Emerging Lessons from the Development of National Health Financing Strategies in Eight Developing Countries

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Abstract—As countries advance economically, they are increasingly under pressure to mobilize and properly manage domestic resources to provide affordable health care for their citizens. The World Health Organization and international donors have encouraged countries to develop a health financing strategy (HFS) to plan how to best achieve these objectives. This article highlights lessons and considerations for countries developing HFSs and for donors supporting the process, in the areas of data use, cross-country learning, evaluation, leadership involvement, and stakeholder management. This article’s review of the United States Agency for International Development (USAID)-supported Health Finance and Governance (HFG) and Health System Strengthening Plus projects’ experiences assisting eight countries with HFS development concludes that the HFS development process generates demand among low- and middle-income country policy makers for health financing data and that countries that complete HFSs accept that basing a strategy on imperfect data is better than not having a strategy. The article also concludes that cross-country learning, through guided study trips and reviews of other health systems and HFS processes, is paramount for developing an HFS and that most countries have not included monitoring and evaluation plans in their HFSs. Finally, in HFG’s experience, countries developing HFSs have been successful in fostering ownership among a broad coalition of stakeholders but diverge in their approaches to involving political leaders in detailed technical debates about health financing reform. These lessons and challenges, based on real-world experiences, can help low- and middle-income countries to develop politically feasible HFSs that promote financial sustainability of the health sector, protect people from burdensome health care costs, improve efficiency, and advance universal health coverage.

INTRODUCTION

Health care costs have been rising globally as the burden of noncommunicable diseases increases, infectious diseases persist, and new, costly treatments are developed. With rising...
incomes, populations want access to better quality, affordable health services and to be protected from the need to make “catastrophic” payments for care. Thus, governments are under pressure to raise additional domestic resources for health, to ensure that their populations are protected from impoverishing out-of-pocket payments, and to improve the efficiency of health spending in order to do more with available funding.

The rise in health care demand and costs and the pressure on the government to respond are not new trends. In 1995, the World Bank compiled and analyzed health care financing case studies to share the lessons learned from Asian, North American, and European countries’ attempts over many decades to finance health care for their populations. The publication notes that health financing policies in these countries evolved gradually over the years and were rarely explicitly reexamined unless a new health insurance program was to be introduced. It also states that developing countries had almost never engaged in strategic planning for health financing. In presenting a framework for health sector reforms, Roberts and colleagues advise that health reforms, including financing reforms, should address challenges comprehensively and that the process should involve a broad group of stakeholders, be guided by a change team, imitate the positive experiences of other countries, and be informed by evidence but not to expect that all evidence desired will be available. Carrin and colleagues developed a framework specifically for developing financing policy for universal health coverage. They acknowledge the need to make “a multitude of interrelated decisions” to develop such a policy but do not explicitly call for the development of structured health financing strategies. Kutzin proposes a framework for health financing policy making for European countries, especially those undergoing economic transition, and Kutzin and colleagues share lessons from implementing such reforms.

Building on this earlier work, the World Health Organization’s (WHO) 2010 World Health Report on financing for universal coverage encourages low- and middle-income countries to engage in structured policy processes to develop health financing strategies (HFSs), often with the support of the WHO and other international development assistance partners. HFSs generally define how resources should be collected, pooled, and spent to advance toward universal health coverage. The WHO published its first detailed guidance for developing HFSs in 2017. According to the WHO, an HFS should be based on a diagnosis of a health system’s current challenges to achieving its goals, focus on the entire population rather than a subset, identify detailed objectives and actions to overcome current challenges, and include an evaluation strategy. Ultimately, an effective strategy should increase people’s ability to use health care based on need, protect the population from financial ruin, and improve the quality of health care.

