu, HSFR/HFG Project***), **Nigeria** (***Lekan Olubajo, National Primary Health Care Development Agency***), **Gabon** (***Helene Barroy, WHO***), **Benin** (***Thomas Azandossessi, Ministry of Finance***), **Tanzania** (***Susna De, Bill & Melinda Gates Foundation***), **Senegal (*Serigne Diouf, UHC Agency*), and Ghana (*David Kollison, Ministry of Finance*)** ***Session Coordinator: Bob Emrey***	
Lunch *12:00pm – 1:00pm*	
IV. Expenditure Management: How to Increase Efficiency and Value for Money	1:00pm – 2:30pm

Day 2: Tuesday, Feb. 16

Raising Resources for Health and Managing Expenditures to Increase Equity

Chair: Evelyne Akinocho, Benin Ministry of Health

Session Objectives:

- Identify the range of policy tools or interventions countries can use to effectively use their resources and manage expenditures
- Build understanding of common misalignment issues that occur between health financing and public financial management systems, causing inefficiency and wastage
- Identify the range of strategic purchasing approaches countries are using, common challenges countries face in moving toward strategic purchasing, and some of the strategies that can facilitate implementation of strategic purchasing mechanisms

Session Contents:

State of the art (15 minutes):

- ***Helene Barroy, World Health Organization and Amanda Folsom, R4D***
- Latest developments in expenditure management
- Public financial management/expenditure management framework, a collaboration of WHO and World Bank
- Other tools and strategies for expenditure management (e.g., strategic purchasing, process efficiencies, and cost-effective health benefits design and planning)

Spotlight Countries (25 minutes):

- Short overviews of a range of expenditure management approaches:
  - Ghana on public financial management reforms, payment mechanisms, and benefits package, ***Anthony Gingong, NHIA***
  - Rwanda on strategic purchasing and provider payment mechanisms, ***Ina Kalisa, University of Rwanda School of Public Health***
  - Senegal on performance-based financing, by ***Adiaratou Ndiaye, Advisor to the Prime Minister of Senegal***

Participant Q&A and discussion (50 minutes):

- Table discussions organized around a range of expenditure management

Day 2: Tuesday, Feb. 16

Raising Resources for Health and Managing Expenditures to Increase Equity

approaches ***Session Coordinator: Catherine Connor***	
V. Spotlight on Pharmaceuticals **Chair: Edith Andrews-Annan, WHO/Ghana** <u>Session Objectives</u>: ○ Understand how countries have selected drugs to be covered under medicines benefit package ○ Learn how countries have successfully managed the key cost drivers of pharmaceutical expenditures ○ Identify important considerations for drug pricing under an insurance scheme. <u>Session Format</u>: <u>State of the art (15 minutes): ***Kwesi Eghan, USAID SIAPS Project***</u> ○ Medicines access objectives ○ Key considerations on medicines benefits design and priority setting for selecting medicines and pricing/reimbursement ○ Regulatory and governance ○ Procurements and distribution systems ○ Data and information needs and how their presence or absence impacts sustainability of medicines programs in health insurance systems. <u>Spotlight country (15 minutes): Ghana</u> ○ Representatives from Ghana will pose a key challenge or dilemma to the group for discussion and feedback <u>Participant Q&A and discussion (30 minutes):</u> ○ Peer advice and discussion ***Session Coordinator: Bob Emrey***	2:30pm – 3:30pm
Coffee Break *3:30pm – 4:00 pm*	

Day 2: Tuesday, Feb. 16

Raising Resources for Health and Managing Expenditures to Increase Equity

VI. Country Work Session Session Contents/ Objectives: • Country teams will meet to begin to identify specific actions they can take to maximize revenue for health, build commitment for pro-poor resource allocations and risk-pooling, and manage expenditures.	4:00pm – 4:45pm
VII. Daily Wrap-Up and Overview of Field Visit Plans	4:45pm – 5:15pm
VIII. Senegal Health Financing Strategy Work Session Session Contents/ Objectives: • Senegal delegation will hold side meeting to discuss their health financing strategy.	5:15pm – 6:15pm
IX. Focused Prep Session for Day 4 Chairs, Speakers, and Coordinators	5:15pm – 6:15pm

Day 3: Wednesday, Feb. 17

Spotlight on Ghana: NHIS Site Visit

I. Prayers	8:00am – 8:05am
II. Site Visits Objective: • Increase understanding of how Ghana's National Health Insurance Scheme works, including its overall governance and financing, and major implementation strengths and challenges Format: o Participants will divide into 5 groups.	Full Day, with early morning departures (to be announced)

○ At each location, participants will visit a claims processing center, health facility (CHAG facility or hospital), and district NHIA Office.	

Day 4: Thursday, Feb 18

Community Engagement, Private Actors, and Mobile Technology

I. Prayers	8:00am – 8:05am
II. Debriefing and Reflections from the Site Visits **Chairperson: Chris Atim, AfHEA Executive Director and Chair of the President's NHIS Review Committee** Session Objective: ○ To share reflections from the previous day's site visits and discuss key themes and questions that arose Session Format: ○ Table discussions (25 minutes) ○ Open plenary discussion (45 minutes) ***Session Coordinator: Amanda Folsom***	8:05am – 9:00am
III. Community-Based Health Insurance – Lessons, Challenges, and Opportunities **Chair: Joachim Koffi, Cote d'Ivoire CNAM (National Health Insurance Program)** Session Objectives: ○ Frame community-based health insurance (CBHI) as another *pro-poor* approach to UHC, building on the messages introduced earlier in the week regarding the need to prioritize the poor ○ Discuss the limitations and opportunities that CBHI offers as a pathway to UHC ○ Identify practical strategies for optimizing existing CBHI schemes to	9:00am – 10:30am

Day 4: Thursday, Feb 18

Community Engagement, Private Actors, and Mobile Technology

improve community engagement and increase financial sustainability, expand population coverage, and deepen the benefits package Session Format: State of the art (15 minutes): ○ ***Hong Wong, Bill & Melinda Gates Foundation*** ○ Evolution of CBHI in Africa and how we understand the role of CBHI in UHC Country Spotlight (30 minutes): ○ Ethiopia: CBHI being scaled up to 800 districts based on the pilot experience in 2011 in 13 districts. ***Zelalem Abebe Segahu, USAID HFSR/HFG Projects, Ethiopia*** ○ Rwanda: Recent improvements to CBHI (e.g. sliding scale premiums) and planned integration with social health insurance programs. ***Therese Kunda, Management Sciences for Health Rwanda Health Systems Strengthening Project*** ○ Senegal: Senegal's UHC vision for reforming mutuelles to expand coverage and increase financial stability "Développement de la couverture maladie universelle de base à travers les mutuelles de santé." ***Cheikh Mbengue, UHC Agency, Senegal*** Participant Discussion (30 minutes): ○ Participants will remain in plenary to engage speakers in Q&A, provide peer feedback, and identify promising CBHI implementation experiences ***Session Coordinator: Catherine Connor***	
Coffee Break *10:30am – 11:00am*	
IV. The Role of Private Health Insurance in UHC **Chair: Sarah Byakika, Uganda Ministry of Health** Session Objectives:	11:00am – 12:30pm

Day 4: Thursday, Feb 18

Community Engagement, Private Actors, and Mobile Technology

○ Articulate the role of the private sector health insurance over time to support attainment of UHC ○ Recognize two contributions that the private health insurance sector offers a UHC initiative and two benefits that a UHC program brings to the private health insurance sector ○ Describe two implementation challenges experienced to establish and scale up a public-private partnership between a private health insurance provider and a government, and how these might be overcome Session Format: State of the art (15 minutes): ○ ***Adeola Majiyagbe, GM Executive at Total Health Trust, Nigeria*** ○ A look at the role of private sector health insurance over time to support the attainment of UHC, with brief overview of private health insurance in Africa Country spotlight (30 minutes): Nigeria ○ Talk show "spotlight" on private insurance sector engagement in UHC programs, including public-private partnership in Nigeria, with ***Jonathan Ekeh, Nigeria National Health Insurance Scheme***, ***Pieter Walhof, PharmAccess***, and ***Dr. Patrick Korie, SUNU Nigeria*** Discussion (45 minutes): ○ Small group discussions on how governments are interacting with private insurance ○ Relate a public-private partnership case from Nigeria to your own county context ○ Describe the stage of your government in its engagement with private sector insurance partners ***Session Coordinator: Jeanna Holtz***	
Lunch and Learn *12:30pm – 1:30pm*	
V. Mobile Facilitated Insurance Products and Solutions **Chair: Cees Hesp, Pharmaccess** Session Objectives:	1:30pm – 3:00pm

