# Health Financing Indicators

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# Reference Sheets—Health Financing Indicators

## 1. Revenue Collection

| **Indicator 1.1: Number of technical resources developed with project assistance to support an increase in revenues for health** | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator Type | Output |
| Purpose | This indicator measures the number of technical resources developed with project assistance that help to generate additional revenues for health. Examples of technical resources may include a health financing policy, costing study, financial accounting tool or health financing eLearning module. |
| Definition of key terms | Technical resources: Technical resources are defined broadly as tools, models, methodologies, guidance, approaches, and strategies. They may include but are not limited to assessments, manuscripts, published articles, reports, training courses, learning modules, software, strategic plans, operational plans, etc. These resources include direct project outputs that may be tracked by the project's records or monitoring and evaluation system.<br><br>Revenues for health: Domestic and external resources allocated to the health sector.<br><br>Project assistance: The project must define "project assistance" in terms specific to the given context. |
| Measurement | Number of technical resources |
| Disaggregation | Type of technical resource |
| Data sources | Project records |

| Indicator 1.2: Evidence of use of project-supported technical resources to inform revenue generation decisions | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator Type | Short term outcome |
| Purpose | This indicator is qualitative in nature, and it reflects the extent to which technical resources or outputs developed by the project or with project assistance are used to inform decision-making related to health resource generation. For example, a costing tool developed with project technical assistance may be used by the Ministry of Health to advocate for additional health resources. The instances of actual utilization of resources in decision making processes may be documented using narratives (e.g. success stories, briefs). |
| Definition of key terms | Technical resources: Technical resources are defined broadly as tools, models, methodologies, guidance, approaches, and strategies. They may include but are not limited to assessments, manuscripts, published articles, reports, training courses, learning modules, software, strategic plans, operational plans, etc. These resources include direct project outputs that may be tracked by the project's records or monitoring and evaluation system.<br><br>Use of: Study and application of the evidence included in the technical resource or output as a means of accomplishing a purpose or achieving a result.<br><br>Evidence: Verbal or written citation or acknowledgement of the technical resource or output. |
| Measurement | Narratives and success stories |
| Disaggregation | Not applicable |
| Data sources | Project records, country/organization documentation |

| Indicator 1.3: Amount of financing mobilized by the private health sector | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator Type | Short term outcome |
| Purpose | This indicator measures the amount of funds that the private health sector is able to mobilize through various mechanisms, such as loans and credits, and therefore reflects access to finance for the private sector. The private health sector's ability to access finance and capital is essential to its long-term sustainability and growth. Access to finance impacts availability and quality of health services by enabling the private sector to increase the size of its facilities, extend training opportunities, purchase equipment, hire additional staff, etc.<br>Projects may provide technical assistance to private providers or health facilities to apply and obtain financing (e.g. loans, grants) from available lending institutions. |
| Definition of key terms | Financing: Means and methods for paying for health care services and products. They may include, for example, loans and other types of credit, grants, or incremental payments.<br><br>Mobilized: Financing that is approved, granted, accessed, and put into action.<br><br>Private health sector: The private health sector is a large and diverse community comprising both for-profit and not-for-profit entities that lie outside the public health sector. The private sector covers a wide range of health sector entities, including individual private practitioners, clinics, hospitals, and laboratories and diagnostic facilities; nongovernmental organizations; faith-based organizations; shop keepers and traditional healers; pharmacies; and pharmaceutical wholesalers, distributors, and manufacturers. |
| Measurement | Total monetary value of financing resources |
| Disaggregation | Type of financing, type of private sector organization |
| Data sources | Project records, partner loan/bank reports |

| Indicator 1.4: External resources for health as a percentage of total expenditure on health | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator level | Long term outcome |
| Purpose | This indicator traces the financing flows from external sources that provide funds to public and private financing agents. It measures the health sector's dependency on external resources to purchase health services. A high percentage indicates a situation in which a country is unable to perform many of the core functions of government, such as operations and maintenance, or the delivery of basic public services, without foreign aid funding and expertise.[1]<br>While specific project activities do not typically directly influence this indicator, projects may still be interested in monitoring its progress over time. |
| Definition of key terms | External resources: The sum of resources channeled to health by all non-resident institutional units that enter into transactions with resident units or have other economic links with resident units, explicitly labeled for health or not, to be used as a means of procuring health goods and services or as an investment in capital goods by financing agents in the government or private sectors. They include donations, loans, cash, and in-kind donations.[2]<br><br>Total expenditure on health: The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind.[3] |
| Measurement | *Numerator:* Total expenditure on health spent by external sources<br>*Denominator:* Total expenditure on health |
| Disaggregation | Government level, health area (e.g. HIV, malaria, TB, reproductive health) |
| Data sources | National Health Accounts; WHO Global Health Expenditure Database |

[1] Brautigam D. 2000. Aid dependence and governance. Stockholm: Almqvist & Wiksell International.

[2] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en).

[3] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en).

| Indicator 1.5: General government expenditure on health as a percentage of total government expenditure | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator level | Long term outcome |
| Purpose | The World Health Organization lists this indicator as a recommended core indicator for measuring the government's commitment to health.[4] The indicator reflects how much government funding is raised for health, relative to total government resources.<br>While specific project activities do not directly influence this indicator, projects may still be interested in monitoring its progress over time. The World Health Organization recommends the 2001 Abuja declaration target of 15% as an aspirational benchmark for countries to achieve.[5] |
| Definition of key terms | General government expenditure on health: The sum of health outlays paid for in cash or supplied in-kind by government entities, such as the Ministry of Health, other ministries, parastatal organizations or social security agencies (without double counting government transfers to social security and extrabudgetary funds). It includes all expenditure made by these entities, regardless of the source, so includes any donor funding passing through them. It includes transfer payments to households to offset medical care costs and extrabudgetary funds to finance health services and goods. It includes current and capital expenditure.[6]<br><br>General government expenditure: Includes the consolidated outlays of all levels of government: territorial authorities (Central/Federal Government, Provincial/Regional/State/District authorities; Municipal/Local governments), social security and extrabudgetary funds. The revenue base of these entities may comprise multiple sources, including external funds and loans. It includes current and capital expenditure.[7] |
| Measurement | *Numerator:* General government expenditure on health<br>*Denominator:* General government expenditure |
| Disaggregation | Government level |
| Data sources | National Health Accounts; WHO Global Health Expenditure Database |

[4] World Health Organization. October 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization.

[5] World Health Organization. October 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization.

[6] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en).

