Health Financing Progress Matrix assessment

Jordan 2024

Summary of findings and recommendations

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Acronyms and abbreviations

CHE	catastrophic health expenditure
CI	confidence interval
CPI	consumer price index
HIA	Health Insurance Administration
GDP	gross domestic product
OOP	out-of-pocket payment
LMIC	lower middle-income country
MIF	Military Insurance Fund
NCHFS	National Committee to develop the Health Finance Strategy
NHA	National Health Accounts
PPP	purchasing power parity
RC	Royal Court
RMS	Royal Medical Services
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
UHC	universal health coverage
VHI	Voluntary Health Insurance
WHO	World Health Organization

About the Health Financing Progress Matrix

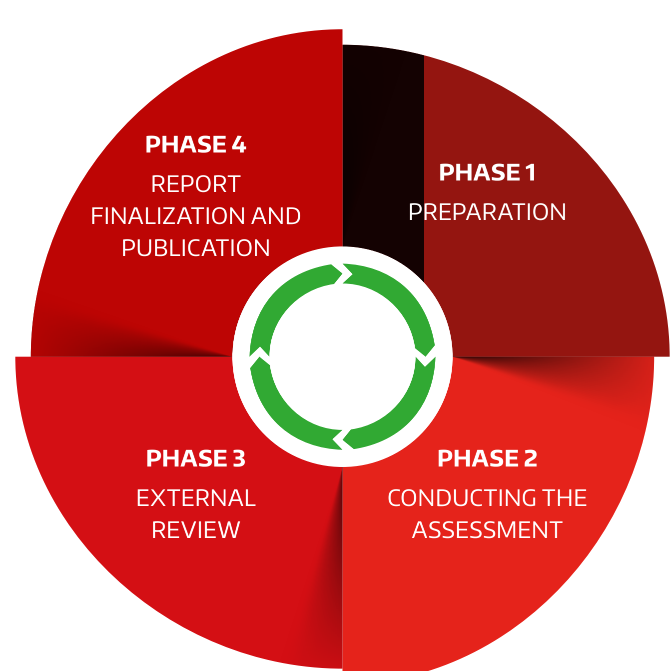
The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's health financing system. The assessment builds on an extensive body of conceptual and empirical work and summarizes "what matters in health financing for universal health coverage (UHC)" into 19 desirable attributes, which form the basis of this assessment.

The report identifies areas of strength and weakness in Jordan's current health financing system, in relation to the desirable attributes, and based on this recommends shifts in health financing policy directions, specific to the context of Jordan, which can help to accelerate progress to UHC.

The qualitative nature of the analysis, with supporting quantitative metrics, allows close-to-real time performance information to be provided to policy-makers. In addition, the structured nature of the HFPM lends itself to the systematic monitoring of progress in the development and implementation of health financing policies.

HFPM country assessments are implemented in four phases as outlined in Fig. 1. In addition to providing information to feed into development and review of health financing strategies, the monitoring of policy development and implementation progress over time, HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Fig. 1: Four phases of HFPM implementation



Phase 2 of the HFPM consists of two stages of analysis:

- Stage 1: a mapping of the health financing landscape consisting of a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.

- Stage 2: a detailed assessment based on 33 questions of health financing policy. Each question builds on one or more desirable attribute of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Countries are using the HFPM findings and recommendations to feed into policy processes, including the development of new health financing strategies, the review of existing strategies, and for routine monitoring of policy development and implementation over time. HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Further details about the HFPM are available online: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix.

About this report

This report provides a concise summary of the Health Financing Progress Matrix (HFPM) assessment in Jordan, identifying strengths and weaknesses in the health financing system, and priority areas of health financing which need to be addressed to drive progress towards universal health coverage (UHC). Findings are presented in several different summary tables, based on the seven assessment areas, and the 19 desirable attributes of health financing.

By focusing both on the current situation, as well as priority directions for future reforms, this report provides an agenda for priority analytical work and related technical support. The latest information on Jordan's performance in terms of UHC and key health expenditure indicators, are also presented. Detailed responses to individual questions are available on the WHO HFPM database of country assessments, or upon request.

This assessment is a living document and is circulated for further feedback and comments; it can also form the basis of annual updates for monitoring purposes.

Methodology and timeline

The National Committee to develop the Health Finance Strategy (NCHFS) was formed by his Excellency the Minister of Health and headed by the Secretary General of the Ministry of Health. The Committee includes representatives from the following organizations: Ministry of Health, Health Insurance Administration, Ministry of Planning and International Cooperation, Department of General Budget/Ministry of Finance, National Centre for Disease Control, Royal Medical Services, Social Security Corporation, National Aid Fund, Central Bank of Jordan and King Hussein Cancer Foundation.

The development of the HFPM is undertaken as part of the situational analysis conducted by the NCHFS. The WHO consultant deployed at the Ministry of Health works and supports the Ministry of Health closely. The data collection phase started in April 2023 and the assessment was conducted over a 4-month period with further updates and reviews conducted through 2024.

For stage 1 of the assessment, the schemes to be included were decided on by the Committee. Data were collected through secondary resources and face-to-face meetings with the relevant stakeholders including all the organizations represented in the NCHFS. The rationale for choosing the schemes to be included is described below.

For stage 2 of the assessment, the answers to the qualitative questions were completed in three rounds. First the WHO consultant (Yousef Zawaneh) answered the questions, in the second round the ratings were presented and discussed by the NCHFS, and finally the Ministry of Health (Anas Al-Mohtaseb) revised and finetuned the final answers. A final round was conducted by external peer reviewers, and the team convened and reached consensus on the ratings.

Rationale for deciding on the schemes included in the exercise:

1. The Health Insurance Administration (HIA) and the Ministry of Health are inseparable from a HFPM perspective and are assessed as a single scheme.

2. The Military Insurance Fund (MIF) is the military scheme run by the Royal Medical Services (RMS), and similar to HIA and Ministry of Health is being assessed as a single scheme.

3. All private health insurance companies (offering their services to employers) and independent health insurance funds (e.g. major employers who run their own schemes and other smaller voluntary schemes held by independent professional associations) are included under Voluntary Health Insurance (VHI) for simplification. They share several characteristics most importantly relying on risk-based premiums.

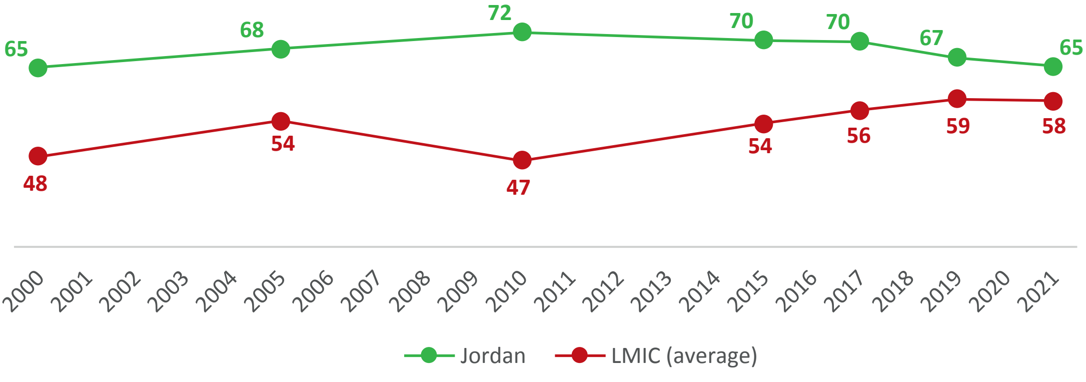
4. Exemptions provided by the Royal Hashemite Court, the Prime Minister's office, the parliament and other similar schemes offered for free are presented under a single scheme as they are similar in terms of target population, share a single financial pool and a similar process of access.

Only major schemes were included in the stage 1 assessment, while smaller health insurance schemes like donors, refugees and universities were not included.

Universal health coverage (UHC) performance in Jordan

SDG indicator 3.8.1 relates to the coverage of essential health services. It is a service coverage index (SCI) with a score between 0 and 100 defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, and services for noncommunicable diseases, as well as indicators of service capacity and access. A low score means high unmet need. In Jordan, the service coverage index has been on a downward trend since 2010 reaching 65 by 2021 (Fig. 2), however, the country is still well above the average for lower middle-income countries, which stands at 58.

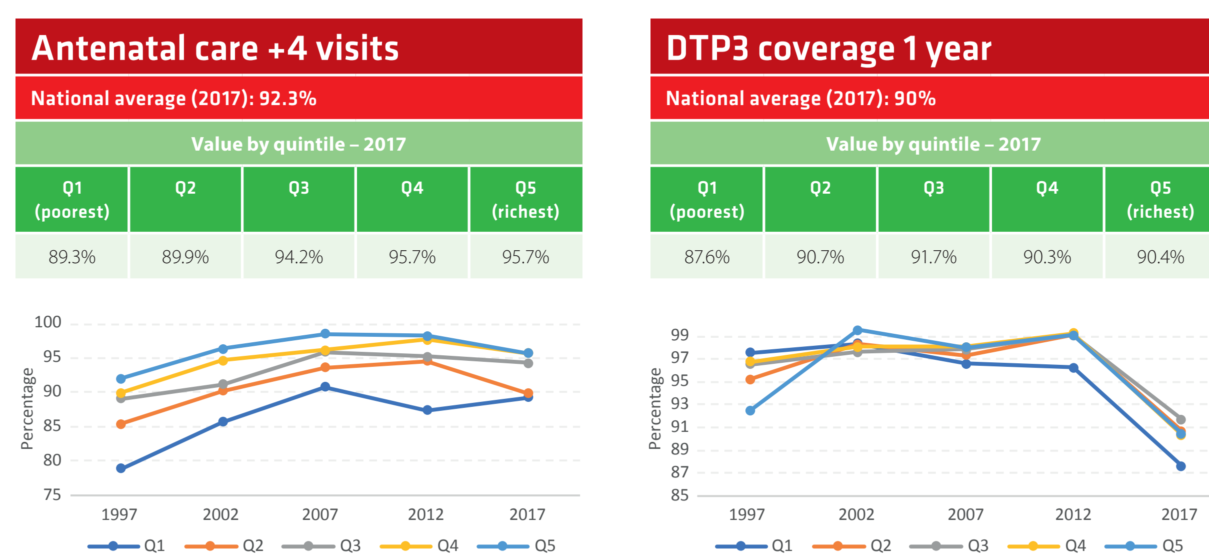
Fig. 2: Service coverage index trend in Jordan 2000–2021



Source: Global Health Observatory 2023 (https://www.who.int/data/gho/data/themes/topics/service-coverage)

For some service components of the index, it is possible to obtain disaggregated information, as shown in Fig. 3, to identify inequalities in access, which have decreased over time.