Day 4: Thursday, Feb 18

Community Engagement, Private Actors, and Mobile Technology

○ Raise awareness of the potential for mobile money to strengthen health insurance operations in support of UHC ○ Highlight specific mobile money innovations in Africa that could be a promising model for adaptation in other contexts ○ Identify specific actions countries can take to promote increased use of mobile money applications for UHC Session Contents: State of the art (15 minutes): ○ ***Adjoa Boateng, MicroEnsure*** ○ Overview of mobile money applications in health insurance Country spotlight (15 minutes): Mali ○ ***Ralph Ankri, Orange Labs*** ○ Spotlight on mobile money partnership with community-based health insurance in Mali Discussion (60 minutes): ○ Facilitator TBD ○ Country examples: • Kenya e-Wallet (***Cees Hesp, Pharmaccess***) • Rwanda's computerization of health insurance functions TBD • Ghana NHIA mobile initiatives (***Thomas Adoboe, Deputy Director-Management Information Systems, NHIA)*** ***Session Coordinator: Pamela Riley***	
VI. Daily Wrap-up	3:00pm – 3:30pm
Coffee Break *3:30pm – 4:00pm*	
VII. Country work session Objectives: ○ Country teams will meet to identify specific actions they can take to	4:00pm – 5:00pm

Day 4: Thursday, Feb 18

Community Engagement, Private Actors, and Mobile Technology

optimize existing CBHI efforts and to leverage private health insurance and mobile health insurance opportunities to move toward UHC.	
VIII. Focused prep session for Day 5 Chairs, Presenters, and Coordinators	5:00pm – 5:30pm
IX. Development Partners (USAID, WHO, Gates) Collaboration Meeting	5:30pm – 6:30pm

Day 5: Friday, Feb 19

Monitoring Progress, Future Planning, and Next Steps

I. Prayers	8:00am – 8:05am
II. "Intelligent Health Systems" **Chair: Dr. Lydia Dsane-Selby, Director of Claims at the Ghana NHIA** Session Objectives: ○ Highlight the importance of monitoring and policy and operational research in ensuring achievement of UHC, particularly in a data constrained environment ○ Understand Ghana's strategy for monitoring progress towards UHC and other health system goals, and ensuring access and equity within interventions Session Format: State of the art (15 minutes): ○ ***Joe Kutzin, WHO*** ○ Brief overview of framework for measuring and monitoring UHC progress, and importance of applied policy and operations research Country Spotlight (10 minutes): Ghana ○ ***Lydia Dsane-Selby, NHIA***	8:05am – 9:45am

Day 5: Friday, Feb 19

Monitoring Progress, Future Planning, and Next Steps

○ Ghana's strategy for monitoring progress, including operational research, equity monitoring, dashboard development, and early warning system Participant Discussion (75 minutes): ○ In plenary or small groups, identify other countries' experiences, including Rwanda's HIMSS system (***Therese Kunda, Management Sciences for Health Rwanda Health Systems Strengthening Project*****)** and UHC measurement in Ethiopia (**Atakelti Abrha, General Director, Ethiopian Health Insurance Agency)** ○ Discuss how countries are measuring their progress on UHC, analyzing their reforms, and linking evidence to policy, and identify examples of data collection, analytics, & processes for continuous learning and improvement ○ Share other research and process innovations from countries and international partners ***Session Coordinator: Danielle Bloom***	
Coffee Break *9:45am – 10:15am*	
IV. Generating ideas for future learning and action **Chair: Bob Emrey, USAID Office of Health Systems Strengthening** Session Objectives: ○ Highlight key themes from the week ○ Discuss country plans and next steps identified by participants Session Format: ○ Plenary reflection on key themes, facilitated discussion (15 minutes) ○ Plenary sharing of country plans, key action items, and agenda for action (90 minutes) ○ Spotlight on Senegal's health financing strategy development (15 minutes) ○ Collect participant feedback (workshop evaluation) ***Session Coordinator: Amanda Folsom***	10:15am – 12:00pm

Day 5: Friday, Feb 19

Monitoring Progress, Future Planning, and Next Steps

V. Closing o Brief closing remarks (2 min. each) by USAID, NHIA, WHO, and Bill & Melinda Gates Foundation	12:00pm – 12:30pm
Closing Lunch *12:30pm – 1:30pm*	

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Annex III. Overview of Sessions

Monday, February 15: Day 1, Session III. Opening Speeches

Ms. Akua Kwateng-Addo, Office Director, Health, Nutrition and Population Office, USAID/Ghana introduced the opening speakers.

Ms. Megan Rhodes, Deputy Health Team Chief, Bureau for Africa, USAID, welcomed all participants. She emphasized that UHC has emerged as a unifying health objective for countries. To effectively serve their populations, countries must ensure that equity and sustainability govern decisions through every aspect of designing, financing and implementing UHC.

Ambassador Robert Jackson, U.S. Ambassador to Ghana, described why health is a right of all citizens and achieving UHC is central to the economic and social cohesiveness of a country, contributing to stability and global security. Ambassador Jackson highlighted two important areas: (1) the need to mobilize domestic resources to finance health, and (2) greater private sector engagement.

Honorable Alex Segbefia, Minister of Health, Ghana, drew attention to the responsibility of the Ghanaian government for the health of its people and the role of the NHIA in doing so. He embraced the launch of the workshop as a means to "learn from one another's experiences as [we] chart and calibrate [our] own paths"; and recommended the establishment of a community of practice on health insurance and health financing as one important outcome.

Dr. Ishrat Husain, Senior Public Health Advisor, Bureau for Africa, USAID provided an overview of the themes to be discussed over the course of the workshop. Dr. Husain emphasized the peer-learning approach and the participatory design of the workshop agenda that included a variety of interactive methods to surface implementation challenges and solutions.

Country Teams shared their specific objectives (Togo N/A):

- **Benin** – learn and improve with an emphasis on integrating the informal sector into the scheme (in its nascent stages through the mutuelle system).
- **Cote D'Ivoire** – while the country has a legal framework for insurance, it would like to better understand the other important tenets of insurance.
- **Ethiopia** – started its national health insurance scheme five years ago but seeking understanding on how to scale-up and manage its benefits package.
- **Ghana** – the path to universal coverage has not been easy; the country would like to learn from the varying experiences and knowledge from participants.
- **Nigeria** – would like to learn how to embrace reform and ensure that those who require support the most are covered by insurance; and move the National Health Act forward.
- **Rwanda** – eager to learn from Ghana's path to success and lessons on creating a more integrated scheme.
- **Senegal –** has made significant strides in improving access and coverage through CBHI. It would like to both share its lessons and learn from others on scale-up.

- **Uganda** – in the very nascent stages of setting up an insurance scheme and would like to better understand how this can be expedited; also curious about the role the private sector can play.

Session IV. Setting the Stage

Session objectives

- Discuss the latest developments in UHC and economic transitions in health
- Learn about funding and implementation of Ghana's NHIS
- Consider how health financing can be a powerful tool for improving equity

Key take-aways:

- Financial protection is a key UHC goal, with health financing a powerful tool to increase equity.
- There is a range of approaches that can put countries on the pathway towards progressive realization of UHC, but no country has ever reached UHC by relying only on voluntary insurance.
- The world of global health is changing rapidly with bold end games for infectious disease and other health priorities, and a grand convergence is now in sight.

Chair: Alex Segbefia, Honorable Minister of Health of Ghana, opened the session.

Keynote: Ariel Pablos-Mendez, Assistant Administrator for Global Health, USAID/Washington. Dr. Pablos- Mendez spoke about *Economic Transitions in Health and UHC in Africa.* Dr. Pablos-Mendez emphasized that as we are facing a transition of development assistance and the growth of direct country funding, we are moving towards a grand convergence on the path towards UHC. Dr. Pablos-Mendez highlighted that gross domestic product (GDP) was flat for most of human history, with a spike in the last 50 years. Further, over the past decade, many formerly low income and lower-middle income countries have seen their economies grow. This economic growth will bring an "economic transition," permitting many of them to finance more of their health sector development without relying on outside donors. However, coverage rates for health care remain low, with half of spending on health care in Africa coming from out-of-pocket expenditures. Globally, there are 50 countries that have achieved UHC, there are 50 countries who are halfway to UHC, and many more that are trying to get there. Dr. Pablos-Mendez emphasized that there is no single path to UHC: the Germans took 50 years to get there, Thailand took 10, and it may be possible to get there faster.