[7] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en).

| Indicator 1.6: Per capita total expenditure on health | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator level | Long term outcome |
| Purpose | The World Health Organization lists this indicator as a recommended core indicator to measure the total resources expended on health relative to the benefit population.[8] The indicator provides information on the overall availability of health funds.<br>While specific project activities do not directly influence this indicator, projects may still be interested in monitoring its progress over time. |
| Definition of key terms | Total expenditure on health: The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind. |
| Measurement | *Numerator*: Total expenditure on health<br>*Denominator*: Total population |
| Disaggregation | Government level |
| Data sources | National Health Accounts (for numerator); UN Population Division (for denominator). |

[8] World Health Organization. October 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization.

| Indicator 1.7: Total expenditure on health as a percentage of gross domestic product | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator level | Long term outcome |
| Purpose | The World Health Organization recommends use of this indicator to measure the level of resources channeled to health relative to a country's wealth.[9]<br>While specific project activities do not directly influence this indicator, projects may still be interested in monitoring its progress over time. |
| Definition of key terms | Total expenditure on health: The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind.<br><br>Gross domestic product: The value of all goods and services provided in a country without regard to their allocation among domestic and foreign claims. |
| Measurement | *Numerator*: Total health expenditure<br>*Denominator*: Gross domestic product |
| Disaggregation | Not applicable |
| Data sources | National Health Accounts (numerator); World Development Indicators (denominator) |

[9] World Health Organization. October 2010. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization.

| Indicator 1.8: General government expenditure on health as a percentage of total health expenditure | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Revenue Collection |
| Sub-Category | Not applicable |
| Indicator level | Long term outcome |
| Purpose | This indicator measures the relative contribution of government (central and local) spending on health within the total value of expenditure on health. An increase in this indicator relative to donor or household contributions to total health expenditure indicates more sustainable financing for health.<br>While specific project activities do not directly influence this indicator, projects may still be interested in monitoring its progress over time. |
| Definition of key terms | General government expenditure on health: The sum of health outlays paid for in cash or supplied in-kind by government entities, such as the Ministry of Health, other ministries, parastatal organizations or social security agencies (without double counting government transfers to social security and extrabudgetary funds). It includes all expenditures made by these entities, regardless of the source, so includes any donor funding passing through them. It includes transfer payments to households to offset medical care costs and extrabudgetary funds to finance health services and goods. It includes current and capital expenditure.[10]<br><br>Total expenditure on health: The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind |
| Measurement | *Numerator*: General government expenditure on health<br>*Denominator*: Total expenditure on health |
| Disaggregation | Government level |
| Data sources | National Health Accounts; WHO Global Health Expenditure Database |

[10] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en).

## 2. Risk Pooling

| **Indicator 2.1: Number of technical resources developed with project assistance to support the establishment and implementation of effective risk pooling** | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Risk Pooling |
| Indicator Type | Output |
| Purpose | This indicator measures the number of technical resources or outputs developed with project assistance to strengthen the capacity of risk pool managers to conduct effective risk pooling. Examples of technical resources may include a health financing policy, definition of the benefit package, costing study, financial accounting tool or health financing eLearning module. |
| Definition of key terms | Technical resources: Technical resources are defined broadly as tools, models, methodologies, guidance, approaches, and strategies. They may include but are not limited to assessments, manuscripts, published articles, reports, training courses, learning modules, software, strategic plans, operational plans, etc. These resources include direct project outputs that may be tracked by the project's records or monitoring and evaluation system.<br><br>Risk pooling: Risk pooling is the collection and management of financial resources that ensures that individual financial risks of paying for health care are distributed among all members of the pool. Risk pooling can provide financial protection to households facing high health care expenditures. Types of risk pooling mechanisms include: national insurance systems; social health insurance systems; community based health insurance schemes; and private health insurance.<br><br>Project assistance: The project must define "project assistance" in terms specific to the given context. |
| Measurement | Number of technical resources |
| Disaggregation | Type of technical resource |
| Data sources | Project records |

| Indicator 2.2: Risk pooling mechanism designed or established with project support | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Risk Pooling |
| Indicator Type | Output |
| Purpose | This is a yes/no indicator that reflects whether a risk pooling mechanism has been designed or established with project assistance. |
| Definition of key terms | Risk pooling: Risk pooling is the collection and management of financial resources so that large, unpredictable individual financial risks of paying for health care are distributed among all members of the pool. Risk pooling can provide financial protection to households facing high health care expenditures. Types of risk pooling mechanisms include: national insurance systems; social health insurance systems; community based health insurance schemes; and private health insurance.<br><br>Project support: The project must define "project support" in terms specific to the given context. |
| Measurement | Yes/No |
| Disaggregation | n/a |
| Data sources | Project records; government records |

| Indicator 2.3: Number of risk pool managers trained with project support | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Risk Pooling |
| Indicator Type | Output |
| Purpose | This indicator measures the number of individuals trained to design, implement, manage and monitor the risk pool(s). |
| Definition of key terms | Risk pooling: Risk pooling is the collection and management of financial resources so that large, unpredictable individual financial risks of paying for health care are distributed among all members of the pool. Risk pooling can provide financial protection to households facing high health care expenditures. Types of risk pooling mechanisms include: national insurance systems; social health insurance systems; community based health insurance schemes; and private health insurance.<br><br>Risk pool managers: Individuals who design, implement, manage and monitor the risk pooling mechanism. They may include staff who oversee the enrollment of beneficiaries, the handling of claims, actuaries, etc.<br><br>Training: Training may include any type of short-term course or mentorship program which teaches or updates the skills of risk pool managers that are relevant to their work.<br><br>Project support: The project must define "project support" in terms specific to the given context. |
| Measurement | Number of risk pool managers trained with project support |
| Disaggregation | Government level; type of risk pool mechanism |
| Data sources | Government records; project records; insurance scheme records |

| Indicator 2.4: Number and percent of population covered by risk pooling mechanisms | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Risk Pooling |
| Indicator Type | Short term outcome |
| Purpose | This indicator reflects the breadth of financial risk protection in the population. A low percentage means that risk protection coverage is low, and large segments of the population may face high out-of-pocket payments or catastrophic health care expenditures. |
| Definition of key terms | Risk pooling: Risk pooling is the collection and management of financial resources so that large, unpredictable individual financial risks of paying for health care are distributed among all members of the pool. Risk pooling can provide financial protection to households facing high health care expenditures.<br><br>Covered: Coverage is defined as an individual's participation/membership in a risk pooling mechanism over a given time period (e.g. in the year in which this indicator is measured). An individual who is covered should have a valid health insurance card or other document that allows him/her to access care at participating providers.<br><br>Risk pooling mechanism: Types of risk pooling mechanisms include: national insurance systems; social health insurance systems; community based health insurance schemes; and private health insurance. |
| Measurement | Number of people: The number of people covered by risk pooling mechanisms<br><br>Percent of the population covered:<br>*Numerator*: Number of people covered by risk pooling mechanisms<br>*Denominator*: Total population |
| Disaggregation | Geographical area; various population characteristics (gender, age, level of education, economic status) |
| Data sources | Government records, Population-based surveys (e.g. Demographic and Health Surveys); tax or insurance records, UN Population Division or country Census (for denominator) |