Fig. 3: Antenatal care and DPT3 coverage by quintile in 2017



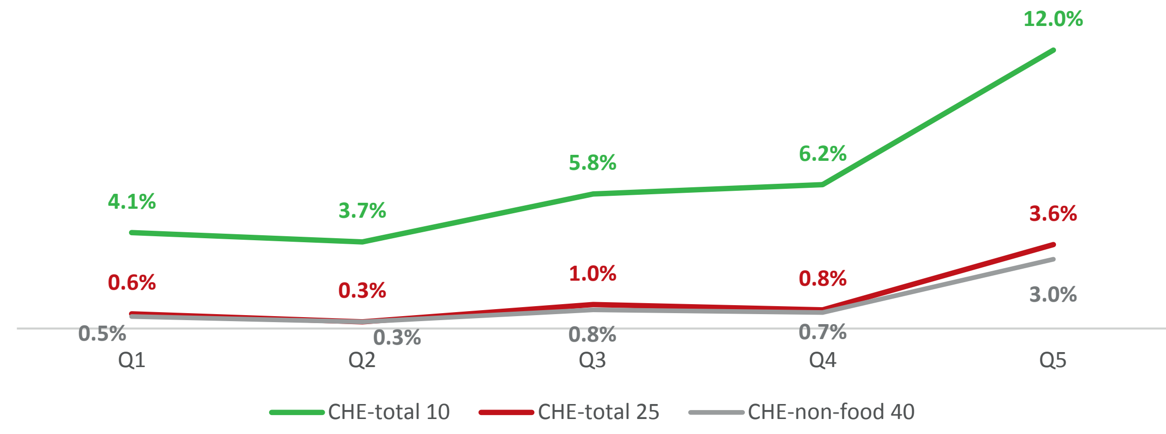
Antenatal care +4 visits				
National average (2017): 92.3%				
Value by quintile – 2017				
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
89.3%	89.9%	94.2%	95.7%	95.7%

DTP3 coverage 1 year				
National average (2017): 90%				
Value by quintile – 2017				
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
87.6%	90.7%	91.7%	90.3%	90.4%

Source: https://apps.who.int/gho/data/node.imr

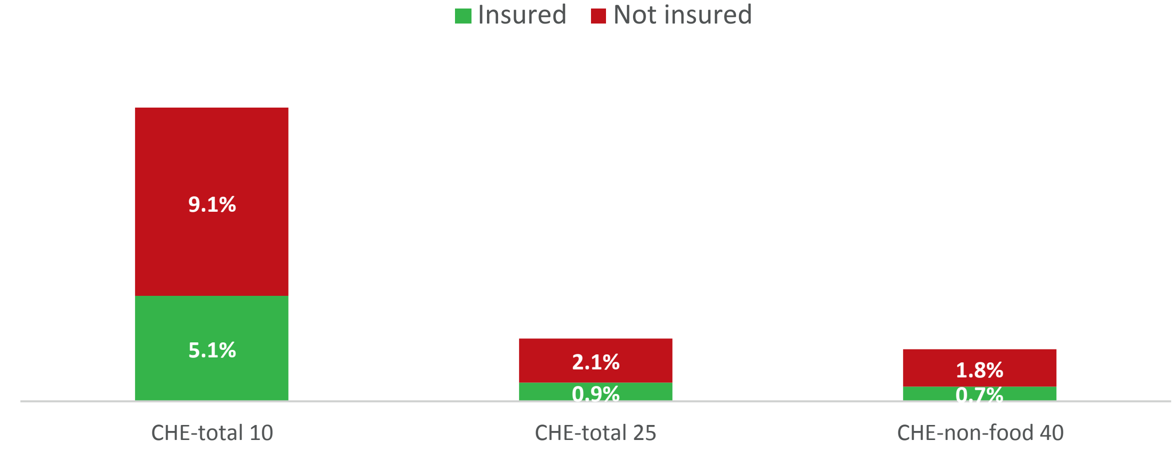
SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending defined as the "proportion of the population with large household expenditure on health as a share of total household expenditure or income". It is calculated using two thresholds: household expenditure on health greater than 10% of household budget or greater than 25% of the household budget. Fig. 4 shows how catastrophic spending tends to be higher among the richest quintile of the population. Fig. 5 compares the incidence of catastrophic spending using the 10% threshold according to insurance status.

Fig. 4: Trend in catastrophic health spending in Jordan



Source: Financial risk protection indicators, 2017–2018

Fig. 5: Percentage of the population pushed below the US$ 1.90 poverty line by household health expenditures, 2017–2018



Source: Financial risk protection indicators, 2017–2018

Summary of findings and recommendations by assessment area

Using the guidelines to the HFPM, the key recommendations that are important for Jordan to make further progress towards UHC are summarized below. All recommendations are backed by evidence on what other countries needed to do to progress towards UHC.

For all the below sections, the recommendations are generated from the extensive evidence review that WHO undertook and documented in the guidebook of the HFPM. The recommendations are adapted to the Jordan context. WHO has summarized what works and has worked in other countries with regards to health financing reform in the various areas in order to make progress towards UHC. The way the below recommendations should be read therefore are "based on evidence from other countries, if we implement this, we will make progress towards UHC".

Summary of findings and recommendations

Assessment area	Summary findings	Status
Policy process and governance	Fragmentation of the health system is a key challenge hindering the sharing of information and producing sound financial policies. Oversight and monitoring in the private sector is limited, while the overlap of roles between providers (Ministry of Health and RMS) and payers (HIA and MIF) hinder effective financing. A single entity, for example the Ministry of Health, should take over the role of governing, monitoring and planning of health financing with authority over public and private sector. A clear separation of payer and provider should be implemented at Ministry of Health/HIA.	Emerging ●○○○
Revenue raising	Revenue raising is mostly regressive, with high reliance on out-of-pocket (OOP) expenditure and VHI. Revenue raising through social health insurance (SHI) is limited. Major changes are required to raise revenue fairly from SHI by expanding the health insurance pool and the deducted contribution. Expanding the pool of insured population through SHI is expected to result in decreasing the share of revenues collected through OOP and VHI.	Progressing ●●○○
Pooling revenues	Fragmentation of the schemes have limited the capacity of pooling funds, and high OOP expenditure further exacerbates the difficulty of pooling funds. The population coverage of the Ministry of Health/HIA scheme should be expanded gradually by including groups of the population currently benefiting from the exemptions and VHI to ensure higher pooling.	Emerging ●○○○
Purchasing health services	Strategic purchasing of health services is rarely applied. The public sector schemes rely on line-item budgets to fund health services provided by Ministry of Health and RMS, and only applies purchasing mechanisms when the service is offered by providers other than their own institutions. VHI purchases health services from privately owned providers. In both private and public sector, when purchasing occurs it is done using fee-for-service mechanisms. The gradual introduction of payment mechanisms like global budgets, output-based budgeting, capitation and diagnosis related groups instead of fee-for-service and line-item budgets would provide more effective purchasing mechanisms. Health technology assessment processes need to be strengthened at Ministry of Health and RMS to guide the purchasing of medicines and medical supplies.	Emerging ●○○○

Summary of findings and recommendations

Assessment area	Summary findings	Status
Benefits and entitlements	Without an explicit benefit package within the public sector and a cost-driven package in VHI, there is limited ability to standardize the services offered to the Jordanian population and improve population health. However, certain positives include the limited use of user charges in public sector. The development of an explicit and costed essential benefit package is crucial. Mapping of services that could be included in the package have been developed by a multisectoral committee led by the Ministry of Health, in collaboration with WHO, and it is to be implemented on a national level.	Progressing ●●○○
Public financial management	The Government has a well-established financial management process; however, these processes are less effective in the health sector because of centralization (no autonomy of facilities) and limited strategic purchasing (payment occurs through budget line items). The programmes defined in the Ministry of Health and RMS budgets do not reflect best practice in that the programmes for tertiary care and primary care do not include expenditure on vaccines, medicines and other supplies. Furthermore, the current budget structure does not reflect arrears from previous years. These factors lead to over-budget spending, the accumulation of arrears, and the misalignment of spending with health sector priorities. A greater degree of autonomy should be granted to providers in the public sector with suitable means to ensure expenditures remain within budget, and that services are provided according to the needs of the population. Medical supplies and medicines should be included within the budget of the programmes, rather than as a separate programme of their own.	Progressing ●●○○
Public health functions and programmes	There are limited vertical programmes with a reasonable degree of integration. In terms of emergency preparedness there is a lack of health specific contingency funds. Furthermore, fragmentation across the health sector and lack of provider autonomy all hinder effective preparedness. It is necessary to strengthen functional integration between the different public health programmes, and to establish a health specific contingency fund to be used in cases of public health emergencies.	Emerging ●○○○

Stage 1 assessment

The health coverage schemes included in Stage 1 were selected according to the criteria outlined in the HFPM Country Assessment Guide. The aim is not to conduct an inventory, but rather to describe the main health schemes and programmes which make up the health system, around which policies are made, and through which money flows for the delivery of health services.

