

**Health Finance Policy  
options for Sudan  
2016**

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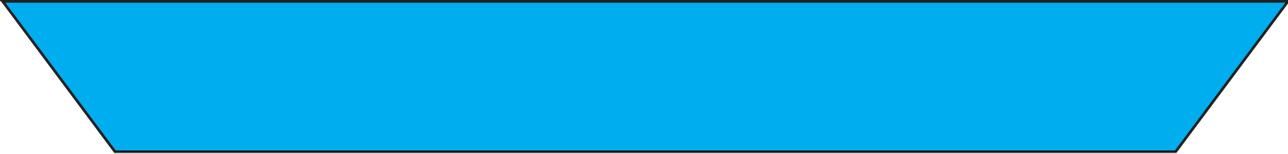
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Sudan

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## List of abbreviations

BP	Basic Package
CSR	Sudan Country Status Report
EHBP	Essential Health Basic Package
EMRO	Eastern Mediterranean Regional Office
FMOF	Federal Ministry Of Finance
FMOH	Federal Ministry Of Health
GDP	Gross Domestic Product
GGHE	General Government Health Expenditures
HF	Health Finance
HI	Health Insurance
HIF	Health Insurance Fund
HPA	Health Purchasing Agency
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MOF	Ministry Of Finance
MOH	Ministry Of Health
NHIF	National Health Insurance Fund
OASIS	Institutional and Organizational Assessment for Improving and Strengthening Health Financing
PHC	Primary Health Care
PHI	Public Health Institute
SOPs	Standard operating procedures
THE	Total Health Expenditure
UHC	Universal Health Coverage
USD	United State Dollar
WHO	World Health Organization

## Introduction

As Sudan is developing the next health sectors development strategy and planning for setting up a health system reform, health financing was one of the top agenda on the reform to achieve UHC. The health financing policy is providing the direction of the country on how the functions of the health system will perform and to address critical gaps and shape the feature of the system that is to be efficient and equitable resources allocation for health. The health finance policy is the main governing document providing a reference for all matters regarding the way the health is financed including the provision of services and insuring its accessibility and quality.

The process of developing this policy document started in 2014. The Health financing system had been assessed extensively in 2014 using OASIS tool. The report described and analysed the performance of the health financing, the bottlenecks and the challenges facing it and affecting its performance. Based on the OASIS report, a policy note on policy options was developed in order to direct the country toward one health financing policy. Different stakeholders and relevant sectors were involved in the process of the development of the policy. This policy is governing the development of the Health Finance Strategy.

## The country Sudan

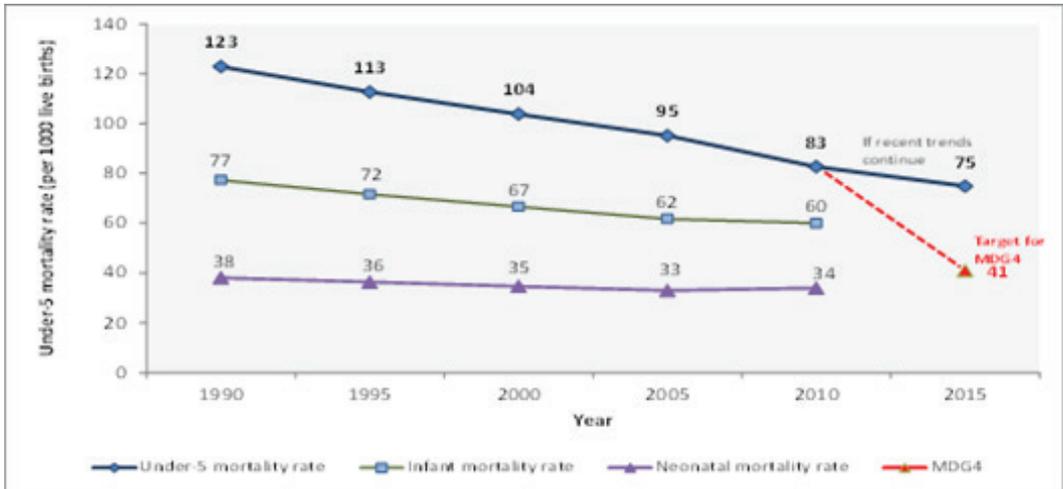
Sudan is a low middle income country with a per capita gross domestic product (GDP) of \$1,940 in 2014. It has an annual economic growth rate of 2.3 percent (2014). After production of oils, Sudan achieved very fast economic growth rates especially in period 2005 and 2007 (7 to 12%). the country faced significant economic shocks between 2010 and 2012, due to the separation of South Sudan and the loss of oil revenue, with GDP growth rates falling to -1.2% in (2010) and -3.5% in (2012), respectively. Sudan, however, recovered relatively quickly. Moreover, the projections of the International Monetary Fund (IMF) indicate that GDP growth rates are expected to rise to 3.9 percent in 2016, with expected annual GDP growth rate of roughly 5 percent until 2020 (*IMF World Economic Outlook, 2015*).

The population of Sudan is about 36 millions with 46.5% of them live below poverty line (earning less than 1\$ per day) and 8% lives in extreme poverty. The poverty distribution shows general inequality and disparities between the rural and urban areas as well as between the different states and the geographical regions of the country. A high rate of poverty is more evident in the semi-rural areas and rural areas, 67.4% and 64.8% respectively, and to lesser extent in urban areas (42.3%) (WB, 2012).