| Indicator 2.5: Percent of underserved population covered by risk pooling mechanisms | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Risk Pooling |
| Indicator Type | Short term outcome |
| Purpose | Reflects the breadth of financial protection among the underserved population and thus the equity of the scheme. A low percentage means that the most vulnerable segments of the population may face high out of pocket payments or catastrophic expenditures. |
| Definition of key terms | Underserved population: Often characterized as poor, vulnerable or rural populations. The definition of underserved populations may vary by country settings.<br><br>Covered: Coverage is defined as an individual's participation/membership in a risk pooling mechanism over a given time period (e.g. in the year in which this indicator is measured). An individual who is covered should have a valid health insurance card or other document that allows him/her to access care at participating providers.<br><br>Risk pooling: Risk pooling is the collection and management of financial resources so that large, unpredictable individual financial risks of paying for health care are distributed among all members of the pool. Risk pooling can provide financial protection to households facing high health care expenditures. Types of risk pooling mechanisms include: national insurance systems; social health insurance systems; community based health insurance schemes; and private health insurance. |
| Measurement | *Numerator*: Number of underserved people covered by risk pooling mechanisms<br><br>*Denominator*: Total underserved population |
| Disaggregation | Government level; risk pool mechanisms |
| Data sources | Government records, Population-based surveys (e.g. Demographic and Health Surveys, Living Standards Measurement Survey); tax or insurance records, UN Population Division or country Census (for denominator) |

| Indicator 2.6: Level of satisfaction of risk pool members | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Risk Pooling |
| Indicator Type | Short term outcome |
| Purpose | This indicator measures the degree of satisfaction among members of a risk pool. It can reflect the sustainability of the risk pool, as those who are satisfied are more likely to remain a member of a voluntary risk pool. The more members there are in a pool, the greater its sustainability is. |
| Definition of key terms | Risk pool members: Members of a risk pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures. Membership for a scheme may be based on specific eligibility criteria. |
| Measurement | Measured through directly asking beneficiaries whether and to what extent they are satisfied. It can also be measured using a satisfaction index that uses multiple indicators to assess customer satisfaction. |
| Disaggregation | Type of risk pool and type of members (e.g. can be disaggregated by sex, age, socioeconomic status) |
| Data sources | Population-based or patient surveys |

| Indicator 2.7: Percent of services covered in the benefit package of a risk pooling mechanism | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Risk Pooling |
| Indicator Type | Short term outcome |
| Purpose | This indicator reflects the depth of financial risk protection. It measures the type and extent of services covered by a risk pooling mechanism. |
| Definition of key terms | Benefit package: The health care items or services covered by a risk pooling mechanism. Benefit packages generally include out-patient and in-patient care, surgical procedures, consultations and diagnostic services. Most schemes also define excluded benefits.<br><br>Covered: Coverage is defined as eligibility of the service for payment (full or partial) by the risk pooling mechanism.<br><br>Risk pooling: Risk pooling is the collection and management of financial resources so that large, unpredictable individual financial risks of paying for health care are distributed among all members of the pool. Risk pooling can provide financial protection to households facing high health care expenditures. Types of risk pooling mechanisms include: national insurance systems; social health insurance systems; community based health insurance schemes; and private health insurance. |
| Measurement | *Numerator*: Number of services covered<br><br>*Denominator*: Total number of services, as defined by country |
| Disaggregation | Type of service (e.g. preventive, curative, rehabilitative) |
| Data sources | Risk pooling organizations, Ministry of Health records |

| Indicator 2.8: Out of pocket expenditure on health as a percentage of total expenditure on health | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Financial Risk Protection |
| Indicator Type | Long term outcome |
| Purpose | This is a WHO-recommended core indicator that measures financial protection at a macro-level. Out of pocket expenditures can have a critical impact on health care choices made by the population and have the potential to cause financial catastrophe in households.<br><br>While specific project activities do not typically directly influence this indicator, projects may still be interested in monitoring its progress over time. |
| Definition of key terms | Out of pocket expenditure[11]: The expenditure on health by households as direct payments to health care providers. It should be netted from reimbursements from health insurance.<br><br>Total expenditure on health[12]: The sum of all outlays for health maintenance, restoration or enhancement paid for in cash or supplied in kind. |
| Measurement | *Numerator*: Total out of pocket expenditure on health<br><br>*Denominator*: Total health expenditure |
| Disaggregation | Geographical area, household characteristics (e.g. income level) |
| Data sources | National Health Accounts |

[11] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en)

[12] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en)

| Indicator 2.9: Percent of households spending out of pocket more than catastrophic threshold on health | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Financial Risk Protection |
| Indicator Type | Long term outcome |
| Purpose | This WHO-recommended indicator provides a direct measurement of burdensome health spending. It shows incidence of burdensome spending in the population and correlates with the financial protection offered by risk pooling mechanisms.[13] |
| Definition of key terms | Out of pocket expenditure[3]: The expenditure on health by households as direct payments to health care providers. It should be netted from reimbursements from health insurance.<br><br>Catastrophic threshold[14]: Health spending is considered catastrophic when a household must reduce its basic expenditure over a period of time to cope with health expenditures. There is little consensus on the threshold for catastrophic health care payments. One benchmark used by the WHO and the WB is out of pocket spending that exceeds 25% of non-food income. Two other commonly used thresholds are out of pocket spending that exceeds 10% of total income or 40% of non-food income. Total consumption or total household expenditure is typically used as a proxy for income in the denominator. |
| Measurement | *Numerator*: Number of households spending more than a specified percentage their income or expenditure on health (based on country specific threshold for catastrophic expenditures)<br><br>*Denominator*: Total number of households |
| Disaggregation | Geographical area; household characteristics (e.g. income level) |
| Data sources | Population-based surveys (e.g. the Living Standards Measurement Survey), World Bank ADePT program. |

[13] Xu, K., Evans, D. B., Kawabata, K., Zeramdini, R., Klavus, J., & Murray, C. J. 2003. Household catastrophic health expenditure: a multicountry analysis. *The Lancet*, *362*(9378), 111-117.

[3] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en)

[14] Wagstaff A, van Doorslaer E. Catastrophe and impoverishment in paying for health care with applications to Vietnam, 1993-98. Health Econ. 2003;12:921–34. doi: 10.1002/hec.776.

Xu, K., Evans, D. B., Kawabata, K., Zeramdini, R., Klavus, J., & Murray, C. J. 2003. Household catastrophic health expenditure: a multicountry analysis. *The Lancet*, *362*(9378), 111-117
http://www.who.int/healthinfo/country_monitoring_evaluation/universal_health_coverage/en/

| Indicator 2.10: Percent of households impoverished annually by out of pocket health expenditure | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Risk Pooling |
| Sub-Category | Financial Risk Protection |
| Indicator Type | Long term outcome |
| Purpose | This is a WHO-recommended indicator. It captures whether out of pocket health expenditures push a household below the poverty line, or further into poverty for those already below the poverty line. |
| Definition of key terms | Out of pocket expenditure[15]: The expenditure on health by households as direct payments to health care providers. It should be netted from reimbursements from health insurance.<br><br>Impoverishment[16]: A household is said to have been impoverished by medical expenses when out-of-pocket health care expenditures have caused it to drop below the poverty line. Families already below the poverty line that incur out-of-pocket health expenditures are also included in the numerator of this measure. |
| Measurement | *Numerator*: Number of households whose total expenditures after health spending are below a given poverty line, in a given year<br><br>*Denominator*: Total number of households in the same year |
| Disaggregation | Geographical area; household characteristics (e.g. income level) |
| Data sources | Population-based surveys (e.g. the Living Standards Measurement Survey), World Bank ADePT program. |

[15] World Health Organization. 2014. Indicator code book: National Health Accounts. Geneva: World Health Organization (http://apps.who.int/nha/database/DocumentationCentre/GetFile/51036491/en)

[16] World Health Organization. 2000. Health systems: improving performance. Geneva: World Health Organization.