Stage 1. Health coverage schemes in Jordan: health financing arrangement

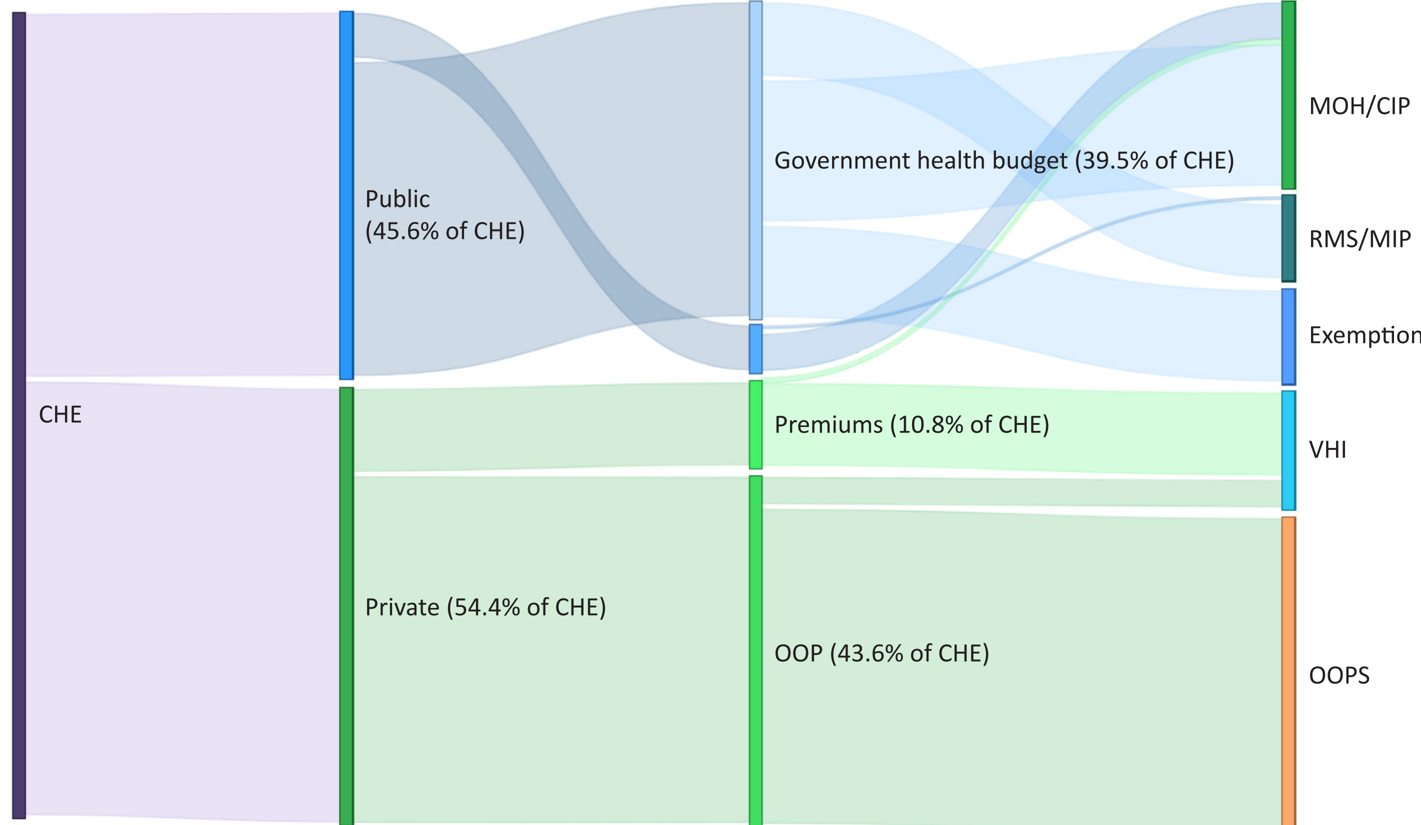
Key design feature	National Insurance Administration	Military Insurance Fund	Voluntary Health Insurance (VHI)	Exemptions from Royal Hashemite Court (RHC), Prime Minister and Parliament
A) Focus of the scheme	• Civil servants and their dependents • People above 60 years • Children under six • National Aid Fund beneficiaries • Blood, organs and kidney donors, and the beneficiary thereof • Poor families • Petra region • Pregnant women • Disabilities Act • Al Ghuwaiba Village	Military and security staff and their dependents	Certain organizations in the private sector offer VHI to their employees	Jordanians without health insurance, or Jordanians with a disease not covered by their health insurance
B) Target population	3 449 592 (source: HIA, 2023)	2 153 301 (source: MIF 2023)	837 000 (source: Annual report on medical insurance, Central Bank of Jordan, 2021)	7 934 969 (all Jordanians)
C) Population covered	3 449 592 (source: HIA, 2023)	2 153 301 (source: MIF 2023)	837 000 (source: Annual report on medical insurance, Central Bank of Jordan, 2021)	Unknown
D) Basis for entitlement/ coverage	Mandatory for all civil servants and direct dependents. Voluntary scheme for non-direct dependents of civil servants (parents, if not covered by other HI, brothers and sisters, if not covered by other HI) and any Jordanian without health insurance for a specific contribution based on age.	Mandatory for all military staff and direct dependents. Voluntary for dependents of military staff (brothers and sisters, widowed or divorced daughters).	Voluntary and offered to employees of certain private sector companies	Any Jordanian without health insurance and in need of treatment
E) Benefit entitlements	• Primary care (preventive and curative) • Outpatient care (curative) • Hospitalizations • Emergency room services • Maternity and newborn care • Mental health (moral support) and substance use disorders, including behavioural health • Prescription medicines • Rehabilitative services and devices • Laboratory services • Preventive and wellness services, and chronic disease management • Paediatric services, including vision and dental • In case of medicines a rational medicine list is used (positive list) • Certain treatments are excluded or limited like IVF	• Primary care (preventive and curative) • Outpatient care (curative) • Hospitalizations • Emergency room services • Maternity and newborn care • Mental health (moral support) and substance use disorders, including behavioural health • Prescription medicines • Rehabilitative services and devices • Laboratory services • Preventive and wellness services, and chronic disease management • Paediatric services, including vision and dental • In case of medicines a rational medicine list is used (positive list) • Certain treatments are excluded or limited like IVF	Varies considerably between different schemes and employers, but in general there is a negative list for medicines and procedures, a cost cap, restrictions on number of outpatient visits, and exclusion of previous diseases	Not clear

Key design feature	National Insurance Administration	Military Insurance Fund	Voluntary Health Insurance (VHI)	Exemptions from Royal Hashemite Court (RHC), Prime Minister and Parliament
F) Co-payments (user fees)	Prescription co-payment (5% of the drug tender price with a minimum of 0.25 Jordanian dinars (JD) and not exceeding 10 JDs) – certain groups are exempted: emergency use in private sector providers co-payment (20%); use of services at private sector providers for first class HIA members (20%)	Prescription co-payment (fixed amount)	Co-payment at point of service (varies between schemes)	No user fees
G) Other conditions of access	Within Ministry of Health facilities: nearest centre, referral system in place but not fully implemented. Non-Ministry of Health facilities: referral should be justified (availability of beds or specific diagnostic or treatment procedures) – first degree members are an exception to this condition	Within RMS facilities: nearest centre, referral system in place but not fully implemented. Non-RMS facilities: referral should be justified (availability of beds or specific diagnostic or treatment procedures) – first degree members are an exception to this condition	No conditions, members can access treatment from a selected list of providers	Patients should first provide evidence of diagnosis
H) Revenue sources	General budget (Ministry of Finance) Mandatory SHI contributions co-payments Out-of-pocket patients treated at Ministry of Health facilities	General budget (Ministry of Finance) Mandatory SHI contributions co-payments Out-of-pocket patients treated at RMS facilities	Contributions from both employer and employee (co-payments)	From the general budget
I) Pooling	Single national pool	Single national pool	Multiple pools	Single national pool
J) Governance of health financing	Governed by Ministry of Health centrally with minor role for governorate directorates	Governed centrally by RMS	Limited governance and oversight, mostly through central bank	Governed by the RHC and the Government
K) Provider payment	Ministry of Health Providers: line-item budget Non-Ministry of Health providers: fee for service or per diem applied according to special agreements	RMS Providers: line-item budget non-RMS providers: fee for service applied according to special agreements	Fee for service	Special agreements with providers, usually a lump sum per an agreed number of patients
L) Service delivery and contracting	Ministry of Health facilities, other public and private facilities in case of referrals Emergency, primary care, outpatient and inpatient	RMS facilities, other public and private facilities in case of referrals Emergency, primary care, outpatient and inpatient	Network of preferred private providers Emergency, outpatient and inpatient services	Primary care, outpatient and inpatient services

Health expenditure by Stage 1 coverage schemes

Fig. 6 representing expenditure flow is based on data from the National Health Accounts report 2019. The small health insurance schemes like the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), other international organizations and private universities were excluded from this assessment, accordingly percentages presented may differ from the National Health Accounts.

Fig. 6: Expenditure flows by scheme



Source: Author estimates based on the HF x FS breakdown available using National Health Accounts 2015, supplemented by the most recent expenditure estimates for the schemes/programmes identified in Stage 1.

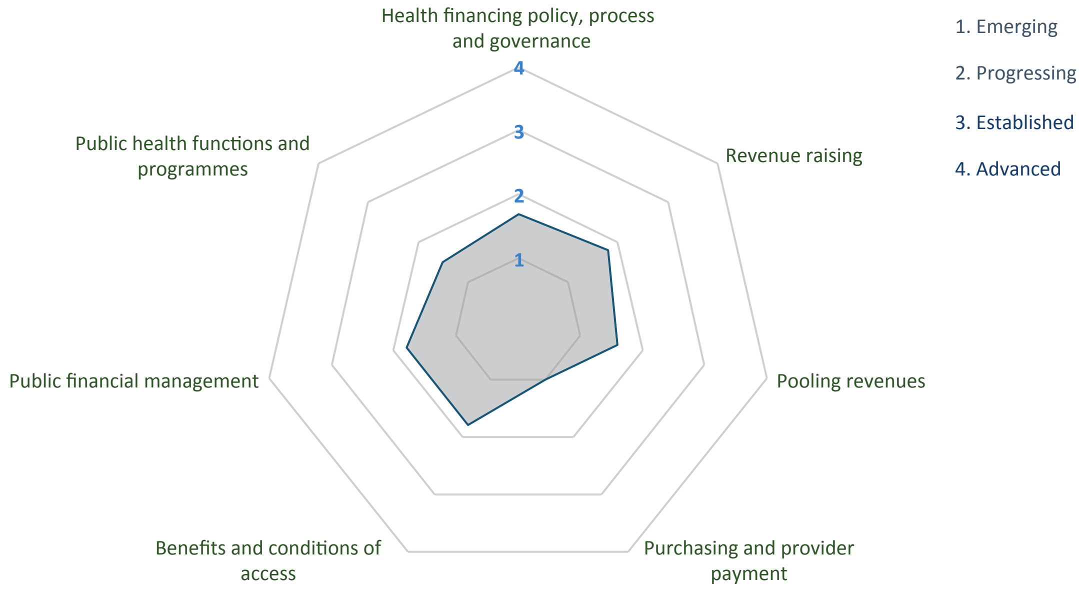
Note: CHE: current health expenditure.

Stage 2 assessment

Stage 2 takes a close look at health financing policies in the country, based on 33 questions organized into seven assessment areas. For each question a rating between 1 and 4 is indicated, using the information provided in the HFPM Country Assessment Guide, and based on extensive discussion and validation; ratings provide signals regarding the current situation in Jordan on each specific area of health financing policy, relative to global best practice.

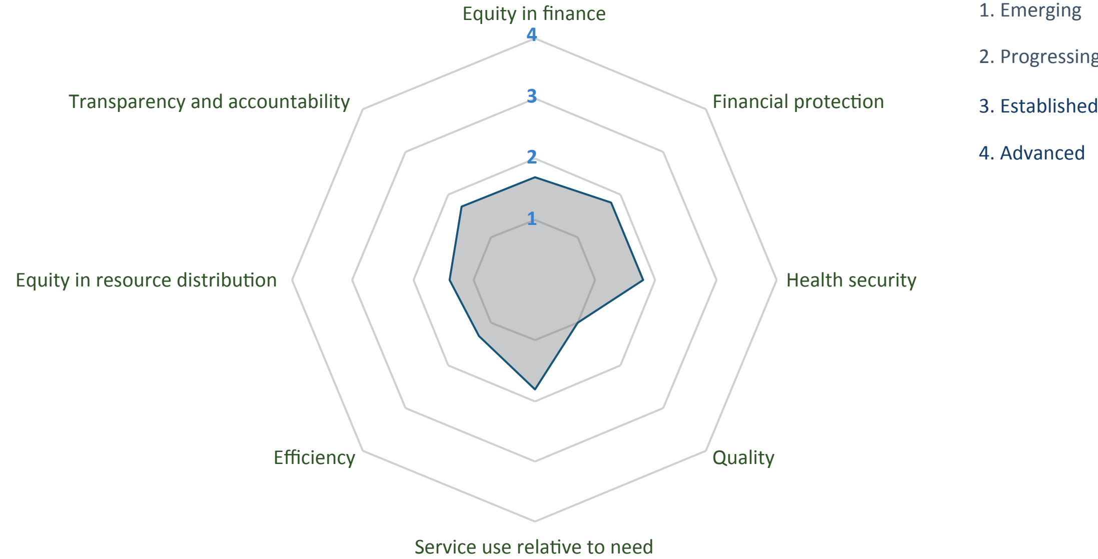
Summary of ratings by assessment area

Fig. 7: Average rating by assessment area



Source: Based on HFPM data collection template v2.0, Jordan 2023

Fig. 8: Average rating by goals and objectives

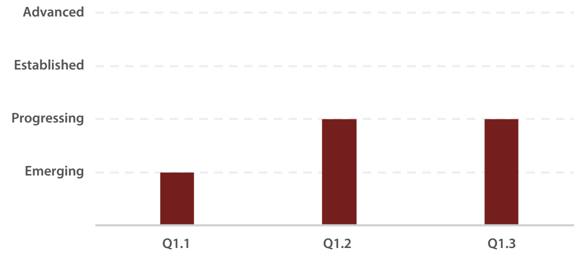


Source: Based on HFPM data collection template v2.0, Jordan 2023

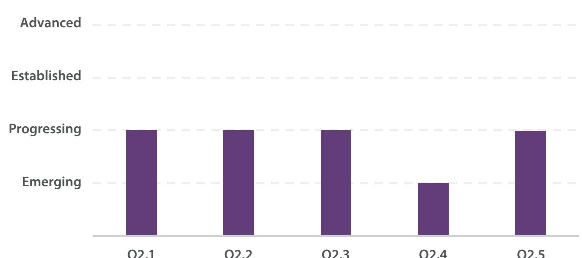
Assessment rating by individual question

