Islamic Republic of Afghanistan

Ministry of Public Health

Health Financing Policy

2012 – 2020

Acknowledgement

Afghanistan's health care system is undergoing significant transitions, from restructuring to development, from a focus on broadening coverage to deepening benefits, and from donor dependence to self-sufficiency. A critical path forward is the design policy, one that is based on evidence and reflects the realities of the country's social, political and economic dynamics that aim to improve effectiveness and efficiencies in health spending. The Ministry of Public Health is working towards the goal of "universal coverage" through establishing an equitable and sustainable financing platform to support delivery of essential health services.

To this end, I would like to acknowledge the contribution of the following people in the process of developing this policy: Dr. Husnia Sadat, MoPH, Dr. S. M. Karim Alawi, MoPH, Dr Noor Arzoie, MoPH, Dr. Hernan L. Fuenzalida-Puelma, HS 20/20 (USAID), Dr. Najibullah Safi, WHO, Dr. Tekabe Belay, The World Bank, and Dr. Sefatullah Habib, EU. Special thanks to Dr. Ahmad Shah Salehi for designing and developing the Health Financing Policy 2012-2020 and Dr Ahmad Jan Naeem for his overall guidance.

While this is a critical step forward, the realization of this policy requires active stakeholder engagement, capacity strengthening at the national and sub-national levels, and careful evaluation. I look forward to working with our partners in furthering the government's commitment to the health of the people.

Sincerely,

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Minister of Public Health, Afghanistan

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1. Introduction

1.1 Brief Country Profile

The Islamic Republic of Afghanistan is a landlocked country with a population of 24.485.600[1]. The natural barriers limit access to health care services, especially for women and children. Overall, Afghanistan faces a high and increasing demand for education, health services, basic infrastructure and jobs. Literacy rate is estimated 12% for females and 39 % for male with high discrepancy between rural and urban areas. In addition, almost nine million Afghans are unable to meet their basic needs (36% of population)[2]. The performance of Afghanistan's economy between 2002-2008 improved and real GDP growth averaged 15% a year and inflation was brought down to single-digit levels in 2007. Revenue collection also improved significantly rising from 4.7 % of GDP in 2002 to 7% in 2008.

1.2 Health Status Data

The health care system was functioning poorly until late 2001. However, Afghanistan has had significant improvement in health of population in the past 10 years. According to Afghanistan Mortality Survey 2010, the following table highlights the health status data:

Total Fertility Rate (TFR)	5.1
Use of some method of family planning	22%
Antenatal care (ANC)	68%
Institutional Delivery	42%
Under 5 Mortality Rate (Excluding the South Zone)	97 per 1000 live births
Infant Mortality Rate (Excluding the South Zone)	77 per 1000 live births
Maternal Mortality Ratio	327 per 100,000 live births
Male Life Expectancy	62 years
Female Life Expectancy	64 years

1 Central Statistic Office, 2010-2011
2 NRVA 2007/08

1.3 Sources of Funding

Donor support to health comes from two directions: (i) On budget support (core budget), which is channeled through the Ministry of Finance (MoF) and then allocated to the health sector. (ii) Off-budget support that is directly transferred to the service providers or Ministry of Public Health (MoPH). Core budget consists of operating budget and developing budget. Developing budget is fully supported by donors while operating budget is supported by the government.

According to the NHA report 2008-2009, since 2008 total health expenditure (THE) in Afghanistan was just over USD 1.0 billion (USD 42 per capita). Private expenditures on health constitute around 76 % of total health expenditures, of which household out of pocket (OOP) is approximately 99.7 %. Donor contributions represent 75 percent of total public expenditures on health, suggesting that health care priorities are largely donor driven. The World Bank channeled its support for the BPHS, EPHS, and technical assistance through the development budget. USAID also channeled its support for the BPHS and EPHS through the development budget while other assistances are externally funded. Government contributions are mainly channeled through the other component of the core budget, the operating budget. The operating budget consists mainly of staff wages, salaries, and other recurrent expenditures (including the purchase of medical goods for public hospitals) and is financed almost entirely by government of Afghanistan. Households provide the largest source of funds for health care in Afghanistan, approximately 75 percent of THE.

1.4 Health Care Financing Instruments

There are five basic health care financing instruments: government funding, social health insurance, community-based health insurance, private health insurance and private out of pocket. In Afghanistan, the current situation is as following:

- **National Health Service:** Afghanistan has a well-developed national health service managed by the MoPH and financed by donors and the Government. It delivers health care goods and services based on the two packages, basic package of health services (BPHS) and essential package of hospital services (EPHS).

- **Social Health Insurance:** Currently, there is no operational social health insurance. There was a previous experience with social health insurance for civil servants and the formal sector during 1960s and 1970s.

- **Community-based health insurance:** There is no community-based health insurance currently implemented in Afghanistan.

- **Private health insurance:** The role of private health insurance in Afghanistan is limited. A few insurance companies are newly established but there has not been any activity on health insurance products.