# 3. Purchasing

## Purchasing: Risk pool management

| **Indicator 3.1: Number of technical resources developed with project support to strengthen provider payment mechanisms** | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider payments: risk pool management |
| Indicator Type | Output |
| Purpose | This indicator measures the number of technical resources or outputs developed with project support to strengthen provider payment mechanisms. Examples of technical resources may include actuarial analyses, costing manuals and analyses, manuals on designing and implementing provider payment systems, etc. |
| Definition of key terms | Provider payment mechanisms: The mechanisms used to transfer resources from the purchasers of health care services (which typically include the Ministry of Health, social security agencies, insurance organizations, and individuals or households) to the providers of care. The most commonly used methods are: 1) *Line item budgets*, which are allocated for each functional budget category such as salaries, medicines, equipment, and administration; 2) *Global budgets*, which are allocated to health facilities and typically depend on the type of facility, size, and utilization or per capita rates; 3) *Capitation*, which allocates a predetermined amount of funds per year for each individual enrolled with a given provider, 4) *Case-based payment*, which involves a set payment to providers for each patient treatment episode, according to a predetermined payment schedule based on an estimated total cost of the medical intervention, and 5) *Fee for service (or user fee),* which is the out-of-pocket payment that patients make for each health care service at the point and time of use.<br><br>Technical resources: Technical resources are defined broadly as tools, models, methodologies, guidance, approaches, and strategies. They may include but are not limited to assessments, manuscripts, published articles, reports, training courses, learning modules, software, strategic plans, operational plans, etc. These resources include direct project outputs that may be tracked by the project's records or monitoring and evaluation system. |
| Measurement | Number of technical resources |
| Disaggregation | Type of technical resource |
| Data sources | Project records |

| Indicator 3.2: Number of claims incurred ratio | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider payments: risk pool management |
| Indicator Type | Short term outcome |
| Purpose | This indicator is applicable to the following risk pooling mechanisms: social health insurance, national health insurance, and private health insurance. It only applies to insurance that uses a fee-for-service or case-based/diagnosis-related group payments. It is the ratio of the number of valid claims received to the total number of enrolled clients. It measures the utilization of insurance by members, and thus reflects members' awareness of their insurance benefits and how to use them. |
| Definition of key terms | Claim: An itemized statement of health care services and their costs provided by a hospital, clinic, or other provider/facility. Claims are submitted to the insurer by either the enrolled member or the provider for payment of the costs incurred. |
| Measurement | *Numerator*: Number of valid claims received by insurer<br><br>*Denominator*: Total number of members enrolled in insurance |
| Disaggregation | Clients/beneficiaries (men, women, children); by inpatient/outpatient |
| Data sources | Health insurance claims and membership management database |

| Indicator 3.3: Incurred claims ratio (also known as medical loss ratio) | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider payments: risk pool management |
| Indicator Type | Short term outcome |
| Purpose | This indicator is applicable to contributory, premium-based risk pooling mechanisms such as social health insurance, and private health insurance which pay providers through a claims-reimbursement process. It is a proxy for the monetary value that clients get from their premium contributions, and highlights the component of premiums that covers administrative costs (and profit, in the case of private insurance). A healthy ratio for private health insurance is typically 65-80%. This means that 65-80% of premiums collected are being utilized for healthcare services, quality improvement, and infrastructure investments. The ratio also reflects the financial viability of the risk pool; a ratio that is too high could indicate a sustainability problem (health care outlays that exceed premium revenue).<br><br>A modified version of this indicator may be used in the case of payments from direct government budgets (see measurement details below). |
| Definition of key terms | Claims: An itemized statement of health care services and their costs provided by a hospital, clinic, or other provider facility. In fee-for-service systems, claims are submitted to the insurer by either the enrolled member or the provider for payment of the costs incurred. |
| Measurement | *For health insurance mechanism*:<br><br>*Numerator*: The total monetary value of incurred claims/reimbursements<br><br>*Denominator*: *For health insurance mechanism*: The total monetary value of earned premiums |
| Disaggregation | Clients/beneficiaries (men, women, children under five) |
| Data sources | Health insurance claims database and financial records |

| Indicator 3.4: Total loss ratio | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider payments: risk pool management |
| Indicator Type | Short term outcome |
| Purpose | This indicator is applicable to the following risk pooling mechanisms: social health insurance, national health insurance, and private health insurance. It is the ratio of the total cost of administering the mechanism against the revenues generated. It measures the efficiency of the risk pooling mechanism.<br><br>A modified version of this indicator may be used in the case of payments from direct government budgets (see measurement details below). |
| Definition of key terms | |
| Measurement | *Numerator*:<br>• *For health insurance mechanism*: Sum of expenses, commissions, and claims incurred by the risk pooling mechanism<br>• *For direct government budget mechanism*: Sum of administrative expenses and total funds spent on health services<br><br>*Denominator*:<br>• *For health insurance mechanism*: Earned revenues from premiums<br>• *For direct government budget mechanism*: Sum of total budget for health services and total budget for administration |
| Disaggregation | none |
| Data sources | Health insurance claims database and financial records<br>Government budget records |

| Indicator 3.5: Claims rejection ratio | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider payments: risk pool management |
| Indicator Type | Short term outcome |
| Purpose | This indicator is applicable to the following risk pooling mechanisms: social health insurance, national health insurance, and private health insurance. It measures the extent to which healthcare providers and clients understand the terms of the insurance and comply with the scheme. If claims reported by the healthcare provider or submitted by the clients are inaccurate or are for services that are excluded from the benefits package, then it is likely that there are misunderstandings of the products from the healthcare provider or from the client. |
| Definition of key terms | Claim: An itemized statement of health care services and their costs provided by a hospital, clinic, or other provider facility. Claims are submitted to the insurer by either the enrolled member or the provider for payment of the costs incurred.<br><br>Claims rejected: Claims that have been disqualified from benefit payment, for any reason. |
| Measurement | *Numerator*: Total number of claims rejected<br><br>*Denominator*: Total number of claims received |
| Disaggregation | Type of service |
| Data sources | Health insurance claims database and financial records |

| Indicator 3.6: Claims settlement | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider payments: risk pool management |
| Indicator Type | Short term outcome |
| Purpose | This indicator measures the promptness of claims settlement.<br>A modified version of this indicator may be used in the case of other types of transfers, such as capitation payments or government fund transfers (see Measurement details below). |
| Definition of key terms | Claim: An itemized statement of health care services and their costs provided by a hospital, clinic, or other provider facility. Claims are submitted to the insurer by either the enrolled member or the provider for payment of the costs incurred.<br><br>Claims settlement: Claims that have been fully processed, which means paid or rejected. |
| Measurement | For claims: Average number of days between service delivered and claim payment received by or denied to clients for the period.<br><br>For capitation: Average number of days between scheduled date of capitation payment and date of actual receipt of capitation payment.<br><br>For government transfer: Average number of days between scheduled fund transfer and the date of actual fund transfer. |
| Disaggregation | Type of service |
| Data sources | Health insurance claims database and financial records<br>Government budget records |