Fig. 9: Assessment rating by intermediate objective and final coverage goals

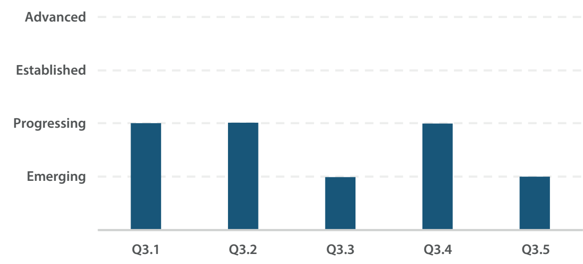
1. Health financing policy, process and governance



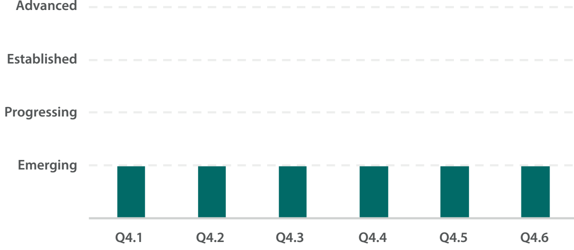
2. Revenue raising



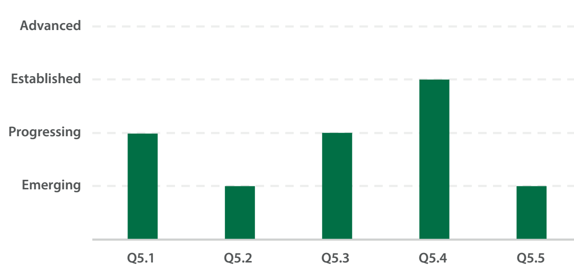
3. Pooling revenues



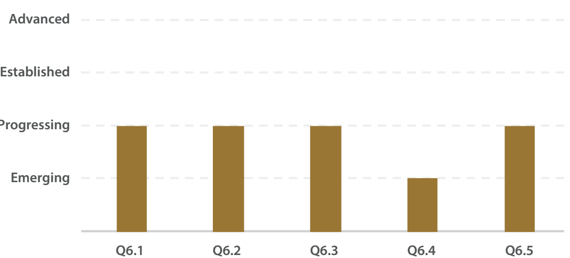
4. Purchasing and provider payment



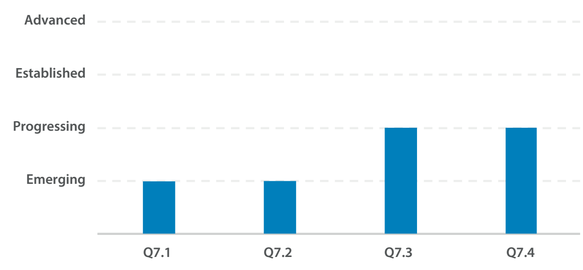
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes

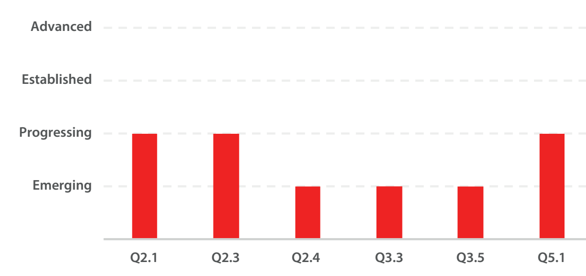


See Annex 2 for question details.

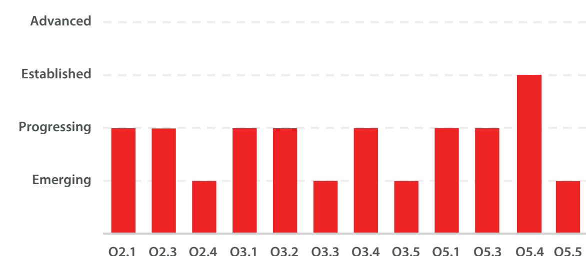
Assessment rating by UHC goals

Fig. 10: Assessment rating by intermediate objective and final coverage goals

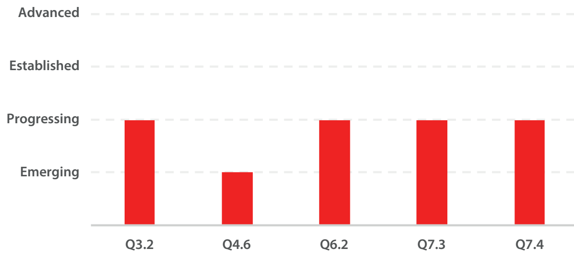
Equity in finance



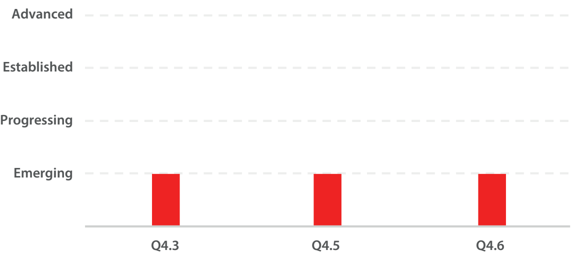
Financial protection



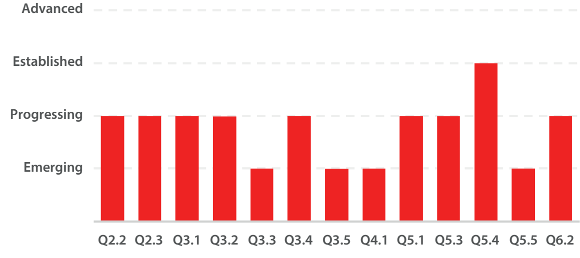
Health security



Quality



Service use relative to need

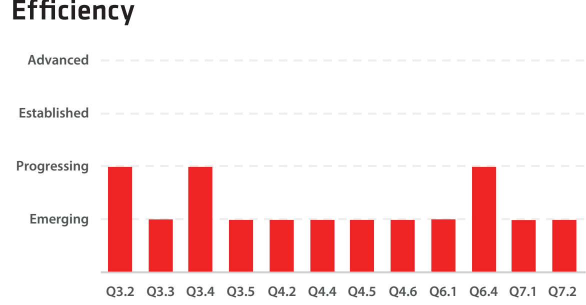


See Annex 4 for question details.

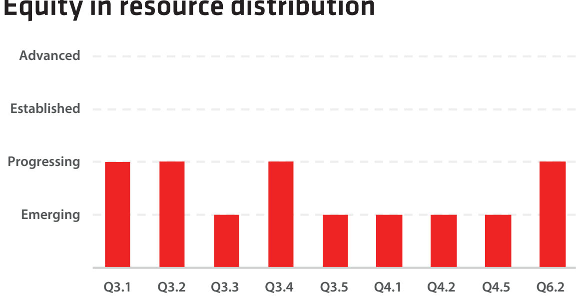
Assessment rating by intermediate objective

Fig. 10 (continued): Assessment rating by intermediate objective and final coverage goals

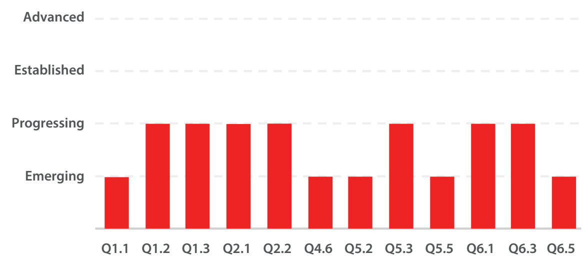
Efficiency



Equity in resource distribution



Transparency and accountability



See Annex 4 for question details.

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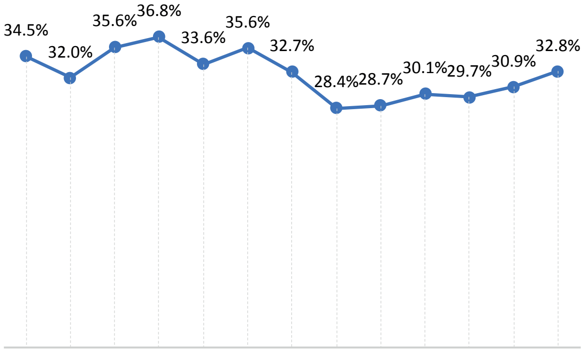
1 All references were accessed on 3 December 2024.