2. The Need for a Health Care Financing Policy

A number of bi-lateral discussions have been underway for the past few years to identify major issues related to health financing in Afghanistan and to determine possible and viable options for addressing them. The major areas identified include:

- ***High level of out of pocket (OOP) expenditure:*** Large body of evidence is emerging that shows large OOP. Recent estimates suggest the OOP comprise over three quarters of the total health expenditure3. The fact that over one-third of the country's population lives below the level of poverty line serves to further exacerbate the situation. It is critical to better understand the drivers behind such substantial OOP and streamline it and mitigate its negative consequences.

- ***Low absorption capacity:*** Although the Ministry of Public Health's budget execution rate is among the highest within the government of Afghanistan, the rate of budget execution remains low (around 60%). Improving absorption capacity is thus one critical challenge the sector is facing. While the execution capacity improved, there will be a demand for more resources and quality health services. In addition, after a decade of rapid expansion of basic package of health care service throughout the country, the focus seems to move towards reaching those who are difficult to access and improve quality. To meet the growing demand

[3] NHA report 2008-2009

for health care services, there is a growing pressure to mobilize more resources for expansion of these services.

- ***The "free" health care:*** The "free" provision of health services and facilities to all citizens of Afghanistan indicated in the Constitution was clarified and specified in the health law. In the Health Law, the MoPH shall provide free preventive and curative services for highly endemic diseases, natural treatment and first-aid services to citizens of the country. The provision of secondary curative services is in the financial purview of government and shall be provided against specified fees according to the legislative documents.

- ***Fragility of quality of health services:*** Based on Afghanistan health sector balanced scorecard 2009/2010, though the overall national performance has shown a steady improvement compared to 2008, the major declines have been encountered on scores of shura-e-sehie activities, salary payments, facilities having TB register, patient history and physical exams, time spent with patient, HMIS index and patient counseling index. Slight decline was seen on the number of indices compared to 2008 such as equipment functionality index, lab functionality index, average new patient visit per month, BPHS facilities providing ANC, clinical guideline index, proper sharps disposal, delivery care according to BPHS, family planning availability index, and patient record index.

- **Donor dependency:** Although the government allocation to health from internal resources (government revenue) from 2002 to 2011 proportionally has decreased (from 8% in 2002 to 4.6% in 2011), in terms of real value it shows a yearly increase (from 11 million USD in 2002 to 56 million USD in 2011). Similarly the donor supports on health sector from 2002 onwards shows a significant increase, for instance; from 2002 to 2011 the donor supports on health increased from 50 million USD to 166 million USD4. It is imperative for the Government and for the MoPH to further develop and implement a health financing strategy to attain financial self-sustainability for the health sector.

[4] Budget Decree of Government of Afghanistan (2002-2011)

3. Health Care Financing Policy Components

3.1 Vision

Health for all Afghans

3.2 Mission Statement

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

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

3.3 Goal

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

3.4 Policy Priorities

The following key policy options will be considered during 2012 – 2020:

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

- Enhancing aid effectiveness and re-aligning of existing resources to ensure that allocations match health priorities and objectives

3.5 Institutional approach

3.5.1 Defining the Benefit Package

This will involve defining the package that are to be provided free of charge through the government funding to the consumer and those that are to be covered under the contributory insurance system. This will result in a package of services to be universally available to all of the population - Universal Package of Health Services (UPHS). Other health care goods and services will be covered under the contributory system. In order to ensure that poor have access to the service covered under the contributory system, an “Equity Fund” will be established to provide subsidies to the poor and vulnerable population without economic activity and stable incomes.

3.5.2 Capacity Building

Building institutional and managerial capacity within the MoPH in planning, financing and delivery of health care, contracting, and monitoring and outputs evaluation are crucial. The MoPH will start with current staff and think on the potential human resources needed for running an effective national health fund by developing a capacity-building plan. At the same time, there are information gap to fully understand the expected outcome of all the options and this gap will be filled as the work progress. One area that needs immediate work is the understanding of the drivers of OOP both in urban and rural areas of Afghanistan to enable design a targeted benefit package.

3.5.3 Developing a New Governance Structure

The MoPH will facilitate to establish a “National Health Fund” (NHF). The NHF will be an autonomous legal entity with its own structure, mandate, functions and attributions. The Fund will pool all financial resources, government, donors, and others and will purchase services from public and private providers and suppliers. It will eventually manage the social health insurance.

Annex 1. Data from Afghanistan National Health Account (NHA)

	2008-2009 (US$)
Total real GDP	$10,843,340,000.00
Per capita income	$426.00
Total government health expenditure	$63,892,239.00
Total health expenditure (THE)	$1,043,820,810.00
THE per capita	$42.00
THE as % of real GDP	10%
Government health expenditure as % total government expenditure	4%
Financing Source as a % of THE	
Central government	6%
Private	76%
Rest of the World	18%
Household (HH) Spending	
Total HH (OOP) spending as % of THE	75%
Total HH (OOP) spending per capita	$31.00
Financing Agent Distribution as a % of THE	
Central government	11%
Household	75%
Non-governmental organizations	5%
Rest of the World	8%
Provider Distribution as a % of THE	
Hospitals	29%
Outpatient care centers	32%
Retail sale and other providers of medical goods	28%
Other	11%
Function Distribution as a % of THE	
Curative care	59%
Pharmaceuticals	28%
Prevention and public health programs	5%
Health administration	5%
Capital formation	2%
Others	1%