| Indicator 3.7: Number and percent of health care providers empaneled or accredited into risk pooling mechanism | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider payments: risk pool management |
| Indicator Type | Short term outcome |
| Purpose | This indicator measures the size of the provider network. |
| Definition of key terms | Empaneled: An empaneled provider is a provider who belongs to the network of a specific risk pooling mechanism.<br><br>Accredited provider: The provider has undergone an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the accrediting body and to ensure that the organization meets a specified level of quality.<br><br>Risk pooling mechanism: Risk pooling is the collection and management of financial resources so that large, unpredictable individual financial risks of paying for health care are distributed among all members of the pool. Risk pooling can provide financial protection to households facing high health care expenditures. Types of risk pooling mechanisms include: national insurance systems, social health insurance systems, community based health insurance schemes, and private health insurance. |
| Measurement | Number of: Number of providers empaneled or accredited into risk pooling mechanism.<br><br>Percent of:<br>*Numerator*: Total number of providers empaneled or accredited into risk pooling mechanism<br><br>*Denominator*: Total number of providers |
| Disaggregation | Type of provider; sector (public/private) |
| Data sources | Project records |

## Purchasing: Performance based payment systems

| **Indicator 3.8: Number of technical resources developed with project support to assist the establishment or implementation of effective performance-based payment systems** | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Output |
| Purpose | This indicator measures the number of technical resources or outputs developed with project support to assist in the establishment and implementation of a performance-based payment system. Examples of technical resources may include situational analyses or feasibility studies, implementation manuals and guidance materials, outreach/dissemination activities involving local media and/or civil society organizations, monitoring and evaluation systems or tools, etc. |
| Definition of key terms | Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health workers' competence and responsiveness in performing their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Technical resources: Technical resources are defined broadly as tools, models, methodologies, guidance, approaches, and strategies. They may include but are not limited to assessments, manuscripts, published articles, reports, training courses, learning modules, software, strategic plans, operational plans, etc. These resources include direct project outputs that may be tracked by the project's records or monitoring and evaluation system. |
| Measurement | Number of technical resources |
| Disaggregation | Type of technical resource |
| Data sources | Project records |

| Indicator 3.9: Performance-based payment system designed or introduced with project support | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Output |
| Purpose | A direct output indicator that reflects whether a performance-based payment system has been designed or introduced with project support. Performance-based payment systems are increasingly being designed and introduced to increase demand for and use of health services, and improve the quality and availability of those services. |
| Definition of key terms | Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level. |
| Measurement | Yes/No |
| Disaggregation | None |
| Data sources | Project records |

| Indicator 3.10: Performance-based payment system that rewards service quality designed or introduced with project support | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Output |
| Purpose | A direct output indicator that indicates whether the quality of services is rewarded as part of the payment system. More and more performance-based payment systems are designed to reward not just the increased delivery of services, but also the quality of those services. |
| Definition of key terms | Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level. |
| Measurement | Yes/No |
| Disaggregation | None |
| Data sources | Project records |

| Indicator 3.11: Number and percent of entities who signed a performance-based payment contract | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short term outcome |
| Purpose | This indicator measures the number and percent of eligible entities (e.g. health facilities) who signed a performance-based payment contract. This indicator reflects the breadth of coverage of the performance-based system for the target population. |
| Definition of key terms | Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Entities: May include health facilities, healthcare providers, officials at the Ministry of Health, health managers at the district, provincial and national level, or others. |
| Measurement | *Numerator*: Number of individuals or entities who have signed a performance-based payment contract<br>*Denominator*: Total number of eligible entities in the target population |
| Disaggregation | By type of provider; geographical area |
| Data sources | Performance-based payment system records |

| Indicator 3.12: Percent of performance-based payments funded by domestic resources | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short-term outcome |
| Purpose | This indicator measures the extent to which performance-based payment systems are financed with domestic resources. The indicator reflects the level of reliance on external financing (e.g. donor funds) to fund performance payments and is therefore a measure of the sustainability of the system. |
| Definition of key terms | Performance-based payments: Payments designed to improve demand for and use of services, and improve the quality and availability of health services. Incentives (financial or non-financial) are linked to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Domestic resources: Includes the government's budget and/or domestic private funds. Excludes funds by external resources, such as donors. |
| Measurement | *Numerator*: Amount of payments funded by domestic resources over a certain period of time<br>*Denominator*: Total amount of performance-based payments over the same period of time |
| Disaggregation | None |
| Data sources | Performance-based payment system records |

| Indicator 3.13: Performance-based payments are managed by target recipients | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short Term Outcome |
| Purpose | This indicator measures whether target recipients (e.g. health facilities), are managing and spending their own performance funds. This indicator reflects the degree of autonomy in the management and use of funds, and is a gage of the sustainability of the system. |
| Definition of key terms | Performance-based payments: Payments designed to improve demand for and use of services, and improve the quality and availability of health services. Incentives (financial or non-financial) are linked to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Managed: The recipients of the performance payments have full decision-making and autonomy in how the funds are spent and used.<br><br>Recipients: May include health facilities, healthcare providers, officials at the Ministry of Health, health managers at the district, provincial and national level, or others. |
| Measurement | Yes/No |
| Disaggregation | None |
| Data sources | Performance-based payment system records |

| Indicator 3.14: Percent of recipients in a performance-based payment system that submit required performance data correctly and on time | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short Term Outcome |
| Purpose | This indicator measures the degree to which recipients of performance-based payments are submitting their performance results correctly (as verified by an external party) and on time, as stipulated in the performance-based contract. It is a reflection of the level of knowledge and understanding of the contract requirements among recipients and their commitment to the success and sustainability of the system. |
| Definition of key terms | Recipients: May include health facilities, healthcare providers, officials at the Ministry of Health, health managers at the district, provincial and national level, or others.<br><br>Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Performance data: Data on the performance of recipients (e.g. health facilities or health providers) over a specific period of time, and against which payments are made. They may include for instance utilization rates of MCH, FP or disease-specific services or quality indices/scores. |
| Measurement | *Numerator:* Total number of recipients who submitted performance data correctly and on time in a given time period<br>*Denominator:* Total number of recipients who signed performance-based payment contract |
| Disaggregation | Recipient type, geographical area |
| Data sources | Performance-based payment system records |