Annexes

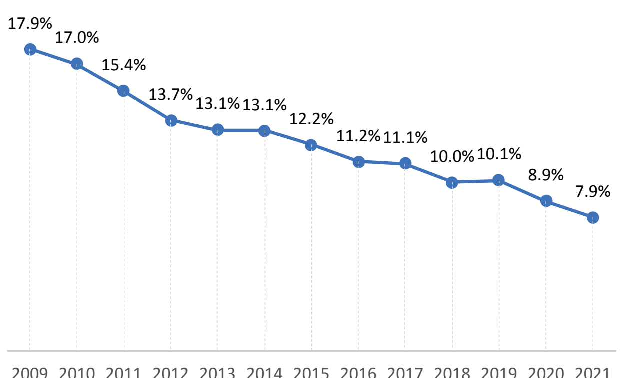
Annex 1: Selected contextual indicators

Fig. A1.1: Health expenditure indicators for Jordan

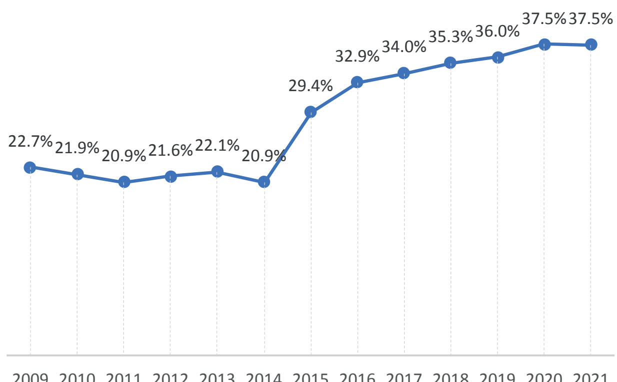
General government expenditure as % of gross domestic product



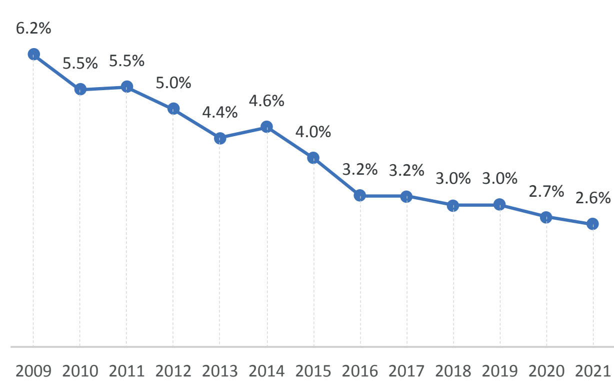
Domestic general goverment health expenditure as % of general government expenditure



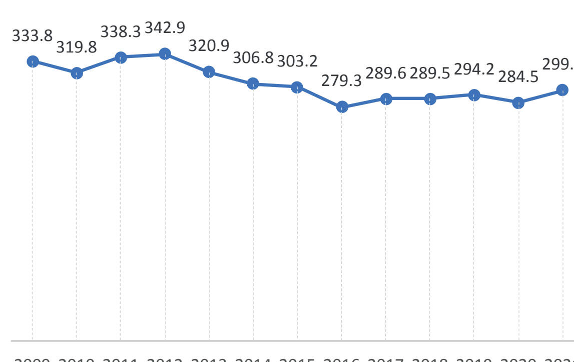
Out-of-pocket spending as % of current health expenditure



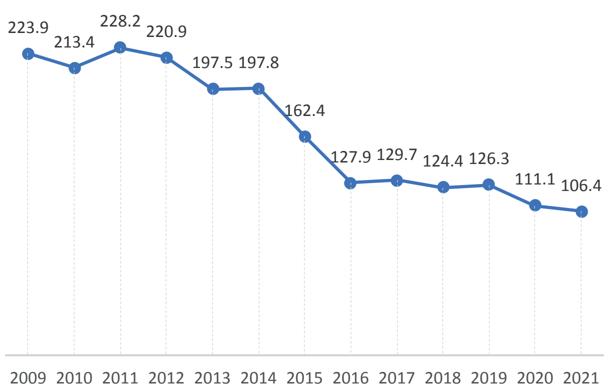
Domestic general goverment health expenditure as % of gross domestic product



Current health expenditure per capita in US$



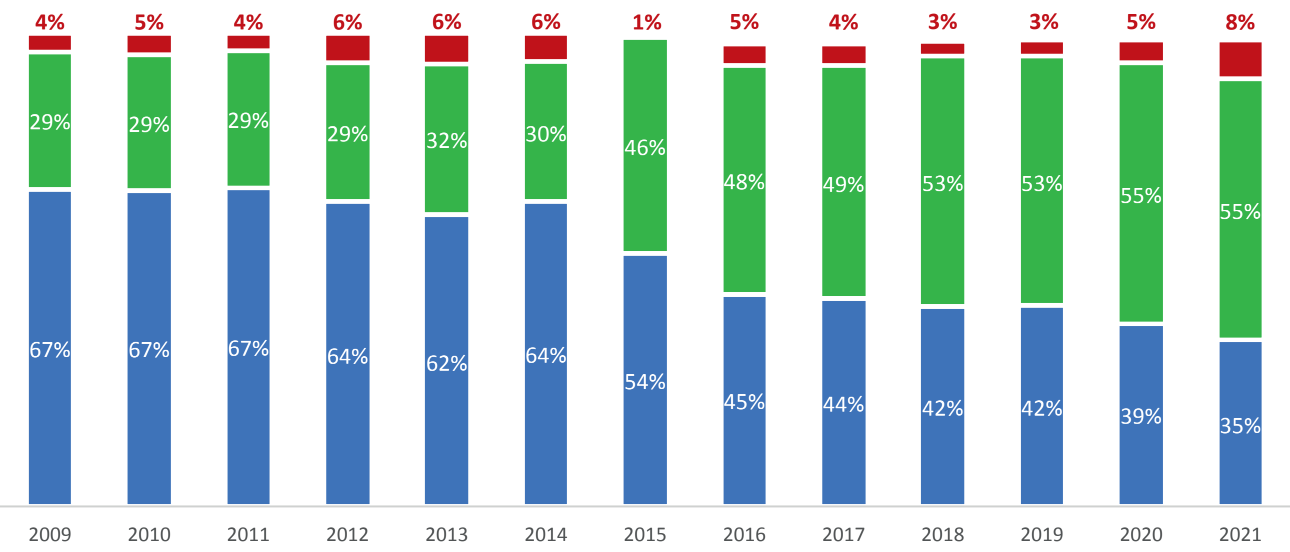
Domestic general government health expenditure per capita in US$



Source: WHO Global Health Expenditure Database, 2023 (https://apps.who.int/nha/database/Home/Index/en)

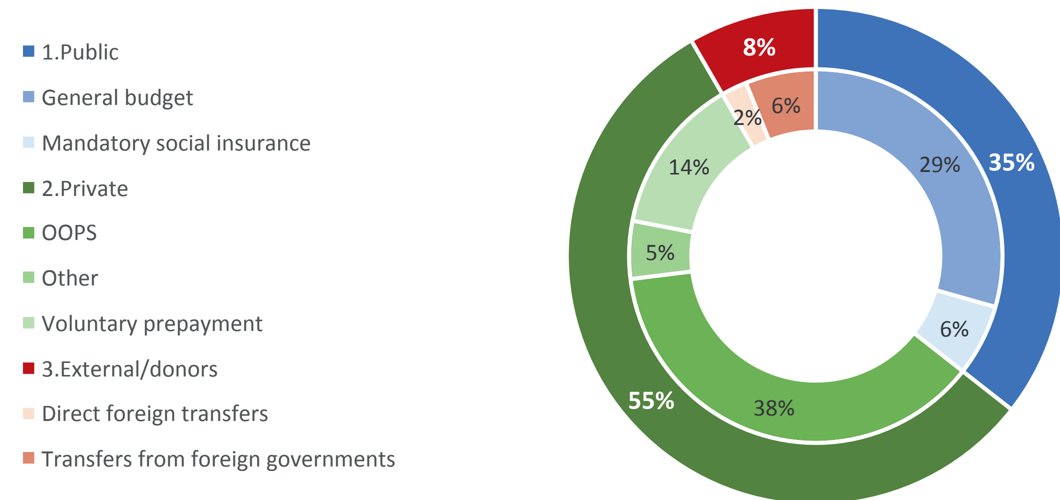
Note: The Ministry of Health is reviewing health spending estimates which will be published in 2025.

Fig. A1.2: Revenue sources for health in Jordan



Source: WHO Global Health Expenditure Database, 2023 (https://apps.who.int/nha/database/Home/Index/en)

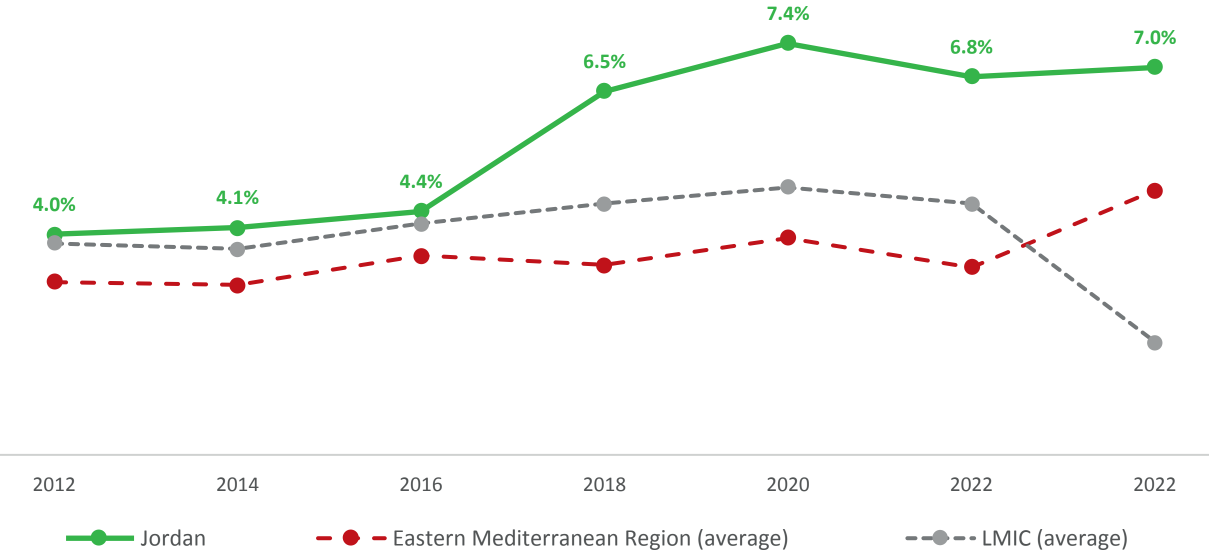
Fig. A1.3: Revenue sources disaggregated 2021



Source: WHO Global Health Expenditure Database, 2023 (https://apps.who.int/nha/database/Home/Index/en)

Fig. A1.4: Cigarette affordability in Jordan

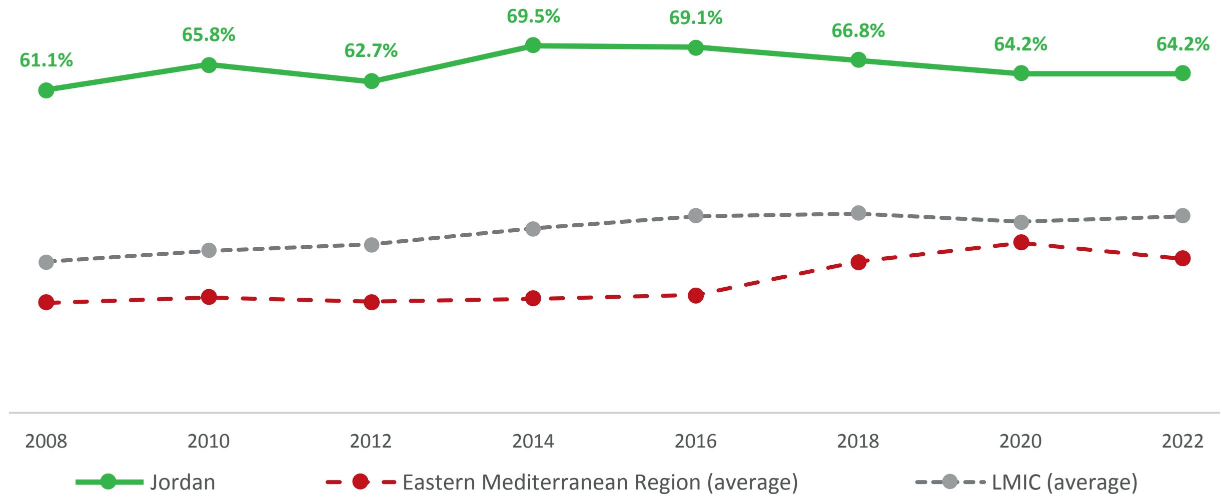
Reducing affordability is an important measure of the success of tobacco tax policy. In the longer term, a positive, higher measure means cigarettes are becoming less affordable. Short-term changes in affordability are also presented.