Abdo Yazbeck, Lead Health Economist, World Bank. Dr. Yazbeck spoke about *Covering the Poor and Ensuring More Equitable Health Financing.* Dr. Yazbeck emphasized that most publically funded health care serves the rich more than it serves the poor. The poor face significantly more challenges because of where they work and where they live. This causes gaps between the poor and the non-poor. We also fail them through lack of access to education and resources- and because we locate facilities in the wrong places. Dr. Yazbeck provided rules of thumb to consider when covering the poor. For revenue provision, one should delink the service provision from the poor having to pay for it. Payment should follow the poor instead of facilities. He also stressed that we must amplify the voice of the poor in health decision making.

Nathaniel Otoo, Acting CEO, NHIA Ghana. Mr. Otoo gave an overview of Ghana's NHIS, laying out the evolution of health care since the 1800's. By the late 90's/early 2000's, CBHI had begun in Ghana, which

helped to increase access to care and create awareness. This movement became important political capital for formation of the NHIS. In 2003, there was a plan to transition to NHI and aggregate the small risk pools that had been formed. 259 CBHIs were integrated into a nation-wide scheme. There are 5 basic sources of funding: VAT which is 73-84% of funding in 2012/13, Social Security transfers, income from premium, investment income and general revenue. However, the scheme is now facing sustainability challenges that will need to be addressed. The report from the NHIS Review Committee will be released in the middle of this year, and will help to shape a way forward.

VI. Financial Protection and Access to Care: In Theory and Practice

Session Objectives

- Understand concepts of financial protection and access to care, including how to they are defined, implemented, and measured
- Identify practical strategies for increasing and sustaining financial protection and access to services, such as use of public funds for extending financial protection (subsidies, waivers, vouchers, insurance) or engaging private providers to expand access

Key take-aways:

- Mexico's Seguro Popular has succeeded in reducing both OOP and catastrophic health expenditures. From 2004 to 2014, OOP dropped from 52% to 44%; catastrophic spending dropped from 3.6% to 2.1%.
- Social health insurance generally offers coverage to formal sector and works against equity.
- CBHI should not be the sole approach; it should be combined with other approaches.

Chair: Nathaniel Otoo, Acting CEO, NHIA, Ghana established the session objectives as stated above.

Laurent Musango, WHO AFRO, provided the state-of-the-art presentation, and defined key concepts and practical strategies for increasing and sustaining financial protection and access to care. This included different forms of health insurance, OOP expenses, protection against risks, and premiums. He emphasized that NHI financed by taxes can promote social solidarity, while social health insurance offers coverage to formal sector and can work against equity. Additionally, he emphasized that mutual health insurance/CBHI at the community level should not be used as an approach to reaching the poor in isolation, but should rather be used in combination with other approaches.

Adolfo Martinez Valle, Mexico MOH, participated in an interactive "fishbowl" interview as a part of a spotlight on Mexico, by the Acting CEO of the NHIA. He explained that the main goals of Seguro Popular are financial protection. Through Seguro Popular, Mexico has been able to move towards realizing the right to UHC by increasing public health expenditures gradually, responsibly, and sustainably. The government was also interested in achieving better allocation of resources between medical care and public health. Seguro Popular is still 18.2% short of universal coverage and is a voluntary scheme. Two groups who remain uncovered are: young people and those in the most remote areas of the country, i.e. with less than 2,000 people per town. Martinez Valle also noted that Seguro Popular increased public health expenditures. However, both OOP and catastrophic health expenditures have been reduced: From 2004 to 2014, OOP dropped from 52% to 44%, and catastrophic care dropped from 3.6% to 2.1%.

Evelyne Akinocho, Benin Ministry of Health, provided brief closing remarks. She stated that in Benin more than 60% of costs for medical care is paid by families, but they have a complementary targeted free system. A UHC system was put into law as of 2015 and will be implemented.

VII. Commitment Generation and Behavioral Economics: Redistribution and Solidarity

Session Objectives:

- Learn about the principles of behavioral economics and their application in the real-world implementation of health systems reform for UHC
- Better understand how countries have generated commitment and built solidarity to ensure coverage of the poor and to distribute/redistribute limited resources, at the provider and population levels

Key take-aways:

- Commitment generation and behavior change are new tools that can contribute to success.
- The human factor (rationality) behind changing behaviors is crucial: Personal preferences are influenced by the context and quality of engagement.

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Chair: Dr. Francis Ukwuije, Federal Ministry of Health, Nigeria opened the session, articulating that commitment generation is hard to achieve, particularly in implementing all of the components of a strategy.

Abdo Yazbeck, World Bank, provided the state-of-the-art presentation by giving an introduction to behavioral economics and application in UHC. The field of behavioral economics borrows from marketing and economics to emphasize the role of rational choice. Different issues such as financing, payment, regulation and behavior are all important topics to tackle, but behavior is the hardest. He emphasized that prices matter for people, as well as information incentives. For instance, opting in versus opting out of organ donation can make a large difference for success.

Christine Papai, Innovations in Poverty Action (IPA) shared IPA's work related to behavioral economics in Ghana. The role of IPA is to generate the evidence around what works. For instance, IPA has found through their research that charging even a small fee for bed nets can reduce usage dramatically.

Professor Irene Agyepong, University of Ghana School of Public Health, discussed Ghana's roll-out of capitation, touching on the importance of incentives and the intangible political realities that are important for the success of different schemes. She stressed that to achieve UHC, countries need multi-level commitment and provider payment reform. Professor Agyepong also highlighted that different types of assets are necessary to move reforms forward, including trust in the system and credibility of networks.

Daniel Kojo-Arhinful, Noguchi Memorial Institute for Medical Research, discussed issues around improving health care quality in Ghana. He emphasized that quality has to move beyond the technocratic definition of quality, and look to the intangibles, including what people actually want. Policymakers should set up reform processes in a way that provides a people-centered exchange of ideas and views, and over time evaluates change.

Tuesday, February 16: Day 2, Session II. Health Financing for UHC: "Two Sides of the Coin"

Session Objectives:

- Highlight the need for both domestic resource mobilization (DRM) and expenditure management as "two sides of the coin" that will be required for countries to create fiscal space for health and sustainably achieve UHC.
- Share policy tools and tips for encouraging a more productive dialogue between MOH and MOF, fostering alignment between health financing and public financial management systems and goals.

Key take-aways:

- Financial sustainability is achievable, with focus on efficiency.
- More money for health alone will not fix underlying inefficiencies on health financing or public financial management systems, and can lead to wastage.
- Pharmaceuticals are a major source of inefficiency.

> *"We need efficiency gains to contain costs and argue for increased funds for the NHIS"*
>
> - Chris Atim, Chair of Technical Review Committee; NHIS, Ghana

Chair: Cheikh Mbengue, Senegal provided the opening remarks as chair of this session, highlighting the importance of domestic revenue generation for achieving UHC goals.

Joe Kutzin, WHO, provided the state-of-the-art for this session by giving an introduction to emerging WHO-World Bank guidance on the macroeconomic, fiscal, and public financial management context for informing dialogue between MOH and MOF in support of UHC. How countries can strike a balance between revenue mobilization and expenditure management (the "two sides of the coin") is important to consider. Joe also stressed that the general budget will always be the backbone of domestic country financing. Revenue raising, pooling, and purchasing are systemic elements that translate the benefits of what is in the package into a reality for users.

Uganda, Rwanda and Cote D'Ivoire representatives then engaged in a roundtable discussion chaired by Joe Kutzin around areas where MOF and MOH have collaborated in country. **Olivia Nassuna,** Uganda MoF, and **Sarah Byakika,** Uganda MoH, discussed unmet funding needs of the health sector and the need to identify alternative ways to mobilize resources. They also discussed how Uganda's decentralized context and input-based budgeting have created inefficiencies in the system, including delays in getting funding from the central level through districts down to providers, and the lack of financial incentives and provider motivation to improve service delivery. They described several approaches they are using to improve efficiency, including each facility (>3,500) opening its own bank account for direct transfers from the federal level, new methods for monitoring accountability, and the roll-out of results-based financing at the district-level. **Marie Lattroh,** Cote d'Ivoire MoF, and **Ghislaine Kouakou-Kouadio**, Cote d'Ivoire MoH, reflected on their new inter-ministerial group for strategic planning and accounting. **Joy Kemirembe Mulisa**, Gasabo District Community-Based Program, Rwanda, and **Michael Karangwa**,

USAID/Rwanda, discussed how the MOH tracks expenditure and premiums year on year using resource tracking, and how Medium-Term Expenditure Framework (MTEF) processes have made a positive impact on budgeting and planning.

III. How to Mobilize Domestic Resources for Health

Session Objectives:

- Raise awareness of global experiences on DRM for health and country transitions from donor assistance.
- Understand the menu of DRM options available to countries and the link between mobilizing new resources and how these resources are pooled and spent to promote efficiency and equity.
- Identify specific actions countries can take to mobilize domestic resources for health, drawing on the specific implementation and governance experiences in Ghana and other countries in Africa.