| Indicator 3.15: Percent of the sample of performance reports by recipients in a performance-based payment system identified for verification that are verified | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short Term Outcome |
| Purpose | This indicator measures the extent to which performance data is verified. Verification of performance reports is an important feature of performance-based payment systems and is an important reflection of the credibility and strength of the system. |
| Definition of key terms | Performance reports: Reports are typically completed and submitted by recipients of the performance-based payments and report the recipient's performance against the established goals or targets. They are typically submitted according to an established timeframe, e.g. quarterly, semi-annually, or annually.<br><br>Recipients: May include health facilities, healthcare providers, officials at the Ministry of Health, health managers at the district, provincial and national level, or others.<br><br>Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Verified: Verification is typically conducted by an external objective party, and involves reviewing the available evidence and data to confirm (or refute) the performance results reported by the recipients in performance reports. |
| Measurement | *Numerator*: Total number of performance reports verified<br>*Denominator*: Total number of sample performance reports identified for verification |
| Disaggregation | Recipient type, geographical area |
| Data sources | Performance-based payment system records |

| Indicator 3.16: Percent of recipients in a performance-based payment system that meet their performance targets | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short Term Outcome |
| Purpose | This indicator measures the degree to which performance-based payment recipients are successful in meeting their performance targets or goals, as stipulated in their contracts. It reflects the effectiveness of the performance payment system. |
| Definition of key terms | Recipients: May include health facilities, healthcare providers, officials at the Ministry of Health, health managers at the district, provincial and national level, or others.<br><br>Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Performance targets: Measureable goals and indicators stipulated in the performance-based payment contract. For example, they may include specific targets on utilization rates or on a quality score for the health service or health facility. They are usually reported according to an established timeframe, e.g. quarterly, semi-annually, or annually. |
| Measurement | *Numerator*: Total number of recipients (individuals or entities) who met their performance target over a specific period of time<br>*Denominator*: Total number of recipients who signed a performance-based payment contract |
| Disaggregation | Recipient type, geographical area |
| Data sources | Performance-based payment system records |

| Indicator 3.17: Percent of recipients in a performance-based payment system meeting performance targets that receive payments on time | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short Term Outcome |
| Purpose | This indicator measures the promptness of performance payments for providers that participate in a performance-based payment system. It is an indication of the credibility and sustainability of the system. When payments are delayed, the future performance of recipients and their trust in the system may be jeopardized. |
| Definition of key terms | Recipients: May include health facilities, healthcare providers, officials at the Ministry of Health, health managers at the district, provincial and national level, or others.<br><br>Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Performance targets: Measureable goals and indicators stipulated in the performance-based payment contract. For example, they may include specific targets on utilization rates or on a quality score for the health service or health facility. They are usually reported according to an established timeframe, e.g. quarterly, semi-annually, or annually.<br><br>On time: Payments received as per the schedules set forth by the performance-based payment contracts. |
| Measurement | *Numerator*: Total number of recipients (individuals or entities) who received their performance payments on time<br>*Denominator*: Total number of recipients who met their performance targets over a specific period of time |
| Disaggregation | Recipient type, geographical area |
| Data sources | Performance-based payment system records |

| Indicator 3.18: Performance results for recipients participating in a performance-based payment system are disseminated or available to the public | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Short Term Outcome |
| Purpose | This indicator reflects the extent to which performance results by providers that are recipients of performance-based payments are published and disseminated to the end user. It reflects the degree of transparency of the system towards the public. |
| Definition of key terms | Recipients: May include health facilities, healthcare providers, officials at the Ministry of Health, health managers at the district, provincial and national level, or others.<br><br>Performance-based payment systems: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Performance results: Results upon which payments are determined and disbursed, as per the performance-based payment contract. For example, they may include utilization rates, a quality score for the health service or health facility, and are usually reported on a regular basis, as determined by the terms of the contract, e.g. quarterly, semi-annually, or annually. |
| Measurement | Yes/No |
| Disaggregation | None |
| Data sources | Performance-based payment system records |

| Indicator 3.19: Value of indicator targeted by a performance-based payment system in a given time period | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Provider Payments: (Supply-Side) Performance Based Financing |
| Indicator Type | Long Term Outcome |
| Purpose | This measure applies for each of the performance indicators in a performance-based payment system. It tracks whether the system is associated with an improvement in target outcomes among intended beneficiaries. Indicators are typically measured quarterly or annually in target performance indicators. Such indicators may include, for example, utilization rates of maternal and child health, family planning or disease-specific services. The primary purpose of performance-based payments is to improve demand for and use of services, and improve the quality and availability of health services. A positive change in a performance indicator may be linked to the effectiveness of the performance-based system. |
| Definition of key terms | Performance-based payment system: Systems designed to improve demand for and use of services, and improve the quality and availability of health services. The systems link incentives (financial or non-financial) to results that measure health worker's competence and responsiveness in performance of their duties. Incentives are paid when pre-determined performance targets are met, or may be withheld as a consequence of lack of performance. Incentives can be given to health facilities, healthcare providers when they achieve performance targets or to health managers at the district, provincial and national level.<br><br>Indicators: Indicators that are used to measure the performance of recipients (e.g. health facilities or health providers) over a specific period of time, and against which payments are made. They may include, for instance, utilization rates of MCH, FP or disease-specific services or quality indices/scores. |
| Measurement | Depending on the type of outcome, this indicator can measure either number of service units (utilization) or percent coverage (e.g. immunization rates) |
| Disaggregation | Type of provider, geographical area |
| Data sources | Performance-based payment system records, HMIS, DHS, facility surveys |

## Purchasing: Demand side financing programs

| **Indicator 3.20: Number of technical resources developed with project support to assist in the establishment and implementation of demand-side financing programs** | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Output |
| Purpose | This indicator measures the number of technical resources or outputs developed with project support to assist in the establishment and implementation of a demand-side financing programs. Examples of technical resources may include implementation manuals and guidance materials, voucher claim forms, eligibility criteria, guide book clarifying operational roles, a monitoring and evaluation system, etc. |
| Definition of key terms | Demand-side financing (DSF) programs: Programs designed to improve equity in access and to increase utilization of targeted health care services by directly subsidizing consumers. Some types of DSF may also improve the quality of care by providing incentives for providers to compete for beneficiaries. DSF mechanisms include vouchers, cash transfers, tax rebates, fee waivers, and other targeted subsidies provided directly to consumers.<br><br>Technical resources: Technical resources are defined broadly as tools, models, methodologies, guidance, approaches, and strategies. They may include but are not limited to assessments, manuscripts, published articles, reports, training courses, learning modules, software, strategic plans, operational plans, etc. These resources include direct project outputs that may be tracked by the project's records or monitoring and evaluation system. |
| Measurement | Number of technical resources |
| Disaggregation | Type of technical resource |
| Data sources | Project records |

| Indicator 3.21: Demand-side financing program designed or introduced with project support | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Short-term outcome |
| Purpose | This indicator assesses whether project assistance has led to the design or introduction of a demand-side financing program. |
| Definition of key terms | Demand-side financing (DSF) programs: Programs designed to improve equity in access and to increase utilization of targeted health care services by directly subsidizing consumers. Some types of DSF may also improve the quality of care by providing incentives for providers to compete for beneficiaries. DSF mechanisms include vouchers, cash transfers, tax rebates, fee waivers, and other targeted subsidies provided directly to consumers. |
| Measurement | Yes/no indicator |
| Disaggregation | None |
| Data sources | Project records |