Source: WHO report on the global tobacco epidemic 2023 (https://www.who.int/publications/i/item/9789240077164)

Fig. A1.5: Excise tax share in Jordan

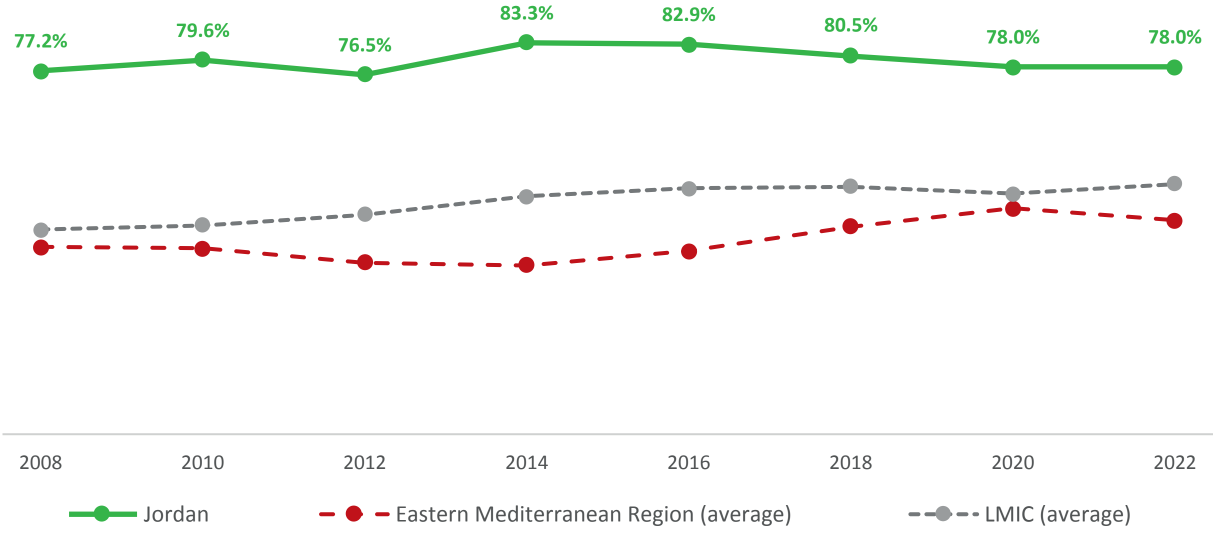
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



Source: WHO report on the global tobacco epidemic 2023 (https://www.who.int/publications/i/item/9789240077164)

Fig. A1.6: Total tax share in Jordan

This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, VAT/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.



Source: WHO report on the global tobacco epidemic 2023 (https://www.who.int/publications/i/item/9789240077164)

Annex 2. HFPM assessment questions

Assessment	Question number code	Question text
1) Health financing policy, process and governance	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) Revenue raising	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) Pooling revenues	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
4) Purchasing and provider payment	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

Assessment area	Question number code	Question text
5) Benefits and conditions of access	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) Public financial management	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
7) Public health functions and programmes	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

Annex 3. Stage 2 results

Annex 3.1. Health financing policy, process and governance

Question 1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?		
Officially, there is no health financing policy statement, despite some attempts to finalize a health financing strategy in 2018, 2019 and 2023. Some evidence generated from health accounts, costing and financing studies are used as an analysis of health financing. There is a growing awareness and demand to produce a health financing strategy.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
There is no clear policy statement with respect to health financing and no legal document that supports implementation is available.	A policy statement is in place but little action to translate this into system change.	An up-to-date policy statement based on a recent diagnosis of the current situation exists.	A clear policy statement based on a diagnosis of the current situation exists, and has been developed in collaboration with other sectors and participation of relevant stakeholders.

Question 1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?		
The key financing agencies are HIA, MIF, VHI and RC. While the roles and mandates of these agencies are clear, they are not suitable and do not reflect the best practices. There is no clear separation between payer and provider in the case of HIA with Ministry of Health and MIF with RMS, which hinders accountability. The mandates between the agencies often overlap, causing duplications and limited oversight on expenditure.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Roles and responsibilities are not clearly defined across governing bodies for health financing, accountability is weak, and there is poor coordination across schemes.	Some roles and responsibilities are defined and divided across governing bodies for health financing, but duplication and poor coordination remains. Some accountability mechanisms are in place but remain weak.	Most health financing schemes have clear reporting lines to oversight bodies, and collectively roles and responsibilities are clearly defined and divided, although better coordination still required. Accountability mechanisms function relatively well.	Governing institutions roles are clearly defined both for individual schemes and the health financing system overall. Both government and non-government stakeholders are systematically involved, with implementing agencies held publicly to account for performance.

Question 1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?

Health financing information are often used in improving health finance policies; however, they are not comprehensive or complete and are not used systematically.

NHA is produced periodically, and the key health financing indicators have been gaining importance at the level of decision-makers.

Only data from the HIA is routinely generated but not clearly and systematically used to monitor, evaluate and improve health financing policy.

There is poor cooperation and coordination between the various components of the health sector.

There is inactivated monitoring and evaluation systems of institutional performance in the public sector.

There are weak systems for oversight in place on the private sector.

Emerging ●○○○	Progressing ●●○○	Established ●●●○	Advanced ●●●●
Information for monitoring is not routinely produced, and few evaluations are conducted, apart from certain programmes. No common data collection format across the health system exists, and little use is made of household survey data for governance purposes.	Monitoring mechanisms exist but are not routinely implemented and depend heavily on external agencies; use of household surveys has increased, but integration with other data is challenging. Governance remains weak.	A monitoring and evaluation framework exists, with NHA, financial protection, and evaluation studies produced more regularly.	A well-designed monitoring and evaluation system for health financing exists, and high-quality data are systematically available and used to inform oversight of health financing, and report to the public on progress.

Annex 3.2. Revenue raising

Question 2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?		
To achieve UHC, there is international evidence on the importance of increasing the fiscal space of public health expenditure, reducing OOP and monitoring catastrophic spending. In Jordan, there is a clear emphasis on mobilizing public funding to health without enough focus on the source of funding (whether it is public, VHI or OOP). • Public funding is estimated around 43% of current health expenditure while OOP has steadily increased between 2016 and 2019 according to the latest NHA report reaching 36%. • Public health expenditure increased significantly in the last 10 years; however, so did OOP and other sources of private funding. • The absence of a health finance strategy and the absence of a clear statement in the national health strategy and the Economic Modernization Vision on health financing does not reflect international experience.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Policy/strategy for domestic resource mobilization reflects poor understanding of lessons from global experience.	Policy/strategy shows some limited understanding regarding the importance of public funding, but policy is not realistic or there is no clear plan for implementation.	Policy/strategy reflects clear understanding of main lessons on importance of increasing public funding but still has problematic aspects.	Policy/strategy recognizes need to maintain a predominant reliance on public funding in a fiscally realistic manner and see explicit complementary role for private financing within an overall policy framework.

Question 2.2	How predictable is public funding for health in your country over a number of years?		
Current and previous Jordanian governments have shown high commitment to spending in the health sector and public funding over the years have been mostly predictable from the annual budgets. On the other hand, actual expenditure of the public health sector often exceeded the budgets with minimal monitoring. The general budget usually suffers from chronic deficit supplemented through loans and donors which may cause instability in public funding in the future.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
There is little or no forward budgeting, and there are large or significant year-to-year fluctuations in public funding for health (and where relevant, external funding).	Although revenue and expenditure scenarios exist, predictability of the level of public funding for the health sector remains poor.	The level of public funding for the health sector is relatively predictable due to well-functioning budgetary processes.	The level of public funding for health is highly predictable.

Question 2.3	How stable is the flow of public funds to health providers?		
The execution of health budgets at Ministry of Health and RMS varies. Certain items are always executed in a predictable and stable manner like staff salaries and other items like rent, water and electricity. On the other hand, the reimbursement of contracted health providers and suppliers are often delayed, and this expenditure item is not well controlled. These include reimbursing private hospitals and university hospitals, as well as pharmaceutical and medical equipment suppliers, causing arears to accumulate over time. However, there have been several attempts to minimize the arears and control spending.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Health budgets at central and subnational levels, and SHI agencies where relevant, are rarely executed as planned.	Health budgets are sometimes executed as planned.	Health budgets (including SHI fund) are usually executed as planned.	Flow of public funds to the health sector is highly stable.

Question 2.4	To what extent are the different revenue sources raised in a progressive way?		
Health revenue sources in Jordan are highly regressive: • Governmental funding is sourced from both direct and indirect taxes. Regressive indirect taxes (value added sales tax) accounted for 4587 million in 2023 while the more progressive direct taxes (income tax) accounted for only 1545 million JDs in 2023. • SHI contributions (MIF and HIA) use a fixed percentage so it is considered slightly progressive; however, the contribution is capped, which means that ultimately they are regressive. • Premiums collected for VHI form 18% of total health expenditure. They are also regressive as they fixed amounts based on age and health risk, not income .			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Most sources of revenues are highly regressive i.e., payment is not based on ability to pay due to, for e.g. low levels of public revenue leading to high reliance on OOP.	There is a greater reliance on public revenue sources which mitigates inequities in health payments to some extent, but significant inequities remain in policy design.	Collection of revenue is designed in favour of equity but faces barriers to effective implementation.	Most revenue sources are highly equitable, i.e., payment is primarily based on ability to pay.

Question 2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?		
A special sales tax is applied on tobacco and alcohol and there are no subsidies for fossil fuels. Although customs and sales taxes together are considered high (more than 80% for the tobacco), the original cost of the products is not high enough to make an impact on the purchase price, which eventually will not affect or influence the behaviour of the people and reduce the tobacco and alcohol consumption in Jordan. As for the sugar-sweetened beverages, there are no policies or laws to support any additional taxes on it, and only standard custom and sales taxes are applied. It is important to highlight that the above-mentioned taxes were not applied following a health rationale but as a mean to increase revenues, and available documents do not provide any health benefits or influencing behaviours as a rationale for these taxes. They are also not earmarked.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
There is no legal basis for health taxes, they are not used as an instrument to influence consumption, and subsidies may exist that are harmful to health.	There is a legal basis for health taxes, and some exist but are set at levels too low to adequately influence unhealthy behaviours, and harmful subsidies may continue to exist.	Tax regime is in place for at least two potentially harmful products, fossil fuel subsidies are eliminated/ reduced, and government is considering plans to increase rates in line with international guidance.	Fiscal measures are used across a range of harmful products to discourage their use/consumption and are set at levels consistent with international guidance.