In the years between the 2010 World Health Report and the release of the WHO’s guidance in 2017, international development partners have nudged politicians and health officials in many low- and middle-income countries to develop strategies for financing their health care systems. However, there have been few attempts to extract cross-country learnings from the experiences of developing such strategies. Since 2010, United States Agency for International Development (USAID)-funded projects have supported the development of HFSs in eight countries (Bangladesh, Botswana, Cambodia, Haiti, Nigeria, Senegal, Tanzania, and Vietnam), with the Health Financing and Governance Project (HFG) supporting seven countries and Health Systems Strengthening Plus (HSS+) supporting Senegal. Given that these HFS development processes were initiated before the release of the WHO’s guidance in 2017, each government took a somewhat different approach to developing their HFSs. This article analyzes these eight national experiences and highlights the lessons and challenges derived from their HFS development processes. Most of the HFSs discussed in this article are still in the development phase, were completed but not formally approved, or were only recently approved. Acknowledging that successful implementation of the HFSs and eventual impact on health and economic outcomes are the ultimate means of assessing HFSs, the implementation and impact of the HFSs discussed here will not be observable for several years. Therefore, providing guidance on implementation of HFSs or evaluating them based on implementation and outcomes is beyond the scope of this article. Rather, this article documents the experiences of these eight countries in drafting their HFSs and offers observations concerning approaches that worked well and those that might require additional thought and consideration. These lessons can serve as valuable guides for the many countries that are currently in the process of developing an HFS or will be updating one in the future. Furthermore, this article provides information based on country experiences that can be incorporated into future guidance on HFS development.

An HFS, if implemented, could have far-reaching impacts on the health sector, economy, and lives of ordinary citizens. As a result, the HFS development process is a delicate art of balancing stakeholder interests, making decisions with incomplete information, and determining when and how to communicate key technical recommendations and proposed policy choices for health financing to political decision makers. The lessons and challenges highlighted in this article can assist countries in their efforts to produce HFSs that advance universal health coverage while being politically acceptable.
and can allow development agencies and international agencies to ensure that the guidance they provide to countries is as relevant as possible.

**METHODS**

HFG is a USAID-funded global health systems–strengthening project assisting more than 30 countries to improve health outcomes by improving financing, governance, and management of their health systems. HSS+ has similar objectives in Senegal. The USAID-financed projects have provided varying degrees and types of technical assistance to the HFS development process in eight countries. This assistance, conducted in close collaboration with national policy makers, has included facilitating stakeholder workshops, conducting research and analysis, providing training sessions on health financing concepts, advising ministries of health and finance on process design, and arranging cross-country sharing of information and lessons, as demonstrated in Table 1.

This article presents lessons gleaned from USAID-financed projects’ experience interacting with the HFS processes and working closely with policy makers in these countries. The authors adapted recommendations from the WHO’s reference guide for developing health financing strategies to create a framework for analyzing eight HFS processes based on firsthand observations and supplemented these observations with a document review and interviews and discussions with other HFG staff. The framework for this article, shown in Table 2, facilitates the analysis of the HFSs’ composition based on their inclusion of six ideal attributes and their processes’ adherence to four “good practices” for managing and facilitating HFS development.

**Review of Eight Health Financing Strategies**

HFG’s review, summarized in Table 3, identified several similarities across eight countries in the composition of their health financing strategies and in the HFS development process. Although the HFS development processes were largely in line with the good practices, one of the six ideal attributes was absent from all of the HFSs reviewed. This section highlights some of the similarities and differences among the HFSs and their alignment (or misalignment) with the ideal attributes and good practices for HFS development.

**Composition of Health Financing Strategies**

Ideally, all HFSs should be informed by a diagnosis of a country’s current health financing situation and

| Country | HFG/Consortium Role | Other Partners |
|---------|---------------------|----------------|
| Bangladesh | Facilitated technical working groups, edited document, facilitated completion workshop, facilitated dissemination | World Bank |
| Botswana | Facilitated technical working group; provided capacity building and technical assistance on health insurance, benefits package design, and provider payment; conducted landscape analysis, NHA, efficiency review | WHO, Joint United Nations Programme on HIV and AIDS |
| Cambodia | Provided capacity building for working group | International Labor Organization, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, Japanese International Cooperation Agency, WHO, World Bank |
| Haiti | Conducted situation analysis, facilitated international conference on health financing, provided capacity building of technical drafting committee, facilitated drafting of document | World Bank, Pan American Health Organization/WHO |
| Nigeria | Developed a governance framework and narrative for the policy that outlined which institutions would be responsible for implementation, developed theory of change of strategy | WHO, World Bank |
| Tanzania | Specific technical assistance | Providing for Health, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, WHO, USAID Health Policy Project |
| Senegal | Provided input in design and technical content for HFS development process | WHO, Japanese International Cooperation Agency, World Bank |
| Vietnam | Supported planning for HFS implementation | WHO, World Bank, European Union, Japanese International Cooperation Agency |