Key take-aways:

- There are a range of DRM options that exist, however, it is difficult to assess what is truly additional if efficiency gains are not assessed.
- Data are critical to understanding what is working and what is not.
- Earmarking can be an easy sell, and resonate with the public- however, management is needed to ensure expenditure does not exceed revenue.
- The total envelope going to health - including other sectors - should be considered.

Chair: Atakelti Abrha, General Director, Ethiopian Health Insurance Agency opened the discussion with an introduction to the topic of mobilizing domestic resources for health.

Bob Fryatt, Director of USAID Health Financing and Governance Project and **Susna De**, Bill & Melinda Gates Foundation, provided a state of the art overview of the latest developments and review of the global experience, including range of DRM options available to countries. They also reviewed methods for engaging policymakers including the MOF and how partners can support DRM. **Danielle Bloom,** R4D, reviewed a global earmarking study. 85 countries earmarking 135 different sources of revenue have been identified so far.

Hon. Kwaku Agyeman-Manu, Member of Parliament (MP) from Dormaa Central and Chair of Public Account Committee and **Hon. Joseph Yieleh Chireh**, MP for Wa West and former Minister of Health, provided perspectives on Ghana's experience with Value-Added Tax (VAT) 2.5% /Social Security and National Insurance Trust (SSNIT) 2.5% contributions, comprising 90% of all funding for NHIA. They reviewed the roles played by their political parties at each stage in development of the government's health insurance schemes in Ghana. Parliament had to consider many factors, including the allocation to the health sector compared to the allocation to education. They see earmarking as a way to ring fence the needs of health, and stated that NHIS would not have been possible without the earmark.

Following the discussion among Parliamentarians, participants shared a series of brief country examples of DRM. Ethiopia (**Zelalem Abebe Segahu**, HSFR/HFG Project) gave an overview of health financing in Ethiopia including a strategy to improve innovative financing and collection of revenue from contributions through CBHI. Nigeria (**Lekan Olubajo**, National Primary Health Care Development Agency) discussed the National Health Bill that legislates at least 1% earmark on consolidated revenue in support of UHC. Gabon (**Helene Barroy**, WHO) discussed the impacts on earmarking different revenue streams including a substantial impact on resulting reductions in the central budgetary line. Benin (**Thomas Azandossessi**, Ministry of Finance) discussed financing strategies for RAMU, including government-contributions, social security payments, and exploration of other sources such as a VAT or tobacco and alcohol taxes. Tanzania (**Susna De**, Bill & Melinda Gates Foundation) touched on the experience with the Sustainable Finance Initiative (SFI), Senegal (**Serigne Diouf**, UHC Agency) described their Equity Fund, and Ghana (**David Collison**, Ministry of Finance) provided further context into the VAT and SSNIT earmarks.

IV. Expenditure Management: How to Increase Efficiency and Value for Money

Session Objectives:

- Identify the range of policy tools or interventions countries can use to manage expenditures
- Build understanding of common misalignment issues that occur between health financing and public financial management systems, causing inefficiency and wastage
- Identify the range of strategic purchasing approaches countries are using, common challenges countries face in moving toward strategic purchasing, and some of the strategies that can facilitate implementation of strategic purchasing mechanisms

Key take-aways:

- Coverage is a long term process, not an event.
- Managing health expenditure is equally if not more important than generating new resources.
- Health expenditure is not just about cuts or costs. It is about how to set up a financial management environment to deliver priority services within an allocated envelope.
- Public financial management (PFM) processes and strategic purchasing can be important expenditure management tools.

Chair: Evelyne Akinocho, Benin Ministry of Health, provided a framing for the session, asking how we can ensure efficiency and optimize the limited resources that are available. She highlighted the economic crisis being faced by many countries as an impetus to examine how we can improve value for money.

Helene Barroy, World Health Organization and **Amanda Folsom,** R4D delivered a state of the art presentation focused on the latest developments in expenditure management. They highlighted tools and strategies for expenditure management (e.g., public financial management reforms, strategic purchasing, process efficiencies, and cost-effective health benefits design and planning). Helene highlighted a number of country examples, including Benin where under execution was an historical issue for financial management. In 2009/10, only around 60% of the allocation to the MOH was spent.

Helene highlighted that managing health expenditure starts with budgeting, and outlined program budgeting as a possible way to provide more flexibility around reforms, with the caveat that more evidence is needed to fully assess impacts.

Anthony Gingong, NHIA Ghana, delivered the first spotlight presentation, highlighting the public management reforms, payment mechanisms, and benefits package that have been put in place in Ghana. Mr. Gingong stated that every method of payment still has its inefficiency. Ghana uses multiple approaches: Fee for service for medicines, GDRG (Ghana Diagnosis Related Groups) for specialty and inpatient services, and has now introduced capitation at the primary health care level to control costs.

Ina Kalisa, University of Rwanda School of Public Health, shared country experience with strategic purchasing and provider payment mechanisms. She discussed the country's experience with performance based financing (PBF), and mentioned the positive impact that has been demonstrated by program evaluations. The government is now institutionalizing PBF.

Adiaratou Ndiaye, Advisor to the Prime Minister of Senegal, shared Senegal's experience on PBF. Mrs. Ndiaye stressed that even within strategic purchasing, providers will find a way to game the system. As such, Senegal has put in place a verification process, whereby each organization has its own account into which funds are put. This helps to improve system transparency so that funds, including premiums and what is paid to providers, can be tracked as a part of the PBF system.

V. Spotlight on Pharmaceuticals

Session objectives:

- Understand how countries have selected drugs to be covered under medicines benefit package
- Learn how countries have successfully managed the key cost drivers of pharmaceutical expenditures
- Identify important considerations for drug pricing under an insurance scheme.

Key take-aways:

- Nearly all countries making reforms and improvements in financing for health struggle to manage the cost and availability of medicines.
- Pharmaceuticals are a major source of inefficiency; fast-response IT systems can assemble data and improve management of adherence, availability and quality, and reduce fraud.
- Burden of disease and cost data can be used to decide on an affordable medicines package. Too generous a package upfront can cause overruns and threaten the sustainability of programs.

Chair: Edith Andrews-Annan, WHO/Ghana, opened by discussing the main cost drivers in Ghana's current review of pharmaceutical expenditures.

Kwesi Eghan, USAID SIAPS Project, discussed key considerations for increasing access to medicines, including the benefit design and priority-setting for selecting medicines and pricing. Eghan discussed studies in multiple countries showing that most LMICs spend as much as half of total health expenditures on medicines, and that 80-90% are typically not covered by health insurance. He described

that access to essential medicines and UHC require four key elements: rational selection of medicines, affordable prices, sustainable financing, and reliable health and supply systems.

Eghan stated that countries should develop a process of Health Technology Assessment (HTA) for selection of medicines. At all stages of a country's development, they can apply HTA so as to ensure the availability of important new medicines while avoiding cost-overruns from adoption of unneeded or duplicative drugs, or inappropriate therapies. As countries' economies become stronger, HTA should move to focus on full marginal analysis for addition or rejections of newly available medicines.

The speaker also stressed computerization of the medicines benefit claims process is an essential step toward controlling medicines costs in health insurance. Newly available mobile technology is being use to permit remotely located pharmacists to adjudicate (seek approval of payment through) insurance coverage for each medicine purchase before handing the medicine to the patient. Finally, he discussed that routine analysis of medicines usage under health insurance can be done using spreadsheets and other manual techniques, but these analyses are more powerful and effective when conducted using computer databases of current medicine claims.

Edith Andrew-Annan, WHO/Ghana**; Kwesi Eghan**, USAID SIAPS Project; and Prof **Daniel Arhinful,** Noguchi Memorial Institute for Medical Research, formed a panel. They discussed the crises previously facing Ghana's medicine benefit under health insurance and described how those earlier crises were resolved. The panelists solicited feedback and ideas from participants on strategies for managing pharmaceutical benefits.

Day 3, Site Visits

Objective

- Increase understanding of how Ghana's NHIS works, including its overall governance and financing, and major implementation strengths and challenges

Participants divided into five groups to visit NHIA offices (regional, district, and claims processing centers) and provider sites (a mix of public and private) in different locations. An overview of the field visits is included in Annex IV.

Day 4, Session II. Debriefing and Reflections from the Site Visits

Session objective

- To share reflections from the previous day's site visits and discuss key themes and questions that arose

Chairperson: Chris Atim, Executive Director of African Health Economics Association **(**AfHEA) and Chair of the President's NHIS Review Committee, led a group discussion around key reflections from the site visits.