Annex 3.3. Pooling revenues

Question 3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?		
There were several initiatives and policy papers in Jordan calling for merging public health insurance funds or addressing the issue of fragmentation through other means like addressing the issue of concentration of exempted vulnerable individuals in the HIA fund by ensuring their contribution is covered by the National Aid Fund. However, to date, there is no official policy to merge the different schemes or mitigate fragmentation.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Policy/strategy is contrary to key principles and lessons from international evidence.	Policy/strategy shows some understanding of key lessons but still segments the population without supporting or compensatory measures, or changes to the flow of existing budgetary revenues.	Policy/strategy reflects main lessons from evidence, reducing fragmentation or mitigating its consequences, but key challenges such as tax subsidies for VHI or separate SHI schemes not fully addressed.	Policy/strategy reflects core evidence and principles on pooling, with explicit actions to address or mitigate fragmentation, and to monitor/adjust unintended equity consequences.

Question 3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?		
The Ministry of Health and RC, which are funded directly from the government budget, provide health coverage to several vulnerable groups, and as such redistributes funds to a degree. Nevertheless, the fragmentation of the system, the existence of multiple pools especially in private sector and high OOP are all factors hindering the ability of redistribution.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Potential to redistribute available prepaid funds from lower to higher need populations is greatly constrained by structural barriers, and few/no mechanisms exist to compensate.	Some redistribution of available prepaid funds exists, but schemes reflect lack of diversity in population coverage and an over-reliance on voluntary participation.	System enables a good degree of redistribution of prepaid funds but fails to include the entire population.	Highly effective re-distributional mechanisms in place that include the entire population.

Question 3.3	What measures are in place to address problems arising from multiple fragmented pools?		
There were many plans over the years to merge pools; however, none have materialized.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
There are no compensating measures to address inequity and inefficiency arising from fragmentation.	Some measures in place to address inequity and inefficiency arising from fragmentation.	Substantial measures in place, though with room for improvement, to address inequity and inefficiency arising from fragmentation.	Compensation measures fully implemented to enable equity and efficiency challenges arising from pool fragmentation to be fully addressed.

Question 3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?		
SHI contributions (collected by HIA and RMS) are complementary to governmental funding and donor funding; however, it only forms a small share of total public funding. In the private sector, the funding streams are not complementary.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
There is no coordination of fund flows from different revenue sources.	Complementarity exists among some revenue sources, but there is no population-wide (universal) framework of health benefit entitlements indicating the specific role of different funding sources/streams.	A benefit framework exists for most of the population with funding responsibilities clearly defined across different revenue streams, but private prepayment still not well-integrated.	There is explicit complementarity of different revenue sources to fund a defined benefit package for the entire population.

Question 3.5	What is the role and scale of voluntary health insurance in financing health care?		
Mostly it is represented by private sector insurance companies and self-administrated funds, which represents 18% of health care finance in 2019, while it only covers 8% of the population. The use of fee-for-service payment, high user charges reaching 20% in certain cases and ceilings of insurance, in addition to high OOP payments, have all led to migration of specialized health professionals from public to private sectors, forcing insured patients to rely on RC exemptions in cases of diseases excluded from coverage to avoid financial catastrophe.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
VHI coverage largely benefits the rich, fragments the system, and has a large inequity impact.	VHI coverage benefits the richer population and is a source of segmentation and fragmentation; spillover effects are limited however, despite government still promoting VHI.	Health financing policy enables VHI to play a supplementary role for faster access or to obtain services from providers not contracted by the main/ public system, with no major spillover effects.	VHI either does not have negative effects or plays a clear complementary role within a publicly defined benefit package, with subsidized coverage for the poor.

Annex 3.4. Purchasing and provider payment

Question 4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?		
The Ministry of Health and RMS apply line-item budgeting to fund the facilities, and individual facilities within the RMS and Ministry of Health do not have independent budgets and are instead funded centrally from Ministry of Health and RMS through line-item budgeting. Accordingly, this mechanism does not inform about the health needs of the population through payment of providers, and instead relies on historical trends and utilization data when available. In the private and university sectors, fee-for-service payment mechanisms are applied with limited use of health needs information.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Historical patterns or input-based norms used without reference to data on population health needs.	There is some use of simple measures of need within payment mechanisms in at least some schemes or government budget allocations.	More sophisticated mechanisms of adjusting for health needs, service mix and provider performance are incorporated into payment methods and applied to most prepaid funding in the system.	The main provider payment methods used in the health system involve methods that incorporate data on population health needs, risk factors, provider performance and service mix.

Question 4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?		
The same services are purchased using different rates and different methods of payment. • Within Ministry of Health and RMS facilities, services are funded through line-item budget and no purchasing occurs by HIA and MIF respectively. • HIA and MIF have bilateral agreements for purchasing services from RMS and Ministry of Health respectively, as well as with other providers (universities, KHCC and private), using different prices for each sector. • Ministry of Health have two different price lists for its own services depending on socioeconomic status of the patient. • Private providers use an official price list published by the Jordanian Syndicate of Physicians for services purchased by VHI, while non-insured patients pay a higher price through OOP payments.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
There is no alignment or harmonization of provider payments within or across purchasers.	There is some limited alignment or harmonization of provider payments for some key services across a few purchasers. There is alignment within major health programmes(s) or scheme(s) across types and levels of care.	Payment methods are aligned or harmonized for most services across most purchasers. Payment methods and funding flows are largely aligned for different types and levels of care within most programmes or schemes.	Provider payment methods and rates are unified or fully harmonized within each purchaser and across purchasers.

Question 4.3	Do purchasing arrangements promote quality of care?		
All services purchased through fee-for-service mechanism have no link to the clinical outcomes and quality of services. Incentives paid to Ministry of Health and MIF staff are linked to years of experience and staff grade but not to performance.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Purchasing arrangements do not provide incentives that promote better quality or coordination of care.	Purchasing arrangements include a few mechanisms which incentivize improved service quality and care coordination, but these are limited in scope.	Purchasing arrangements include mechanisms that encourage providers to focus on service quality and care coordination, but measurement of impact is limited.	Purchasing instruments, such as financial incentives, are used to promote quality of care and coordination; information and indicators which measure both elements are routinely available.

Question 4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?		
There are very limited mechanisms to address potential over use and under use of services as there is limited capacity to monitor provided services through digital systems or audits. While copayments for prescribed medications are in place in the public sector, they are small and have limited impact on controlling use.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Payment system incentives allow providers to over- or underprovide services, and there are no complementary administrative measures in place to limit this.	Provider payment system starts to introduce incentives aligned with objectives, but only cover a small share of the population. Limited review of administrative data to control for fraudulent reporting.	Purchasing strategies which address over- or underprovision are implemented in schemes covering most of the population, including either/ both payment methods and administrative controls.	Payment methods aligned across the health system to set coherent incentives to address under or over-provision, and regularly reviewed; administrative mechanisms in place to control for unintended consequences.

Question 4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?		
No, there is limited oversight from the purchasers on the providers activities for the following reasons: • billing systems are still under-development in Ministry of Health and RMS providers, and no data are reviewed by the HIA and MIF. • data about services purchased from private providers by HIA, is reviewed by a third party with the objective of preventing fraud, but no data are provided to guide purchasing decisions.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Information on patients' activities submitted to purchasing agencies is basic and of limited use to inform purchasing decisions.	Although still limited, the comprehensiveness and reliability of provider activity data are improving. However, quality issues persist limiting use for improving purchasing decisions.	Providers' activity data collected through patient encounter records are greatly improved in terms of detail, reliability and timeliness, and is increasingly used to inform purchasing decisions.	Purchasing agencies regularly collect detailed, reliable information on provider activities; information is routinely analysed and used to inform purchasing decisions and broader health system stewardship.

Question 4.6	To what extent do providers have financial autonomy and are held accountable?		
Public providers do not have any autonomy.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Public providers have no or extremely limited autonomy and cannot respond to financial incentives through the payment system.	Public providers are given greater managerial and financial autonomy, but accountability mechanisms are weak.	Public providers are granted further increases in managerial and financial autonomy and compliance with accountability requirements is progressively improving.	Providers enjoy substantial managerial and financial autonomy, have clear incentives to improve performance and are held accountable for their performance.

Annex 3.5. Benefits and conditions of access

Question 5.1	Is there a set of explicitly defined benefits for the entire population?		
The public sector have identified a number of high priority services that are provided free of charge, like vaccination programmes and maternal care. However, there is an explicit benefit package in place that defines the other services provided by the Ministry of Health and RMS. In the private sector, there is no regulation governing the benefits covered by VHIs and it is usually left for the VHI and the beneficiary to decide on the services provided.			
Emerging	**Progressing**	**Established**	**Advanced**
Entitlements are implicit for most of the population, and there is no prioritization for vulnerable population groups.	Explicit entitlements are linked to contributions for relatively well-off groups but are implicit for most of the population, other than perhaps some vertical programmes.	Entitlements are explicit for most of the population, and measures taken to explicitly universalize certain benefits on a non-contributory basis; differences in entitlements across schemes remain.	Benefit entitlements are defined explicitly for the entire population with provisions for vulnerable groups and/or for other health policy goals.

Question 5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?		
While there is no explicit benefit package, decisions to provide health technologies and services are made with no clear criteria or process.			
Emerging	**Progressing**	**Established**	**Advanced**
Decisions on publicly funded benefits are not made transparently, with no criteria or process defined as the basis for decisions, and no inclusion of stakeholder perspectives.	Some decisions on publicly funded benefits are assessed against selected criteria and plans to establish a formal process, are being considered, but decision-making is largely opaque (not transparent).	Larger number of assessments conducted to inform benefit decisions, and decision taken to institutionalize an explicit process including criteria such as cost–effectiveness and budgetary impact.	Laws or regulations in place requiring proposed changes to publicly funded benefits to be subjected to systematic assessment and deliberation; expert and non-expert stakeholders are incorporated.

Question 5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?		
Within the public system it is clear. However, within VHI and RC exemptions there is no clarity in the entitlements.			
Emerging	**Progressing**	**Established**	**Advanced**
Entitlements and conditions of access are not clearly defined, and people do not understand them.	Entitlements and conditions of access are clear for part of the population but remains uncertain for most; some efforts made to communicate but limited.	Significant action taken to make entitlements and conditions of access explicit for most of the population but remains unclear for many.	Entitlements and obligations are clearly defined on the key dimensions and are clearly communicated and understood by the population.

Question 5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?		
User charges in public sector are small and only apply to certain services like medication or use of private facilities. No user charges apply for exempted patients from RC. However, within VHI user charges are high and patients often need to make informal payments.			
Emerging	**Progressing**	**Established**	**Advanced**
Regardless of policy design, patients typically must make informal payments in order to obtain care.	Patient co-payments are highly detailed and/or defined in percentage terms and linked to treatment provided rather than ability to pay; some protection mechanisms in place.	Co-payment schedule is limited and clear, organized by level of care, structured as fixed fees, and includes mechanisms to exempt the poor; implementation challenges remain.	Co-payment schedule is easy to understand, and has a structure and design that protects vulnerable persons.