**TABLE 1.** HFG and Other Development Partners’ Roles in HFS Development
The WHO has developed a guide to facilitate situational analysis was a critical starting point for HFS development in all eight countries reviewed, regardless of the quantity or quality of existing health financing data. The most recent National Health Account (NHA) information was the most common data source used to inform the situational analysis across the eight countries. Countries also used public expenditure reviews, household surveys such as demographic and health surveys and living standards surveys, fiscal space analyses, and estimation of current and future costs and revenues. Botswana, Cambodia, Senegal, and Tanzania included examples from international experience or comparisons to peer countries in their situation analyses. Overall, the countries analyzed their current situation and, with one exception, did not let the absence of up-to-date data keep them from advancing with the development of a strategy.

The eight countries studied were able to establish specific objectives for their HFS documents, providing a snapshot of some of the most pressing health financing–related concerns and priorities in low- and middle-income countries. The most common HFS objective related to financial sustainability of the health system, especially in the context of declining donor funding. Six of the eight countries (Cambodia and Haiti are the exceptions) included objectives that related to increased pooling, such as an expansion of national health insurance, to provide financial protection or reduce out-of-pocket spending. Half of the HFSs (Bangladesh, Botswana, Nigeria, and Tanzania) have objectives related to improving efficiency. Few of the countries studied prioritized targeting financing for the poor (only Tanzania and Senegal), and only Vietnam’s strategy included improving quality of health care as an objective. Other hot topics in health financing, such as the involvement of the private sector, are only mentioned at the objective level by Botswana’s strategy. Overall, the

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### Ideal Attributes of HFS Composition

1. Informed by a diagnosis of performance relative to health system objectives
2. Applies to the entire population and the “national health system”
3. Defines specific objectives and actions for addressing identified problems
4. Contains an evaluation strategy
5. Included in or linked to national health policy or other strategic health sector document or national development plan
6. Comprehensively addresses revenue raising, pooling, purchasing, benefit design and entitlement, and governance

### Good Practices for Facilitating HFS Development Processes

1. Engage key stakeholders (defined inclusively to go beyond government), especially government agencies responsible for health and finance
2. Form a multisectoral task force or steering committee with clear terms of reference, a timeline, and support from full-time dedicated staff
3. Employ best available knowledge, expertise, and data, including additional analyses beyond those immediately available
4. Prepare for a multiround consultation and revision process to achieve final approval

### TABLE 2. Framework for Analyzing Eight HFSs Supported by USAID

| Country     | Diagnosis of Performance | Entire Population | Specific Objectives | Evaluation Plan | Linked to National Policy | Includes All WHO Health Financing Technical Areas | Inclusive Stakeholders | Multisectoral Committee | Additional Analyses | Multiround Consultation |
|-------------|--------------------------|-------------------|--------------------|----------------|--------------------------|-------------------------------------------------|-----------------------|------------------------|----------------------|------------------------|
| Bangladesh  | X                        | X                 | X                  |               | X                        | X                                               | X                     | X                      | X                    | X                      |
| Botswana    | X                        | X                 | X                  | X             | X                        | X                                               | X                     | X                      | X                    | X                      |
| Cambodia    | X                        | X                 | X                  |               | X                        | X                                               | X                     | X                      | X                    | X                      |
| Haiti       | X                        | X                 | X                  |               | X                        | X                                               | X                     | X                      | X                    | X                      |
| Nigeria     | X                        | X                 | X                  |               | X                        | X                                               | X                     | X                      | X                    | X                      |
| Tanzania    | X                        | X                 | X                  |               | X                        | X                                               | X                     | X                      | X                    | X                      |
| Senegal     | X                        | X                 | X                  |               | X                        | X                                               | X                     | X                      | X                    | X                      |
| Vietnam     | X                        | X                 | X                  |               | X                        | X                                               | X                     | X                      | X                    | X                      |

### TABLE 3. Review of Health Financing Strategies in Eight Countries
review revealed that these countries are prioritizing financial sustainability, financial protection through pooling/insurance, and improving efficiency in their health financing strategies.