Participants were impressed overall by their visits to service delivery sites and found a number of NHIS strengths. Specific strengths of Ghana's health system that participants noted included:

- Premiums generally seemed affordable
- High demand for NHIS registrations at certain sites; providers encouraging NHIS registration
- Good examples of patient education while waiting for registration
- Good software (e.g., electronic registration systems) that were in place to reduce fraud
- Culture of continuous quality improvement in the NHIS

Participants also noted some challenges or potential areas for improvement, including:

- Delays in provider reimbursement
- High workload and specialized skills (e.g., clinicians and accountants) needed for processing claims; need to move toward more e-claims
- Annual re-enrollment processes that are potentially unnecessary for certain population groups (e.g., seniors) and may lead to attrition
- Premiums may need to be reviewed for certain groups based on variations in income of the informal sector or variations in premiums by district

Dr. Atim concluded by presenting the framework for the NHIS review and describing the thematic focus on Sustainability, Equity, Efficiency, Accountability and User Satisfaction. Atim described that there are seven sub-committees focusing on various issues including financial sustainability, epidemiology, and provider payment. The earmark is also being considered as a part of this review, as well as the benefits package, with is very generous and politically sensitive.

Session III. Community-Based Health Insurance – Lessons, Challenges, and Opportunities

Session Objectives:

- Frame community-based health insurance (CBHI) as another pro-poor approach to UHC, building on the messages introduced earlier in the week regarding the need to prioritize the poor
- Discuss the limitations and opportunities that CBHI offers as a pathway to UHC
- Identify practical strategies for optimizing existing CBHI schemes to improve community engagement and increase financial sustainability, expand coverage, and deepen benefits package

Key take-aways:

- CBHI has a role to play in reaching UHC: If a country does not already have CBHI, begin with the national model, and start pro-poor UHC scheme from the beginning.
- Community contributions are insufficient: CBHI without public financing is "empty" -- countries need to pool risks and integrate CBHI with other prepaid schemes.

Chair: Joachim Koffi, Cote d'Ivoire CNAM (National Health Insurance Program), opened the session.

Hong Wang, Bill & Melinda Gates Foundation, gave the state of the art presentation on CBHI, putting forward a typology of three types of CBHI schemes: generic, enhanced, and nationwide.[1] He suggested that if countries have sustainable CBHI it could help cover poor, rural and informal sectors.

Zelalem Abebe Segahu, USAID HFSR/HFG Projects, discussed CBHI being scaled up to 800 districts based on the pilot experience in 2011 in 13 districts in Ethiopia. He discussed that CBHI is part of the performance contracts of local officials, and that it is embedded in local government structures, including a board of directors. Paying members contribute while indigents get a subsidy. Registration is open once a year for 3 months, and benefits include outpatient and inpatient services. Copayments are now being added in urban areas.

Therese Kunda, Management Sciences for Health Rwanda Health Systems Strengthening Project, discussed recent changes to CBHI (e.g. sliding scale premiums) and planned integration with social health insurance (SHI). Kunda mentioned that CBHI has moved management to the Rwanda Social Security Board (RSSB), which is under MOF, to include a separation of functions between providers and purchasers, and improve CBHI management through a single pool.

Cheikh Mbengue, UHC Agency, Senegal, discussed Senegal's UHC vision for reforming mutuelles to expand coverage and increase financial stability. Cheikh stressed the importance of politics in UHC. He discussed that each political candidate had UHC in their mandate for the last elections. At the strategic level, Senegal has established an inter-ministerial steering committee for UHC. Currently there are over 500,000 beneficiaries enrolled in CBHI and more than 1.6 million indigents in the process of enrollment.

Nigeria (Johnathan Ekeh, National Health Insurance Scheme), raised a number of questions about the role of CBHI in Nigeria, including how CBHI schemes can ensure private sector participation, how they can work with or take the shape of health maintenance organizations (HMOs), and how the legal framework will treat CBHI.

IV. The Role of Private Health Insurance in UHC

Session Objectives:

- Articulate the role of private sector health insurance (PHI) over time to support attainment of UHC
- Recognize two contributions that the private health insurance sector offers a UHC initiative and two benefits that a UHC program brings to the private health insurance sector

[1] Generic model: voluntary participation, revenue is collection through membership prepayment, funds are managed by community, services covered include outpatient, inpatient or both at local level, purchasing through FFS or capitation. Enhanced model: multi-community/regional, poor are covered through government subsidy, risk pooling is through re-insurance within the network of communities, funds are managed by community with network of technical support, services are covered through a provider network and purchased through capitation or case-based payment. These schemes run into problems of scaling up. Nationwide model: population at national level is targeted; there is a government subsidy and risk equalization mechanism. There is professional management with community participatory roles and services covered include a standardized benefits package.

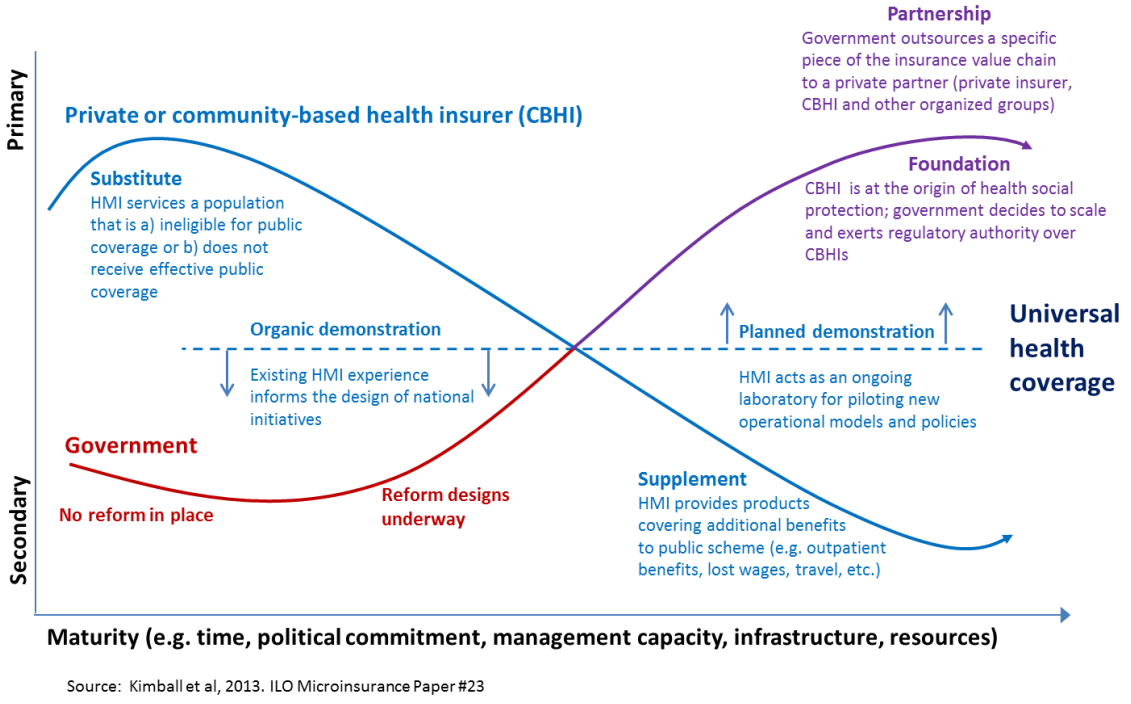
- Describe implementation challenges in establishing and scaling a public-private partnership between a private health insurance provider and a government, and how these might be overcome

Key take-aways:

- Private health insurance (PHI) can complement government-sponsored UHC programs.
- Community and private sector actors have an important role in helping to access populations.
- Mobile technology solutions can be achieved through public-private partnerships.
- Need legislative framework to create an inclusive, coordinated environment.
- Private health insurance providers can drive efficiency and viability of insurance programs.

Chair: Sarah Byakika, Uganda Ministry of Health, described the evolving role of PHI as UHC advances.

Adeola Majiyagbe, GM Executive at Total Health Trust, Nigeria examined the role of private health insurance over time to support the attainment of UHC, with brief overview of PHI in Africa. Majiyagbe presented a framework that describes five key roles of PHI and governments over time, as UHC evolves: substitution, foundation, partnership, supplementary, and demonstration. She stressed that PHI actors can complement public efforts to achieve UHC. The roles that governments and private insurance actors play change over time, and are context-specific.



Source: Kimball et al, 2013. ILO Microinsurance Paper #23

Majiyagbe then facilitated a talk show to "spotlight" private insurance sector engagement in UHC programs, illustrating public-private partnerships in Nigeria, with **Jonathan Ekeh,** Nigeria NHIS, **Pieter Walhof,** PharmAccess (The Netherlands), and **Dr. Patrick Korie,** Managed Healthcare Services (part of SUNU), Nigeria. Together the panelists illustrated that PHI can drive efficiency and viability of insurance programs, including those sponsored by governments. PHI can provide innovation

(e.g., mobile technology applications) and is accountable to deliver to clients to retain and expand business. Critical success factors include political will, building and maintaining momentum, and adequate regulation to create an inclusive environment.