| Indicator 3.22: Percent of demand-side financing recipients who meet target recipient characteristics | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Short-term outcome |
| Purpose | This indicator measures the degree to which targeting of demand-side financing subsidies is effective (i.e. subsidies reach the intended beneficiaries). Low values for this indicator indicate that targeting guidelines/criteria are unclear and/or are not properly implemented (e.g. there may be leakage of program subsidies to people outside of the target group such as wealthier individuals receiving subsidies meant for the poor). |
| Definition of key terms | Demand-side financing (DSF) programs: Programs designed to improve equity in access and to increase utilization of targeted health care services by directly subsidizing consumers. Some types of DSF may also improve the quality of care by providing incentives for providers to compete for beneficiaries. DSF mechanisms include vouchers, cash transfers, tax rebates, fee waivers, and other targeted subsidies provided directly to consumers.<br><br>Target recipient characteristics: DSF programs typically target specific population groups such as pregnant women, children, or the poor. Program guidelines should specify how these characteristics are verified (e.g. prerequisites may include a below-poverty line card or registration for antenatal care). |
| Measurement | *Numerator:* Number of program recipients who meet target recipient characteristics<br><br>*Denominator*: Total number of program recipients |
| Disaggregation | Geographic area; type of target recipient |
| Data sources | DSF program records; survey of recipients that measures target characteristics |

| Indicator 3.23: Number and percent of health care vouchers redeemed | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Short-term outcome |
| Purpose | This indicator measures the degree to which vouchers (a common demand-side financing mechanism) are being utilized. Higher values for this indicator indicate better functioning of the voucher program. |
| Definition of key terms | Vouchers for health care services: A financing mechanism for subsidizing health services and products for target population groups. Vouchers aim to improve access to and utilization of health services. They may also improve the quality of care by providing incentives for providers to compete for beneficiaries. Voucher programs typically target specific population groups such as pregnant women, children, or the poor. |
| Measurement | Number:<br>Number of vouchers redeemed in a given time period<br><br>Percent<br>*Numerator:* Number of vouchers redeemed in a given time period<br><br>*Denominator*: Number of vouchers distributed for use in the same time period |
| Disaggregation | Geographic area; type of provider that redeemed vouchers (e.g. public vs. private); voucher recipient characteristics (e.g. age group) |
| Data sources | Voucher program records |

| Indicator 3.24: Functioning verification system for a demand-side financing program established or strengthened with project support | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Short-term outcome |
| Purpose | This indicator is one measure of the extent to which a demand-side financing program functions properly. A verification system aims to ensure that beneficiaries belong to the target group and that payments to providers (e.g. vouchers claimed) reflect actual receipt of subsidies and utilization of services by the intended program beneficiaries. The presence of a verification system reflects the credibility and reliability of the program. |
| Definition of key terms | Demand-side financing (DSF) programs: Programs designed to improve equity in access and to increase utilization of targeted health care services by directly subsidizing consumers. Some types of DSF may also improve the quality of care by providing incentives for providers to compete for beneficiaries. DSF mechanisms include vouchers, cash transfers, tax rebates, fee waivers, and other targeted subsidies provided directly to consumers.<br><br>Functioning verification system: A system designed to check whether recipient characteristics meet required criteria and to verify the validity of payments claimed by providers serving program beneficiaries. The project must define the criteria for "functioning" in the context of the program. |
| Measurement | Yes/no indicator |
| Disaggregation | none |
| Data sources | DSF program records |

| Indicator 3.25: Percent of health care voucher claims/ payments verified | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Short-term outcome |
| Purpose | This indicator is one measure of the extent to which a vouchers system (a common demand-side financing mechanism) functions properly. Verification by the program ensures that vouchers claimed by providers reflect actual utilization of target services by the intended program beneficiaries. Higher values for this indicator indicate better functioning of the voucher program. |
| Definition of key terms | Vouchers for health care services: A financing mechanism for subsidizing health services and products for target population groups. Vouchers aim to improve access to and utilization of health services. They may also improve the quality of care by providing incentives for providers to compete for beneficiaries. Voucher programs typically target specific population groups such as pregnant women, children, or the poor. |
| Measurement | *Numerator:* Number of vouchers claims/payments verified<br><br>*Denominator*: Number of vouchers claimed/paid to providers |
| Disaggregation | Geographic area; type of provider that redeemed vouchers (e.g. public vs. private) |
| Data sources | Voucher program records |

| Indicator 3.26: Number and percent of target/eligible population covered by a demand-side financing program | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Short-term outcome |
| Purpose | This indicator reflects the extent of coverage of demand-side financing programs. |
| Definition of key terms | Demand-side financing (DSF) programs: Programs designed to improve equity in access and to increase utilization of targeted health care services by directly subsidizing consumers. Some types of DSF may also improve the quality of care by providing incentives for providers to compete for beneficiaries. DSF mechanisms include vouchers, cash transfers, tax rebates, fee waivers, and other targeted subsidies provided directly to consumers.<br><br>Population covered: An individual covered by a DSF program is one that has received a DSF payment (e.g. a cash transfer) or a payment option (e.g. a voucher). |
| Measurement | *Numerator:* Number of individuals covered by a DSF program<br><br>*Denominator*: Total target population |
| Disaggregation | Geographic area; demographic characteristics |
| Data sources | DSF program records (for numerator); country census, program eligibility records, UN population estimates (for denominator) |

| Indicator 3.27: Value of indicator targeted by a demand-side financing program in a given time period | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Demand-side Financing |
| Indicator Type | Long-term outcome |
| Purpose | This indicator applies to each of the outcomes targeted by a demand-side financing program (e.g. immunization coverage, number of deliveries in health facilities). It tracks whether the program is associated with an improvement in target outcomes among intended beneficiaries. Indicators are typically measured quarterly or annually. |
| Definition of key terms | Demand-side financing (DSF) programs: Programs designed to improve equity in access and to increase utilization of targeted health care services by directly subsidizing consumers. Some types of DSF may also improve the quality of care by providing incentives for providers to compete for beneficiaries. DSF mechanisms include vouchers, cash transfers, tax rebates, fee waivers, and other targeted subsidies provided directly to consumers. |
| Measurement | Depending on the type of outcome, this indicator can measure either number of service units (utilization) or percent coverage (e.g. immunization rates) |
| Disaggregation | Geographic area; demographic characteristics of target beneficiaries. |
| Data sources | DSF program records; health management information system records; population-based surveys. |

## Purchasing: Resource allocation

| **Indicator 3.28: Number of technical resources developed with project support to strengthen health resource allocation** | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Resource Allocation |
| Indicator Type | Output |
| Purpose | This indicator tracks the number of technical resources developed with project assistance to strengthen health resource allocation. Examples of technical resources may include a health financing policy, costing study, economic evaluation, resource allocation methodology, or health financing eLearning module. |
| Definition of key terms | Technical resources: Technical resources are defined broadly as tools, models, methodologies, guidance, approaches, and strategies. They may include but are not limited to assessments, manuscripts, published articles, reports, training courses, learning modules, software, strategic plans, operational plans, etc. These resources include direct project outputs that may be tracked by the project's records or monitoring and evaluation system.<br><br>Strengthen: The project must define "strengthen" in terms specific to the given context, but it may include providing technical assistance to identify inequities in health status or in access to health care services, identifying gaps in the prevention or treatment of a targeted or high burden disease, etc.<br><br>Health resource allocation: The distribution of government resources to health care institutions and populations with the intention of improving equity in access to health care and reducing inequities in health status. According to the World Bank, "deprived groups should receive preferential allocation of health care resources to achieve more rapid improvements in their health." [17] |
| Measurement | Count of the number of technical resources |
| Disaggregation | Type of technical resource |
| Data sources | Project records |