Strikingly, none of the HFSs reviewed included a specific evaluation plan, and only four of the eight have any guidance for monitoring the strategy. This is in contrast to the WHO’s emphasis on the importance of learning from implementation experience, making mid-course changes to the strategy, and being accountable to the public.7 Senegal’s HFS was the closest to including a monitoring strategy but still lacked important details such as a final list of monitoring indicators. The Senegal HFS assigns the task of monitoring and evaluation to the multipartner universal health care steering committee, which includes an annex of potential monitoring indicators, and calls for a mid-course internal evaluation and an external final evaluation. The Bangladesh strategy includes indicators but no time frame or an explicit plan for evaluation. The Cambodia strategy includes the provision for the creation of a council to oversee the whole social protection strategy, including pensions, health, and social assistance efforts. Among the council’s functions is the evaluation of the strategy every five to ten years, but this falls considerably short of an evaluation plan. The Vietnam HFS includes a table that has broad categories of indicators for monitoring, but it also falls short of a specific evaluation strategy.

All of the health financing strategies are documents explicitly linked to broader sector or national strategies and are not stand-alone efforts, although none of the eight HFSs meets the ideal of being embedded within a national health policy, other strategic health sector document, or national development plan. For example, the Cambodia health financing strategy is part of an overall national social protection strategy, and the development of health financing strategies in Haiti, Botswana, and Tanzania was called for in the countries’ health sector strategies. Botswana’s HFS cites its long-term development plan “Vision 2036: Achieving Prosperity for All”10 and Senegal’s HFS cites its “Emergent Senegal”11 vision. Vietnam’s strategy is considered a document of the country’s 12th Party Congress on socioeconomic orientation.

Ideally, all HFSs should address the WHO framework’s five aspects of health financing: revenue raising, pooling, purchasing, benefit design and entitlement, and governance.7 Though all eight HFSs include revenue raising, pooling, and purchasing explicitly or implicitly, only two of the strategies address all five areas recommended by WHO. Senegal’s and Botswana’s HFSs explicitly address benefits design, calling for the development or revision of a basic package of services to be covered for all. Both strategies also address governance: Senegal’s strategy specifies a multipartner universal health care steering group chaired by the prime minister and supported by a secretariat at the ministry of health, and Botswana’s calls for improved public financial management. Cambodia’s strategy does not address benefits design but does address governance, calling for a multiministerial national social protection council. The other HFSs do not address governance or benefit design/entitlement and thus are potentially leaving important aspects of health financing out of their strategies.

The composition of the HFSs includes several ideal attributes such as a situation analysis, addressing the whole population, having specified objectives, and being linked to other national policies. They deviate, however, from the ideal in terms of including explicit evaluation strategies and addressing benefits packages and governance mechanisms, though each of these items is partially addressed by one or more of the HFSs. The recurring themes that appear in the objectives of the HFSs provide a glimpse of the health financing priorities in low- and middle-income countries. These include sustainability in the context of stagnating donor spending, financial protection through risk pooling, and efficient use of resources.

Health Financing Strategy Development Process

All of the HFSs examined showed the importance of involving a multitude of stakeholders, including those from outside the health sector, in the HFS development process. As expected, the government agencies responsible for health (usually ministry of health) led the development of most HFSs, with the exception of Cambodia. In that country, the Ministry of Economy and Finance led the development of the social protection strategy of which the HFS was a component. Surprisingly, some countries did not include the government agencies responsible for finance in the development of their strategies. Despite being the agency responsible for allocating budgets to the rest of the government, ministries of finance were only included in five of the eight HFSs. International assistance partners were involved in the HFS development process in all countries, albeit with different roles in each country. The private sector actively participated in the HFS processes in only three countries: Botswana, Tanzania, and Senegal.

All of the HFS processes examined were guided by a multisectoral steering committee or technical working group, with the exception of Haiti. The processes resulted in a draft strategy after nine months to two years of work, regardless of timelines established by the countries. The Senegal HFS development effort had an aggressive timeline of six months and used a USAID-financed Senegalese staff, but the country
was able to complete a draft strategy after nine months of work and achieve formal approval in a little more than a year. Cambodia did not have a specific timeline but arrived at an approved social protection strategy in about two years using Ministry of Economy and Finance staff as a secretariat. In Bangladesh, the HFS was designed and approved in a year from the launch workshop and was supported by the Ministry of Health’s Health Economics Unit and donor-financed consultants. In Haiti, the process has taken over three years and has yet to be completed. Delays have been the result of changes in government and lack of political will. Botswana’s strategy was started in 2012 but work stalled for nearly three years due to loss of donor technical support. After HFG assistance began in 2015, a draft was developed by donor-funded consultants and the Ministry of Health and Wellness’s health economics staff and submitted to the minister of health one year after the first stakeholder meetings.