Participants then formed discussion groups by country to discuss the role of PHI in promoting UHC in their countries. Participants were encouraged to relate the public-private partnership examples from Nigeria to their own context, and describe the stage and nature of their government's engagement with private insurance partners. Important issues raised included regulation, business models, fragmentation and the need to ensure that private insurance can be inclusive. In some countries, such as Rwanda, PHI plays a key role in contributing toward subsidies for public health insurance (CBHI), as by law they must contribute 5% of their revenue. In other countries, like in Senegal, PHI is largely serving higher income and formal sector populations.

V. Mobile Facilitated Insurance Products and Solutions

Session Objectives:

- Raise awareness of the potential for mobile money to strengthen health insurance operations in support of UHC
- Highlight specific mobile money innovations in Africa that could be a promising model for adaptation in other contexts
- Identify actions countries can take to promote increased use of mobile money applications for UHC

Key take-aways:

- Mobile technology is both an opportunity and risk. It depends how you use it, not whether you use it. Government needs to get engaged.
- Mobile-enabled technologies are here, and can improve efficiency and outreach of insurance.
- Multiple countries are using mobile platforms to support UHC programs (e.g., mobile enabled enrollment or premium collection). Simple private health insurance products for savings and health are targeting low-income "mass" market, and some markets are scaling up rapidly.
- These products can complement government sponsored health insurance and health provision, but this requires oversight/coordination. An example of a country with UHC that offers complementary "top-up" products is France.
- Interoperability of mobile platforms is an important issue, and stresses the need to keep innovating!

Chair: Cees Hesp, Pharmaccess, highlighted that 900M Africans now have mobile subscriptions. By 2030, 70% of Africans will have a smartphone, and India just released a $4 version.

Adjoa Boateng, MicroEnsure provided an overview of the use of mobile money applications in health insurance. She described Airtel insurance, which began as a free "loyalty" program then started to offer a set of optional paid products including life, accident, hospital and cash benefits (HospiCash is the greatest demand). Best practices include the need for a flexible payment schedule and benefits, the need for customer education and marketing, and making claims simple.

Ralph Ankri, Orange Labs delivered a spotlight on mobile money partnership with community-based health insurance in Mali. Orange includes mobile led microinsurance, which is a combination between financial services and telecoms to help reduce costs. They also provide microinsurance for women, and have reached 127% mobile penetration in their target population in Mali, providing 12 months of life, disability, and maternal health insurance.

The discussion continued with Michael Karangwa sharing Rwanda's computerization of health insurance functions, including highlighting Rwanda's Mganga.net, which uses cellular point-of-services (PoS) devices to record use of health services, and their use of the MicroEnsure product to target moto taxi drivers for automatic healthcare savings plans. Thomas Adoboe, **Deputy Director-Management Information Systems,** spoke about Ghana's experience with mobile technology, and discussed the mobile registration and authentication system, which is done at facilities. For claims authentication, each claim receives an automatically generated Claim Check Code (CCC). There is also work being done on an e-payment architecture and focused rollout of mobile services and intuitive apps to strengthen the NHIS.

Day 5, Session II. "Intelligent Health Systems"

Session objectives:

- Highlight the importance of monitoring and policy and operational research in ensuring achievement of UHC, particularly in a data constrained environment
- Understand Ghana's strategy for monitoring progress towards UHC and other health system goals, and ensuring access and equity within interventions

Key take-aways:

- Intelligent health systems lie at the heart of evidence-based decisions.
- Indicators alone cannot explain change: Data must be readily available to help make decisions around health policy at the national level, and ongoing implementation throughout the system.
- Global frameworks should not get in the way of countries designing systems that reflect their needs.
- Thinking about data integration from the start is important, by creating coding and ways for different data sources to speak to one another.

Chair: Dr. Lydia Dsane-Selby, Director of Claims at the Ghana NHIA, opened the session by stressing that monitoring should not just be an afterthought, and should rather be included from the start.

Joe Kutzin, WHO, gave the state of the art presentation, including a brief overview of framework for measuring and monitoring UHC progress, and importance of applied policy and operations research.

While he gave an overview of the global WHO-WB framework and SDG indicators for progress to UHC, he stressed that UHC is not a goal in itself: What is important is improved health outcomes and creating space for improved financial status, and the need to consider context when judging progress.

Lydia Dsane-Selby, NHIA, provided the spotlight on Ghana, and discussed how Ghana is sitting on a wealth of data that it needs to be able to access in order to adequately monitor progress. She described the process that the agency took to develop an evidence-based dashboard, and the multi-stakeholder working group that was formed to determine where they should focus with respect to priority indicators. One criterion was that indicators be actionable, and not just "good to know", as well as based on available data. She described a standing technical committee on operations research that helps to examine key research issues when they arise, ensures results are feasible to implement, and sends findings to management. She stressed that data are important for on-the-job use, and that when people realize the value of data, they are more motivated to get better quality information.

Therese Kunda, Management Sciences for Health Rwanda Health Systems Strengthening Project, described the system for automated generation of reports for indicating progress across levels, while **Atakelti Abrha,** General Director, Ethiopian Health Insurance Agency spoke about the evolution of the Ethiopian data management system from "family folders" to a well-integrated HMIS system that includes a system of red, yellow or green "flags" to indicate performance at the federal level.

A group brainstorming session followed around challenges and solutions related to three key topical areas (development partners, feedback loops, and institutional roles and responsibilities). For the latter, key challenges included facilities sometimes not knowing standard data expectations before they join schemes. A related solution was that strategic planning should be used to guide systems, including software and computerization that connect systems to each other and national entities from the start.

Annex IV. Overview of Site Visits

Financial Protection and Improved Access to Health *Care*: Peer-to-Peer Learning Workshop

Field Trip – Wednesday, February 17, 2016

As part of the broader objective of the workshop all or interested participants will embark on a **site visit** to five different sites in four regions of Ghana. Each country participant will be assigned to one of the five groups below. There will be about 20 -25 people in each group. Each group will visit a different site and then share their experiences with their colleagues at the workshop on return. Participants will observe and learn, on one hand, the practical operations of Ghana's National Health Insurance Scheme, and on the other hand, the operations of a mix of providers of the NHIS.

Things to see and learn at the NHIS Sites:

Participants will learn about the governance structures of the NHIS at the regional and district level, strategies for enrollment, premium collection process, live registration of members, claims processing and the mutual relationships between NHIS and health care providers at different sites.

Things to see and learn at the Provider Sites

Participants will visit different categories of health care providers, including Teaching Hospitals, District/Municipal Hospitals, Health Centers and Maternity Homes at different sites. They will also see the contrast between government health care providers and the Christian Healthcare Association of Ghana (CHAG) and Private Hospitals and Clinics. They will learn the practical operations of these health care providers in relation to the NHIS, morbidity patterns, especially, the top 10 diseases in Ghana.

Group No. Resource person	Design element	Venue(s)	People to talk to	Things to see	Venues/coordinators
Group 3 Abass Suleymana	NHIS District Operations. Provider Payments And Engagement	Sogakope, Volta Region NHIS, Comboni Hospital and District Hospital)	NHIA Scheme Manager and His team. Health Administrator	Operations Enrollment Process, Premium Collection Capitation and Selection of Preferred Primary Health Care Providers	Felix S.Bankas Richard Ametordzie Natahiniel K. Geyevu Francis Y. Dorkenu Paul Gagbe, Administrator (Comboni Hospital)