[17] Diderichsen, Finn. 2004. Resource allocation for health equity: issues and methods. Washington, DC: The International Bank for Reconstruction and Development / The World Bank. http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Chap8DiderichsenRAforHlthEqtyFinal.pdf

| Indicator 3.29: Expenditure tracking system developed and implemented with project support | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Resource Allocation |
| Indicator Type | Output |
| Purpose | This is a yes/no indicator that reflects the availability of financial information that enables health sector stakeholders to track the source of funds and where they are being dispensed. An expenditure tracking system can also support decisions and oversight in the areas of cost efficiency, decentralization, and accountability. |
| Definition of key terms | Expenditure tracking system: A system that traces the flow of financial resources from origin to destination and could assist in identifying the location and scale of any disbursement/expenditure anomalies. Examples include the World Health Organization's National Health Accounts methodology and the World Bank's Public Expenditure Tracking System.<br>Developed: Projects must define "developed" in terms specific to the given context. |
| Measurement | Yes/No; qualitative description of implementation phases completed |
| Disaggregation | Government level |
| Data sources | Project records |

| Indicator 3.30: Percent of total expenditure on health spent on country priority health services | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Purchasing of Health Services |
| Sub-Category | Resource Allocation |
| Indicator Type | Long term outcome |
| Purpose | This indicator measures the extent to which funds are appropriately targeted to the major sources of disease burden in a country. |
| Definition of key terms | Total expenditure on health: The sum of all outlays for health maintenance, restoration, or enhancement paid for in cash or supplied in-kind.[18]<br><br>Country priority health services: Projects must define "country priority health services" in consultation with the appropriate government authorities. Priority health services may be identified in national health policies or strategic plans. |
| Measurement | *Numerator*: Total expenditure for country priority health services<br>*Denominator*: Total expenditure on health |
| Disaggregation | Government level; type of service (e.g. preventative, curative, rehabilitative); health area (e.g. HIV, FP, MCH) |
| Data sources | National Health Accounts |

[18] World Health Organization. Indicator code book: national health accounts. Geneva: World Health Organization.

## 4. Cross-cutting indicators

| Indicator 4.1: National Health Accounts estimation completed [within a specified period of time] | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Cross-Cutting |
| Sub-Category | National Health Accounts |
| Indicator Type | Short term outcome |
| Purpose | This is a yes/no indicator that reflects whether a National Health Accounts (NHA) estimation has been recently (or on a regular basis) completed in the country. NHA reports provide a snapshot of the distribution of health resources (including their sources and allocation) in a country and underpin evidence-based policies in the area of health financing. |
| Definition of key terms | National health accounts (NHA): A methodology that presents data tables that summarize the flows of health spending through the health system in a country over a specified period of time, typically 12 months. |
| Measurement | Yes/No |
| Disaggregation | Geographic region; disease/health category (e.g. NHA sub-accounts for HIV/AIDS, reproductive health, etc. may be completed) |
| Data sources | Project or government records |

| Indicator 4.2: Level of capacity in country to produce and publish National Health Accounts data | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Cross-Cutting |
| Sub-Category | National Health Accounts |
| Indicator Type | Short term outcome |
| Purpose | This is a scoring indicator that measures the level of country officials' capacity (e.g. at the Ministry of Health or a national institute of statistics) to produce and publish National Health Accounts estimates. |
| Definition of key terms | National health accounts (NHA): A methodology that presents data tables that summarize the flows of health spending through the health system in a country over a specified period of time, typically 12 months. |
| Measurement | This indicator may be measured using the NHA capacity assessment tool which assigns a score between 1 and 5 to the level of capacity, whereby 1- Nonexistence, 2 – Startup, 3- Developing, 4 – Expansion, 5 – Sustainability |
| Disaggregation | none |
| Data sources | Project records |

| Indicator 4.3: National health financing strategy approved and adopted by government | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Cross-Cutting |
| Sub-Category | Policy |
| Indicator Type | Short term outcome |
| Purpose | This is a yes/no indicator that measures whether a health financing strategy has been approved and adopted by the government. The preparation of the strategy may have involved technical assistance from the project. |
| Definition of key terms | National health financing strategy: A document developed at the national level which lays out the vision, goals, and objectives for health financing in the country, or for a component of health financing (such as revenue generation, risk pooling, resource allocation, purchasing of health services, financial management, resource allocation, etc.).<br><br>Approved: The project should define "approved" according to the given context, but generally approved means the appropriate government authorities have signed off on the document.<br><br>Adopted: The project should define "adopted" according to the given context. Generally, adopted will mean a decision by the authorities (e.g. national government) to implement the strategy, followed by administration of the strategy. |
| Measurement | Yes/No; qualitative description of the project's definition of approval and adopted and the progress of the strategy in meeting those definitions. |
| Disaggregation | N.A. |
| Data sources | Project records |

| Indicator 4.4: Number of [target audience] trained, with project support, in health financing [topics/skills] | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Cross-Cutting |
| Sub-Category | Training |
| Indicator Type | Output |
| Purpose | This indicator measures the number of people trained, with project assistance, in a given area of health financing. Examples of topics and skills include costing, national health accounts, and risk pooling mechanisms. |
| Definition of key terms | Health financing topics/skills: Any topics or skills related to the basic functions of health financing – collecting revenues, pooling resources, and purchasing services (such as revenue generation, risk pooling, resource allocation, purchasing of health services, financial management, resource allocation, etc.). |
| Measurement | Number of individuals from target audience (e.g. health workers, Ministry of Health officials) trained |
| Disaggregation | Topic/skill area, type of trainee |
| Data sources | Project records |

| Indicator 4.5: Percent of [target audience] who received project-supported training in health financing [topics/skills] who say they are using their new knowledge/skills on the job [X] months after training | |
|---|---|
| Building Block(s) | Health Financing |
| Category | Cross-Cutting |
| Sub-Category | Training |
| Indicator Type | Short term outcome |
| Purpose | This indicator measures the extent to which training content is being utilized. The indicator applies to training provided with project assistance. |
| Definition of key terms | Health financing topics/skills: Any topics or skills related to the basic functions of health financing – collecting revenues, pooling resources, and purchasing services (such as revenue generation, risk pooling, resource allocation, purchasing of health services, financial management, resource allocation, etc.). |
| Measurement | *Numerator:* Total number of individuals trained who say they are using their new knowledge/skills on the job [X] months after training<br>*Denominator:* Total number of individuals trained |
| Disaggregation | Topic/skill area; type of trainee |
| Data sources | Post-training follow-up interviews or surveys |