Half of the countries found it necessary to conduct additional analysis to inform the development of their HFS. Tanzania commissioned working papers in multiple thematic areas, although the papers took approximately one year to complete. Haiti and Botswana supplemented their situational analyses with stakeholder discussions and interviews, and HFG assisted Botswana to conduct a financial gap analysis and produce reports on options for improving health sector efficiency and potential national health insurance design.12–14 HFG supported Nigeria with a political economy analysis to inform the strategy. Although Senegal, Cambodia, and Vietnam did not conduct additional analyses to inform strategy development, they did make use of existing international experience to assist their HFS processes. Senegal made bibliographies of global experiences available to its thematic working groups, and Cambodia and Vietnam extracted lessons from international experience with implementation of aspects of their strategies. In Haiti, requests for new analysis have stalled the strategy development process, and some stakeholders have expressed that additional analysis is not necessary.

All eight countries used a multiround consultation and revision process to move toward final approval, and the approval process has been slow moving and complex in most countries. For example, Senegal’s HFS went through ten drafts between March and July 2017 before initiating the formal ministry of health approval process. It still needs to be approved before it can be implemented. Botswana submitted its strategy to the minister of health in October 2016. At the time of writing, the health financing technical working group is still responding to the minister’s questions and concerns.

DISCUSSION

Systematically reviewing and reflecting upon these eight countries’ experiences with developing HFSs has revealed several lessons and challenges that may be useful for other countries wishing to develop or update existing HFSs. Here we explore five themes that emerged from this analysis.

Use of Data

This review of health financing strategies highlights two lessons related to the production and use of data. First, HFS development processes have nurtured an appetite for health financing data among policy makers in low- and middle-income countries. Most HFS processes reviewed in this article generated opportunities for policy makers to review and discuss national health accounts data, fiscal space analyses, and household survey results when analyzing their health financing situations. These discussions allowed policy makers in ministries of health and other institutions to see the usefulness of interpreting multiyear trends in health financing data and analyzing sub-national and cross-country data and revealed when health financing data were out-of-date or missing. The authors’ experiences suggest that observing the importance of health financing evidence during the course of an HFS process can solidify commitment among policy makers to generate accurate, timely health financing data.

Second, this review of HFS development processes revealed the need to advance strategy development regardless of the quality of data available. The countries examined in this article largely accepted that developing a strategy using the best data available was better than having no strategy, despite the fact that some health financing data were missing or out of date. For example, Botswana advanced with its HFS development using NHA projections from 2010 while collecting 2013–2014 NHA data in parallel.15 Several countries were able to commission and complete additional studies relatively quickly to inform HFS development but limited these exercises to those that could be completed within a year. The additional studies included financial gap analyses, political economy analyses, and policy options or thematic working papers. In contrast, Haiti’s Ministry of Health and other stakeholders have delayed HFS development with various requests for additional information, such as a costing of the essential health package and estimations of the amount of resources that could be raised through innovative financing. Though important and useful, this information is not critical to the development of an HFS.
Cross-Country Learning
The experiences of countries reviewed in this article demonstrate that cross-country learning is valuable for developing an HFS, despite the uniqueness of each country’s context. With the support of development partners, countries employed several creative mechanisms for benefiting from international experience in the development of their HFSs. For example, Cambodian officials participated in study tours to Indonesia, Thailand, South Korea, and Japan to gather ideas for designing their health financing arrangements. In Botswana, officials closely reviewed and discussed health insurance designs in Ghana and Thailand to explore whether and how they might be relevant for the country. They also learned from South Africa’s experience and invited private medical aid schemes to be heavily involved in the HFS process to avoid the resistance to reform demonstrated by similar entities in South Africa. Vietnam asked for an analysis of how other countries had sequenced the implementation of components of their HFSs. Senegal expedited its HFS development process by relying on bibliographies of technical content and guidance gathered from other countries and international organizations rather than commissioning its own studies. Senegal’s steering committee saved time defining its HFS vision by borrowing ideas from the policies of other countries that resonated most with the local context.