Group No. Resource person	Design element	Venue(s)	People to talk to	Things to see	Venues/coordinators
Group 2 Christian Ashiagbor	Claims Processing Provider engagement	Cape Coast: NHIA Claims Processing Center. Regional Office. Cape Coast Teaching Hospital Oguamansin NHIS Office Outpatient and In-Patient Services and Cases.	Deputy Director, CPC and Team CEO and medical director and Team Manager and medical director	Claims Processing system. Facility-level systems for receiving patients. Claims submission Process.	William Omane Agyekum and Team Dr. Daniel Assare (CEO) and Dr. Ngyedu (Medical Director and Team
Group 4 Marian Musah		<u>Koforidua</u>: NHIA Regional Office, District NHIS office. <u>Tinkong:</u> Live Now Private Clinic, Ados Maternity Home and Tinkong Health Center	Regional Operations Koforidua and AKuapem North District Manager. District Manager. Health Administrators and Medical Directors	NHIS Operations – regional and District levels. Mix different Levels Gov't and Private Providers	Charles Nkrumah, Akuapem North District Manager John Awuku. A .Regional Operations Manager. <u>Tinkong</u> Opare Edwin (Administrator, Live Now Clinic)
Group 1 Stella Adu-Amankwah And Ophelia Abrokwah	Military Provider Engagement And Governance Structure	Accra: 37 Military Hospital, NHIA National Claims Processing Center (CPC)	Commander of the Hospital – Brigadier Gen Ametepi and CEO of the Hospital , Col.S.K.Adjei	Presentation about the Hospital Service at the Board Room. Systems for receiving patients and Emergency care coping strategies Relationship with NHIS and Public	Isaac Mensah Addo (NHIS Focal Person at the Hospital. Officer Osei-Boateng
Group 1 Stella Adu-Amankwah And Ophelia Abrokwah	Population coverage, premium collection, and provider payment	Ayawaso District NHIS, Dwurwulu	Scheme Manager, MIS officer, PRO	Systems for marketing, enrollment, tracking membership, Premium Collection.	Ayawaso District Health Insurance Scheme Manager Freida Reynos and Team

Group No. Resource person	Design element	Venue(s)	People to talk to	Things to see	Venues/coordinators
Group 5 Richard Badu	Population coverage, premium collection, and provider payment	Winneba NHIS Office, Winneba Health Centre, Winneba Municipal Hospital, Otoo Memorial Hospital(Private)	Scheme Manager MIS officer, PRO, Claims Officer	Evolution of NHIS in Winneba, Enrollment Strategies, Relationship with providers, Coverage Statistics	Rev. Sampson Adjei Nyarko, Richard Odonkor and Philip Bonney

Field Trip Schedule

7:00 CAPE COAST, WINNEBA, SOGAKOPE AND KOFORIDUA GROUPS Gather at in Front of Movenpick Ambassador Hotel.

7:15: CAPE COAST, WINNEBA, SOGAKOPE AND KOFORIDUA Groups Depart

7:30 Accra Group Departs

Site Visit Experience Sharing

Participants from each group will share their site visit experience with each other during a debriefing session on Thursday, February 18, 2016.

Annex V. Country Commitments

Country Name	Commitments	Resources needed	Markers of Progress
Benin	1. Restructure and define role of ANAM Agency. 2. Re-launch UHC training activities (GTT). 3. Organize UHC workshop for journalists. 4. Develop implementation plan for health financing strategy (including a review of benefit package, premiums, and innovative financing). 5. Develop a mechanism for M&E of UHC.	• Technical and financial support for UHC training activities (GFF and journalist workshop). • Technical and financial support for M&E strategy and implementation. • Support with recruitment of health insurance administrator and IT specialist.	• UHC is on the political agenda in Benin (1 month) • National UHC training plan developed and validated (6 months) • UHC M&E strategy developed and validated (6 months) • Health insurance administrator recruited (6 months) • IT partner recruitment and information management software is in place (6 months)
Cote d'Ivoire	1. Conduct series of technical studies (including costing, actuarial analysis, fiscal space analysis, budget analysis, and study on the poor). 2. Update benefits package. 3. Disseminate tools (benefits lists, service nomenclature, pharmacy benefits, etc.) and train providers on use of the tools. 4. Implement UHC pilot among students. 5. Create electronic and inter-connected health information	• Technical and financial support to conduct technical studies, IT system development, and RBF pilot implementation. • Financial support for all other activities	• Number of beneficiaries increases • Out-of-pocket spending as % of total health expenditure (THE) decreases from 51% (2013 NHA) • Public share of THE increases from 33% (GHED WHO, 2013) • Public spending on health increases as % of total public budget (Abuja Target)

Country Name	Commitments	Resources needed	Markers of Progress
	system. 6. Implement results-based financing pilot program. 7. Engage in exchange of UHC experiences with Mexico and Cuba.		
Ethiopia	1. Finalize draft health financing strategy. 2. Capacity building for health financing. 3. Institutionalize performance measurement in National Health Accounts. 4. Build IT infrastructure to support UHC.	• Support to reinforce institutional capacity development • Building IT infrastructure • Developing research and evaluation efforts	• Finalized health financing strategy • 80% of population covered by health insurance • Increased health care utilization from 0.5 to 0.8 visits per capita • Reduced OOP • Increased DRM
Ghana	1. Complete work of NHIS Review Committee. 2. Implement proxy means testing for coverage of the poor and vulnerable by the Department of Social Welfare and the Ministry of Gender, Children, and Social Protection.	• Data analytics for strategic purchasing and expenditure management • Improvements to medical audits system	• Increased coverage by health insurance, particularly among the marginalized and the affluent (who will cross-subsidize the rest) • Improvements in equity of coverage and utilization of services • 80% of providers are paid within 120 days of submission • Claims liability dashboard with red flags
Nigeria	1. States develop frameworks for health financing with core analytical inputs. 2. Develop national-level strategy to support states to develop health financing strategies, technical working	• State-level analytics support • Support to develop national health financing strategy and policies • Support for UHC community of practice across states	• National health financing strategy developed with equity considerations • Core analytics and evidence inform State-level frameworks and strategies for health financing • UHC investment case and economic impact analysis

Country Name	Commitments	Resources needed	Markers of Progress
	groups, and other units. 3. Support 'fast-track' engagement and tools for 10 states that already have health financing structures. 4. Build robust advocacy tools targeting National Council on Health, Governor's, state-level Budget Offices, Economic Development Departments, and state and federal MoH and MoF. 5. Create national level framework for health financing and strategies to operationalize National Health Act.		
Rwanda	1. Strengthen institutional capacity of Rwanda Social Security Board and MoH. 2. Implement CBHI reforms aimed at ensuring expanded membership and affordable and equitable premiums and benefit package 3. Implement effective information management systems to provide real-time data to monitor progress. 4. Diversify resources to bridge CBHI funding gap (through		• CBHI membership increases • Premiums and benefit package are more equitable and affordable • Management information systems provide more real-time, actionable data (e.g., expenditure tracking tools) • More domestic resources are mobilized for health. • Increased efficiency through coordination of partner support • UHC can be tracked to health sector performance

Country Name	Commitments	Resources needed	Markers of Progress
	innovative financing and private sector engagement). 5. Improve coordination of technical support from partners. 6. Enhance multi-sectoral engagement and dialogue. 7. Implement reforms (e.g., provider payment and linking PBF to accreditation) to better align health financing and service delivery.		
Senegal	1. Define benefit package at each level. 2. Identify and map gaps in health coverage. 3. Develop investment plan for filling identified gaps. 4. Monitor quality of care via supervision and accreditation. 5. Promote CBHI and other financial protection mechanisms. 6. Implement professional units to promote better management of CBHI. 7. Implement a UHC M&E framework. 8. Develop public-private partnerships.	Financial and technical support (not specified).	• Key tools available (including benefits package, gaps analysis, investment plan) • Quality indicators and protocols developed. • Increase in the % of the population covered by health insurance • CBHI management units established and are operational. • M&E system implemented. • Increase in the number of PPPs.

Country Name	Commitments	Resources needed	Markers of Progress
Togo	1. Finalize national health financing strategy. 2. Strengthen INAM capacity to reach target population (e.g., proactive enrollment strategies). 3. Implement coverage of the rest of the formal sector (private sector). 4. Implement coverage of non-contributory groups (e.g., indigents, pregnant women, children <5, elderly >70). 5. Implement coverage of the informal sector and rest of the population.	• Technical and financial support to develop health financing strategy • Other forms of technical and financial support to include: workshops, sensitization campaigns, studies of the target population, developing institutional frameworks, mechanisms to identify the poor	• Health financing strategy developed. • Increase % of population enrolled in mandatory health insurance (INAM). • % of population enrolled in health insurance (by population group)
Uganda	1. Develop roadmap for Government, partners, and other stakeholders to move forward on UHC. 2. Finalize health financing strategy. 3. Enact NHIS bill. 4. Analyze various NHIS frameworks. 5. Work with partners and civil society to advocate for UHC. 6. Conduct costing of current benefits package. 7. Build capacity for NHIS functions.	• Close collaboration with partners to support UHC advocacy. • Technical support to develop NHIS capacity.	• Health financing strategy developed by April 2016 • NHIS Bill passed by Cabinet by June 2016.

Country Name	Commitments	Resources needed	Markers of Progress
	8. Integrate ICD classifications for diseases in HMIS. 9. Disseminate service delivery standards to all providers. 10. Institutionalize quality of care program.		

Annex VI. Summary of Partner Meetings

Representatives of three international technical agencies (USAID, WHO, Gates Foundation) met during the workshop and identified an eleven-item list of priority areas for coordinated action to improve health financing.