Question 5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?		
There are no defined benefits and the services offered by the public system are not aligned with available funds.			
Emerging	**Progressing**	**Established**	**Advanced**
Decisions on benefit entitlements are made without consideration of available funds, no mechanisms in place to ensure funds flow to entitlements.	Costing of interventions and explicit provider payment mechanisms exist for some benefits but are small scale and typically outside the core public financial management system.	Additions to publicly funded benefits are supported by new revenues and increasingly there is an explicit provider payment link with priority services.	Benefit expansion decisions are subject to budgetary impact, available funds, and service readiness, and are supported with incentive and accountability mechanisms for providers.

Annex 3.6. Public financial management

Question 6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?		
No specific PFM bottlenecks have been identified in the health sector recently, but a performance overview is available through various resource materials, including the pandemic preparedness and health system resilience assessment in 2022, the Muhanna study in 2018 and the Jordan strategy Forum review in 2020. However, it should be noted that recommendations made by these three reports regarding the broader health financing were not implemented.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
No generic PFM assessment exists or only an outdated assessment.	Only a generic PFM assessment has been conducted, which is up to date.	A rapid health-specific assessment was conducted in the last 2 years which examined some bottlenecks in health spending.	Extensive, up-to-date health-specific diagnosis/assessment conducted; key bottlenecks identified.

Question 6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?		
Programme-based budgets are used to develop the general government budget and the Ministry of Health budget. The programmes described in the Ministry of Health budget do not necessarily reflect sectoral objectives and priorities. For example, three key programmes are in place in the Ministry of Health budget, namely primary care, tertiary care, and medical treatments, vaccine-supplements and pharmaceuticals. The medical treatments programme covers part of the treatments delivered in facilities outside Ministry of Health hospitals, while the tertiary care programme is specific to Ministry of Health hospitals and excludes Prince Hamzah Hospital which has its own budget; finally, primary care is separate from both and incorporates all public health and epidemic projects. The last programme represents purchase of medical supplies and medicines for all providers, whereas it would be better if this programme is split across the three earlier programmes. The budget structure in its current form hinders the reallocation of funds to match spending to priorities and to ensure the flexibility required to allocate resources efficiently.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Health policy priorities are poorly defined, and not reflected in the budget; rigid input-based line-item budget dominates.	Input-based line-item budget and ex-ante financial control still dominates; some piloting of programme-based budgets provides more flexibility in resource use, and performance information is increasingly used.	Use of performance information and implementation of programme-based budgets are becoming widespread, better directing budgets to sector priorities using mechanisms that are consistent with provider payment incentives, thereby providing greater flexibility in resource use.	Health sector priorities, medium term expenditure framework and annual budgets are fully aligned and structured around well-designed budgetary programmes, and stable, predictable funds are directed to health sector priorities and service providers.

Question 6.3	Are processes in place for health authorities to engage in overall budget planning and multiyear budgeting?		
Health authorities are engaged with the Ministry of Finance in developing the budget. t in accordance with financial cycle calendar. The budget development cycle starts in April of each year with the Budget directorate (Ministry of Finance) developing draft budget ceilings for the ministries and directorates. The Ministry of Finance holds meetings with a team from the Ministry of Health (finance and other key directorates). The draft budget ceilings are revised and confirmed by the Budget Department in liaison with the respective ministry by September and based on the input received, prepare the annual estimated budget for the year. The Ministry of Finance also develops a multiyear indicative budget for each ministry and directorate, however, it is based on macro-level economic indicators, so input from programmes and projects is not considered for the development of the indicative budgets of the next two years. The governance arrangements of the Ministry of Health and RMS are as such that hospitals, regional governorates and primary care centres have no autonomy (they are not recognised as spending units and accordingly are not involved in the budget preparation process) and are managed and run centrally. This means that most budgets are prepared using historical data without considering and incorporating information about needs and requirements. It should also be noted that current budget structure does not make note of any arrears, which further limits the use and accuracy of relying solely on historical budget data.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Current budget process often bypasses the Ministry of Health, with no or very limited dialogue between the Ministry of Health and the Ministry of Finance.	Budget process is consultative and transparent but to a limited extent, and input from health sector is minimal; the Ministry of Health is not consulted over mid-year re-allocations.	Budget process is consultative and transparent but to a limited extent, and input from health sector is minimal; the Ministry of Health is not consulted over mid-year re-allocations.	Budget process is consultative and transparent, based on dialogue between the Ministry of Health and the Ministry of Finance, within a clear multiyear budgeting framework; all appropriate administrative levels are consulted and engaged.

Question 6.4	Are there measures to address problems arising from both under and over budget spending in health?		
There are several processes to address under and overspending; however, the processes are circumvented through different means. First, the budget is developed in a way that only reports actual expenditures made during the financial year, but does not report any arrears. Accordingly, the execution rate for the Ministry of Health often shows 100% execution or small surpluses, while in fact the ministry have spent well above the budget ceiling resulting in arrears. While the law does not allow purchasing without availability of funds, in the Ministry of Health this is often bypassed through a loophole allowing "health security" purchases, which applies to pharmaceutical purchases. Finally the scheme described as exemptions is vast and usually is not allocated enough funds if any, and is usually covered from otehr budget items leading to more arrears. The budget structure does not allow arrears to be reflected and accordingly makes the monitoring of over-spending difficult.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Health budget implementation frequently fails to comply with basic budget discipline due to poor planning, insufficient or unpredictable revenue streams, and few if any measures are taken to address the issue.	Health budget implementation complies with basic budget discipline, but with still major shortfalls and significant underspending in health.	Limited under or over-spending on a yearly basis, but delays remain in fund releases for health service providers specifically.	Health budgets are fully executed and comply fully with budget discipline; significant underspending rarely happens.

Question 6.5	Is expenditure reporting in health comprehensive, timely, and publicly available?		
Computerized systems are in place for FMIS, which is not the case at the level of health service facilities. The health facilities currently have electronic medical files in place, but is yet to develop a billing system and a claims systems. Accordingly, only paper-based billing systems are reported back to the Ministry of Health and HIA finance teams although reporting is not a requirement in the current status quo. Without a degree of financial autonomy of the facilities, data on expenditure data are not reviewed and do not inform decisions.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
No computerized systems for performance or expenditure monitoring; numerous parallel reporting systems with no centralized reconciliation.	Computerized system being developed and strengthened, but with limited or poor-quality routine data; financial reporting in health remains fragmented.	A functioning financial information system in place but is not aligned with health sector accountability requirements	Financial management information system allows monitoring by multiple categories; information is publicly available and used to inform new budget decisions

Annex 3.7. Public health functions and programmes

Question 7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?		
Limited alignment and integration between finance strategies and health programmes can be noted because: 1. There is no clear health finance strategy to date. 2. The four health insurance schemes identified in Stage 1 of this assessment have completely separate funding, procurement and delivery systems (with the exception of Royal Court exemptions), with limited coordination and integration between each other. 3. Limited coordination and integration is noted within each of these schemes, for example in the Ministry of Health, the Primary Health Care programme is separate from the tertiary care programme, which is further separated into tertiary care provided in Ministry facilities and those provided in non-Ministry facilities, which operate under different policies and regulations. This fragmentation at the level of schemes, as well as programmes within each scheme, leads misalignment and uncoordinated streams of money funding common functions.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
Specific health programmes are not addressed in, or aligned with, overall national health financing policy.	Health financing policy considers health programmes but guidelines for aligning functions for integrated service delivery are purely aspirational.	Health financing policy has guidelines for aligning health programme functions within the health system, but these have not been implemented.	Health financing policy reflects careful consideration of health programme services and funding flows.

Question 7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?		
The fragmentation of the health system leads to poor coordination and integration in service delivery. In addition to the fact that 52% of current health expenditure is private and not pooled with public revenues, public expenditure is also fragmented, flowing through multiple payers and providers, with the RMS, the Ministry of Health, and the Prince Hamzah Hospital, as well as others, having separate budgets. There is also limited coordination and integration between the different health insurance schemes, and the health programmes they each run. This level of fragmentation leads to significant inefficiency due to suboptimal coordination and integration across health programme and the broader health system.			
Emerging ●○○○	**Progressing** ●●○○	**Established** ●●●○	**Advanced** ●●●●
All health systems functions remain separate for specific health programmes.	There have been some efforts to develop mechanisms to integrate certain functions across specific health programmes.	Substantial measures for integration and coordination of functions are in place, though with room for improvement, to address inefficiencies arising from separate pooling.	Full harmonization of all key functions across health system allows for functions to operate at the system level rather than being organized by programme.

Question 7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?		
On a national level, there is suitable processes to handle emergencies; however, as this only applies to NCSCM, Ministry of Health and RMS, fragmentation again plays a key role in hindering effective preparedness. This is also not reflected at the subnational level as everything is managed centrally. There is a contingency fund at the governmental level for emergencies, however it is not specific for health emergencies and there is no clear definition for the emergencies or disasters that would trigger use of the contingency fund.			
Emerging	**Progressing**	**Established**	**Advanced**
There is no budgetary allocation available or identifiable to finance the implementation of IHR capacities	A budgetary allocation, or substantial external financing, is made for some of the relevant sectors to support IHR capacities but are not fully implemented.	Budgetary allocations for IHR capacities are made across relevant sectors to support implementation but there is no clear coordination across sectors in their execution.	Sufficient budget for IHR capacities is distributed, executed, and coordinated in a timely manner across all relevant ministries and levels of government.

Question 7.4	Are public financial management systems in place to enable a timely response to public health emergencies?		
During COVID-19, an extra-budgetary fund was established (Himmet Watan) and served to facilitate pooling new funds for a timely response to the emergency. Similarly, a defence law was implemented (similar to martial law) which allowed the cessation of any regulation that may delay the response and facilitated quicker purchasing decisions and reallocation of funds by overruling any unnecessarily bureaucratic procedures. However, it would be preferable to establish a clear system that allows for more efficient, responsive and timely purchase and allocation of funds, without resorting to the defence law.			
Emerging	**Progressing**	**Established**	**Advanced**
Funding to respond to public health emergencies is identified but public financial management system does not allow for effective or timely disbursement during a public health emergency.	An emergency public financing mechanism exists that allows for structured reception and rapid distribution of funds in response to public health emergencies	Financing for public health response is identified for immediate mobilization when needed at all levels of government for relevant sectors in advance of a public health emergency.	Financing can be executed and monitored in a timely and coordinated manner at all levels for all relevant sectors, with an emergency contingency fund in place to respond to public health emergencies.

Annex 4: Desirable attribute of health financing

Policies which help to drive progress to UHC are summarized in terms of 19 desirable attributes of health financing policy. For further information see: https://www.who.int/publications/i/item/9789240017405.

Desirable attributes of health financing systems		
Health financing policy, process and governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing and provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits and conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them and report on spending and output

Desirable attributes of health financing systems		
Public health functions and programmes[3]	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

Annex 5: Questions mapped to objectives and goals

Each question represents an area of health financing policy, selected given its influence on UHC intermediate objectives and goals, as explicitly defined below.

Objective/goal	Question number code	Question text
Equity in resource distribution	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
Efficiency	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	Are there measures to address problems arising from both under- and over- budget spending in health?
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

Objective/goal	Question number code	Question text
Transparency and accountability	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
Service use relative to need	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

Objective / goal	Question number code	Question text
Financial protection	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
Equity in finance	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
Quality	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
Health security	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

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