Fostering cross-country learning and exchange of ideas is one of the principle roles of development partners for supporting HFS processes. Development partners can promote the diffusion of health financing innovations and good practices by serving as neutral facilitators of knowledge exchange among low- and middle-income countries. HFG found that connecting government officials in countries developing HFSs with information and people from low- and middle-income countries that had recently undergone health financing reform and interpreting the context of these reforms were seen as valuable contributions to the HFS development processes.

Evaluation and Improvement
The 2010 World Health Report envisioned designing and implementing a health financing strategy to be a cyclical process of constant reevaluation and adaptation of existing policies. The WHO’s guidance for HFSs suggested that all countries include an evaluation strategy. In practice, none of the eight HFSs reviewed here included a well-developed evaluation strategy with defined indicators, timelines for review, and clear responsibility assigned to an institution for monitoring and evaluation. The countries instead structured the development of an HFS as a one-off or ad hoc task, albeit to varying degrees, with no clearly defined plan or legal mandate for revising the strategies or repeating the strategy development processes.

There are several reasons why the countries reviewed in this article may not have included defined monitoring and evaluation plans for their HFSs. First, the multisectoral committees and technical working groups established to develop the HFS were inclusive of many interests and stakeholders but in most countries were not institutionalized and resourced to engage in ongoing assessments and revisions of the strategies. (Senegal and Cambodia were exceptions that at least assigned responsibilities for monitoring the strategy.) Some countries have too few staff and lack the capacity in the policy or health financing departments of their ministries of health to produce health financing data or even qualitatively evaluate their HFSs without significant support from development partners. Second, it is possible that countries will monitor and evaluate their HFSs but have not found it necessary to include an evaluation plan as a section of the HFS. The WHO’s health financing guide states that an HFS should “live somewhere between high level documents which outline a vision for the health sector, and implementation documents which provide detailed plans.” The countries reviewed here may decide to develop evaluation plans that are linked directly to implementation documents developed after receiving formal approval of the strategies, rather than to the broader HFS. Finally, countries may prefer to integrate monitoring and evaluation of the HFS into a comprehensive monitoring and evaluation framework for the health sector to avoid the proliferation of multiple plans. Overall, the countries reviewed in this document do not have the resources or capacity to monitor and evaluate their HFSs or will use another mechanism, separate from the HFS itself, to monitor and continuously improve the HFS.

Leadership Involvement
HFSs have the potential to impact all areas of a national health sector and large segments of the economy and can produce visible changes in the lives of people and bottom lines of companies. HFSs are inherently political and the stakeholders developing the HFS, especially ministers of health and ministers of finance, cannot avoid engaging with politicians, parliaments, and interest groups during the HFS development, approval, or implementation processes. Hence, countries need to consider how closely cabinet-level ministers should be involved in the development of the HFS. Involving ministers or their top advisors closely in the process from the beginning provides several advantages. Ministers of health and finance can provide guidance on the types of reforms that will or will not be
palatable for the political leadership, thus steering the strategy toward politically viable and financially feasible solutions and away from reforms that may in theory achieve the health system’s objectives but never be implemented due to political opposition. Furthermore, close minister-level involvement will prepare ministers of health and finance to advocate for the reforms defined in the strategy in front of legislatures, executives, and the general public. For example, the active leadership of the Cambodian Secretary of State of the Ministry of Economy and Finance as the chair of the Social Protection Working Group may have helped the social protection strategy, which included health financing, to win swift approval. On the other hand, close involvement of minister-level leaders presents several risks. Ministers of health and their top advisors have many responsibilities and busy agendas. Structuring an HFS process around a minister’s availability could delay the process and prevent the steering committee or working group from meeting regularly. As political appointees, ministers of health and finance can be replaced with frequency. Tying the HFS development process too closely to the minister of health risks jeopardizing the process if the minister is replaced. This occurred in Haiti, delaying the HFS development process.