In the group's first meeting, , they shared plans for their agencies' upcoming work on health systems strengthening in Africa and especially on health financing in advancing progress toward UHC. The group also discussed any known gaps in their plans where resources likely will not fully match countries' needs. They identified nine high priority action areas where one or more of the agencies will be active but could benefit from coordination to avoid duplication and/or enhance collaborative action.

The following seven items were identified in the first meeting --

1. Capacity development--skills in health financing and governance at country and subnational level (with lower-cost approaches than we face with typical training courses)
2. Sustainable financing--how it is being approached (including Domestic Resource Mobilization)
3. Progress tracking – toward UHC and improved financial and human resources (including public and private sectors)
4. National strategies—health financing strategy development
5. Pharmaceutical management—medicine benefit packages
6. Non-African successes—innovative country examples of UHC progress
7. Political support—Advocacy for UHC and health financing reforms

In the second meeting, on the next to last day of the Workshop, the group reviewed their action list from the first meeting and discussed items that came up in the week's presentations and discussions. The group decided to list two more items in addition to the original seven:

8. Information Systems—Platforms and processes for handling information, interoperability, unifying data sets, use of mobile technology
9. Service delivery—Strategies for improving coverage, linking financing to service operations, linking financing to quality of services.

Also, the group identified other agencies and programs, such as the Joint Learning Network (JLN) and Providing for Health (P4H), whose mandate and resources focus also on health financing for UHC.

At the conclusion of the second meeting, the group agreed to exchange information on plans at least quarterly, and USAID agreed to organize the first set of plans, with other agencies such as possibly WHO or the World Bank, eventually taking over future coordination.

Agencies participating in the Workshop's two coordination meetings were: the World Health Organization, the Bill & Melinda Gates Foundation, and the U.S. Agency for International Development. (The World Bank, provided its expertise for the Ghana Workshop but was unable to join these discussions due to scheduling conflicts.) Staff members from the agencies came from their headquarters, regional offices, and nine country offices (Benin, Cote d'Ivoire, Ethiopia, Ghana, Nigeria, Rwanda, Senegal, Togo, and Uganda).

Annex VII. Summary of Participant Evaluations

Financial protection and Improved Access to health care: Peer to Peer Learning Workshop, Finding Solution to Common Challenges

Summary of Participant Evaluations

To provide feed-back on the workshop participants were asked to score on a "Likert Scale" of 1 to 5 the usefulness of the workshop (1 being least useful and 5 being most useful). The analysis showed that 6.52% scored 3 (useful), 39.13% scored 4 (very useful) and 54.35% scored 5 (most useful), no score for 1 and 2 (least useful). These results indicate that the workshop was significantly useful. Below are excerpts of the comments and suggestions from participants who evaluated the workshop:

1. Most relevant piece of information learned in relation to country health financing context

"Turning theory into practice and comprehensive overview of the key concepts in financial protection"

"Learning from country experience, especially, perfect, comprehensive coverage was an important lesson learned from Ghana, and greatly appreciated the field trip- hands on view of how the scheme is implemented".

"I learned that countries should make health financing reforms from the on-set."

"All Insurance schemes should use family adhesion and government put some percentage for covering the indigents."

"We don't need to get it right from the beginning. Jump into the swimming pool then learn to swim (explore). Sustainability of health insurance and reforms in the health sector".

"Strategies for pharmacy management and importance of evidence –based decision making."

"Expenditure management to increase efficiency and value for money".

"UHC seen from both sides of the coin"

"Political part –UHC –session with the parliamentarians."

"Chaque pays doit s'adapter a son context. Il n'est pas un modele unique et standard pour la definition & la mise en oeuvre d'une strategie de financement" (Each country must work within her specific context, for, there is no strait jacket or gold standard model for health financing)

"Coordination de toutes les parties prenantes de la CUS"

"Thank you for the excellent logistics, assembly of experts and the opportunity for the field visit"

"Private sector engagement"

"The need for greater efficiency in all aspects of health financing value chain especially using innovation and technology"

"Behavioral Economics, and Mexico example of health care financing"

"Resource Mobilization mechanisms such as earmarking and how to tap into the expertise of the private sector."

"Ways of domestic resource mobilization and community based health insurance and membership registration systems."

"The UHC context, theory and practice"

"Insights into the politics behind the scenes with regards to decisions and policies, arguments, etc relating to the Ghana's NHIS and the financing arrangement"

"The Ghana Context of NHIS is such a mind blowing experience that has obviously shown that NHIS is possible, even though there are challenges that could be encountered"

"Ghana's political experience with the NHIS"

"Suivi et Evaluation" (Monitoring and Evaluation)

"Expenditure management was very relevant because Ghana's NHIS is facing sustainability challenges."

"Institutional capacity in the private sector is critical to success of UHC and also for PPP arrangement."

"Field visit experience to witness the process through which NHIS is delivered."

"The need to have a national scheme which is mandatory. The scheme should have public –private mix though with different roles"

"Using technology to improve health financing and coverage"

"Que cela necessite la participation de tous les acteurs a tout le processus"

"Une bonne mise en place dela couverture maladie universelle necessite un dispositive institutionel organise impliquant different acteurs et des moyens financiers adequats"

"Behavioral Economics, mandatory /voluntary systems and variety of lessons learned, "two sides the coin"

2. Important Topics for Future Learning

"Behavioral Economics"

"How medical and clinical audit can be strengthened as a cost containment measure. This is relevant because fraud, waste and abuse cannot be separated from health insurance."

"Equity and private sector engagements"

"Benefit package, performance based financing and mobilizing domestic resources for health"

"Health governance and accountability"

"Claims administration"

"Monitoring and Evaluation"

"Membership registration system"

"Operations of CBHI in a developing country context"

"Approaches to identify the poorest of the poor"

"Data management systems to be applied in the health insurance system."

"Claims management processes"

"Means of identifying the poor"

"Core analytics topics such as fiscal space analysis, costing tools and political economy"

"Intelligent health systems"

"Creating active buyers/enrollees/citizens"

"Expenditure management and provider payment methods that stimulate efficiency"

"Evidence based health financing research"

"Evidence of citizens engaging in health financing".

"Using technology to improve health financing reforms"

3. Priority Challenges in implement Equitable Financing that were not addressed

"Effective Strategies to address systemic leakages that constitute a challenge to sustainability and how to combat fraud and abuse more effectively showcasing experience from other jurisdictions that have made progress on provider side moral hazards".

"Peculiarities of different countries still need to be discussed more, may be at the country levels but I feel donors can still contribute".

"The importance of religion and culture on health insurance policy".

"Means of identifying the poor"

"Data management of NHIS"

"Domestic Resource mobilization"

"La mise en charge de pauvre"

"Political economy of health care financing reforms"

"Design of benefit package"

"Systemic accountability"

"Assurance supplementaire pour les personnes indigentes"

4. Additional Feed-back relating to the Agenda, logistics or any other aspects

"Workshop methodology was very innovative"

"The workshop was well planned and the agenda/topics were very appropriate."

"More time should have been allocated to the group work"

"Not good to sign for travel allowance in Ghana, and too much paper work."

"Le programme etait coherent et pertinent, le logistique et la accommodation tres satisfaissantes"

"Absentee invitees and how to reduce such incidences and make more actors benefit from such rich programs and knowledge sharing experience."

"Field trip was particularly useful and should be maintained."

"Cycle of operational research."

"Discussion of the supply-side and organizational frameworks will enhance financing of health care"

"Facilitate mobile facility insurance products and solutions."

"For USAID staff: how to look across different vertical programs to make the case to partner governments to invest in health while adequately financing key interventions to ensure improved health status."

“It appears these conferences end here without much impact; I hope there are plans to measure the impact of this conference in the health sector of the countries involved”

“You may have to take a look at the lunch option for a field trip, especially, when Africans dominate the participants”

“The private sector should be considered in such workshops for their side of the coin.”

“Nigeria is extremely appreciative that the conference allowed large country delegation to attend”

“Satisfied! Well done!”

“Format of workshop: Excellent! Logistics: Superb! Thank you for including field trip and, mobile team parliamentarians and private sector.”

“Love the peer -to –peer learning.”

“The program was very packed so could not do much deep dive into the topics.”

“Les solution doivent etre contextuelle”

“Working with the subnational levels that are the theatre of engagement in implementing of health services.”

“Country teams worked in Isolation without external advisors/facilitators which made them a bit static. More prompts and one-on-one TA in the workshop would be great.”

“Pas suffisament traites: Equite et durabilite financiere de ce systeme (Equity and financial sustainability were not adequately addressed in the workshop)”

“Bonne Organisation de l ‘atelier! Merci pour tout!” (Well-planned and organized workshop) Thank you for everything!)