Progressing with the HFS process without close involvement of high-level ministers has its own advantages and risks. Excluding high-level politicians from initial technical discussions could allow technical staff to work on solutions that would be dismissed quickly by politicians due to fear of political resistance. It could also give space for technical experts representing different stakeholders to brainstorm compromise solutions among competing organizations or industries. Politicians may be less willing to engage in such discussions. Moreover, not being involved in technical discussions could allow ministers of health to portray the working group or committee as an independent body of experts not influenced by politics. The HFS could then be used to advocate for changes to the political environment to accommodate technically superior health financing arrangements, rather than allowing the political environment to dictate or limit specific technical reforms to those with superficial political appeal. On the other hand, not involving high-level ministers in the HFS development process makes it more difficult for the minister to understand the details of proposed reforms and how and why the group decided to pursue certain paths. In Botswana, technical staff from across the government, private, and nonprofit sectors designed the HFS with limited input from the minister of health. When presented with a draft, the minister responded with many questions about the findings of the situational analysis, the decision-making process for developing the HFS, and the implications of the suggested reforms. At the time of writing, the health financing technical working group has been working for nearly nine months to address the minister’s concerns and win approval of the strategy.

Stakeholder Management
Management of stakeholders is an important aspect for countries to consider when developing an HFS. Ministries of health will typically need to decide who to invite to participate in the HFS development process and how to assign tasks to specific stakeholders. The WHO recommends the involvement of an inclusive group of government agencies including health, finance, local government, social security, and education, in addition to legislative bodies and nongovernmental partners. The WHO also suggests including in the development of the strategy those organizations responsible for its implementation. The eight countries reviewed in this article invited a host of government agencies, including ministries of defense and justice in Cambodia, regional and local governments in Tanzania and Senegal, and the Competition Authority (antitrust agency) in Botswana. Foreign assistance agencies, private insurers, and nongovernmental agencies were also invited. Service provider representatives did not participate in the process in any of the countries, despite the potential impact of an HFS on their work. The countries reviewed in this article sought to build inclusive coalitions for HFS development in order to foster a broad sense of ownership for the strategy and prevent resistance from stakeholder groups to the strategy’s approval. It is not clear how including certain stakeholders in the process may have influenced the technical content of the strategy and thus the strategy’s likelihood of contributing to health system objectives. For example, HFS development processes with large participation of the private insurance sector may be skewed in favor of private insurance options at the expense of health sector efficiency.

The second aspect of stakeholder management involves how to organize stakeholders and delegate specific tasks required for HFS development. Senegal divided stakeholders into thematic working groups focusing on revenue collection, pooling, purchasing, governance, monitoring and evaluation, and social determinants. In Botswana, private insurers were asked to present on health insurance operations. In Cambodia, development assistance partners were only invited to comment on drafts of the document. Despite their differences, all of these approaches resulted in HFS documents that were aligned with health sector objectives.

CONCLUSION
In the years since the release of the 2010 World Health Report and subsequent guidance from the WHO, the global
health community has reached a consensus that low- and middle-income countries can benefit from developing HFSs roughly aligned with the framework discussed here. Based on work supporting eight countries, this article highlights valuable lessons and considerations for future HFS development efforts, including guidance on useful data for situational analyses, ways to take advantage of cross-country knowledge exchange, ideas for how and when to involve cabinet ministers, and examples of how to manage broad stakeholder groups. It also provides critical information, based on real-world experiences, to guide international organizations supporting HFS development in low- and middle-income countries. For example, this analysis found that countries often are not including monitoring and evaluation plans within their HFSs and provides guidance on how development partners can encourage and facilitate cross-country learning for HFS development.

As more countries produce or update their HFSs, development partners and governments should continue identifying good practices for the development process and, most important, the implementation of the strategies. Governments would benefit from more guidance for navigating the political aspects of the development process, such as which stakeholders to include and how to reconcile conflicting political preferences. Countries wishing to develop HFSs would also benefit from a comparison of different approaches to developing HFSs and their impact on implementation of the strategies. Finally, more extensive documentation of local policy makers’ experiences and feedback on HFS development processes, including their opinions on the best structure, utility, and outcomes of such processes, would provide an essential perspective on HFS development processes not captured here.

The ultimate impacts of the eight HFSs reviewed here may not be visible for years, but past experience suggests that HFSs can be a catalyst for major health system reforms.16 The lessons and challenges highlighted in this article can help low- and middle-income countries to develop HFSs that are technically strong, politically viable, and potentially critical steps toward advancing universal health coverage.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors report no conflict of interest.

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