## Health status

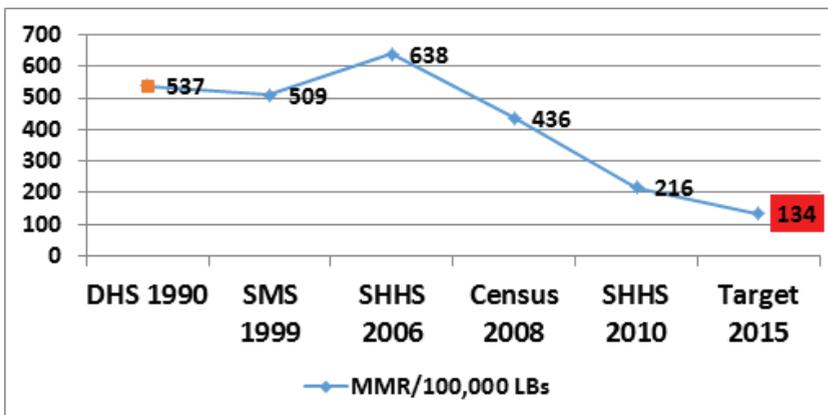
Children less than fifteen years comprise about 43.2% of total population. Infant morbidity and mortality are due mainly to the persistence of infectious and parasitic diseases, malnutrition and a number of socio-economic, geographic, demographic and individual predisposing factors. The below figure shows that Sudan didn't achieve the targets of MDGs of child health.

**Figure 1**



The same applies for maternal mortality. Although improvement achieved still Sudan is far from achieving the target as presented in the below figure.

**Figure 2**

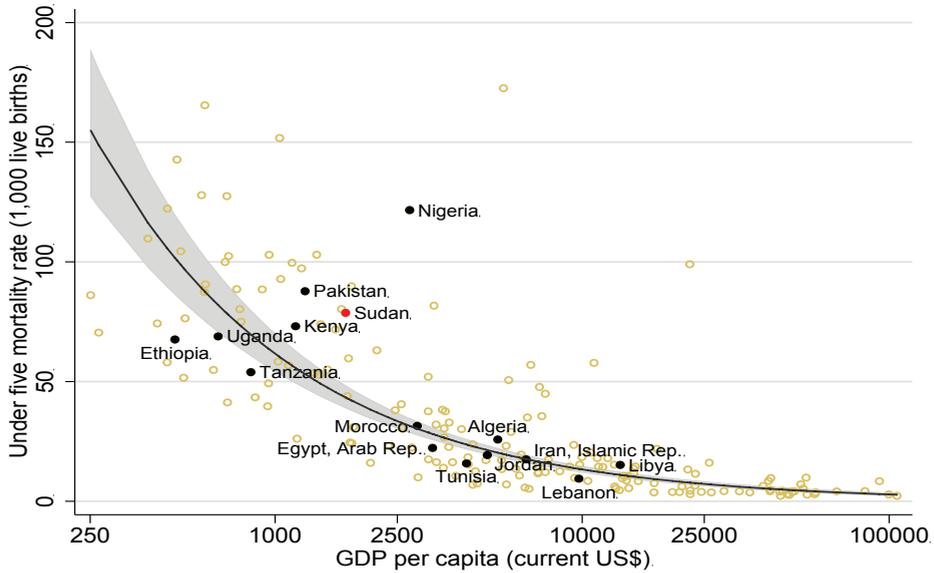


Source: World Bank development indicators (2014). Note: x-axis log scale. Gray area indicated 95% confidence interval for fitted line

### Sudan in comparison with countries with similar income

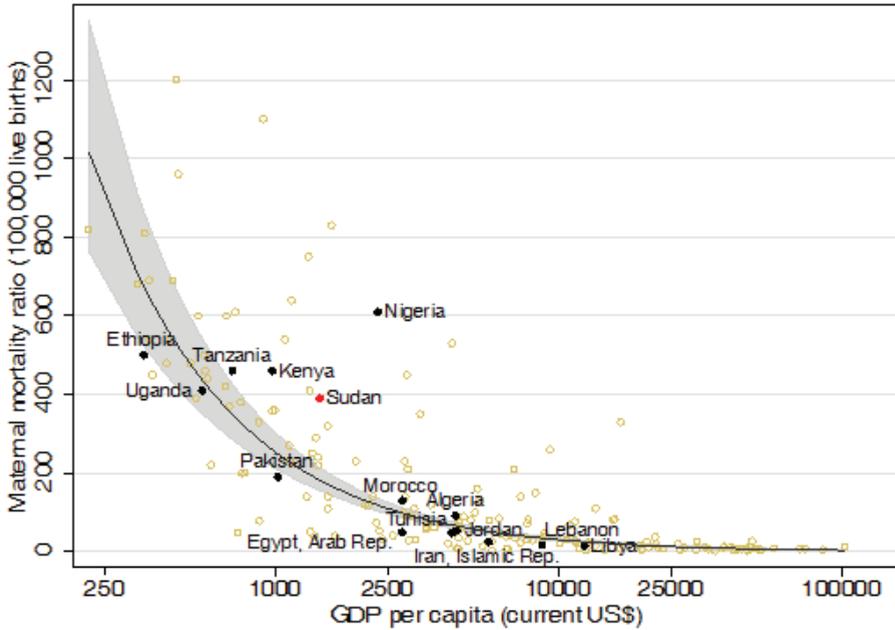
As shown in the below figures Sudan performing less than countries with similar income in improving maternal and child health.

**Figure 3: Under-five mortality rate in Sudan is higher than countries of similar income or in the same region: U5MR per Capita (2012)**



Source: World Bank development indicators (2014). Note: x-axis log scale. Gray area indicated 95% confidence interval for fitted line

**Figure 4: Maternal mortality ratio in Sudan is higher than countries of similar income or in the same region: MMR Vs Income Per Capita (2010)**



Source: World Bank development indicators (2014). Note: x-axis log scale. Gray area indicated 95% confidence interval for fitted line

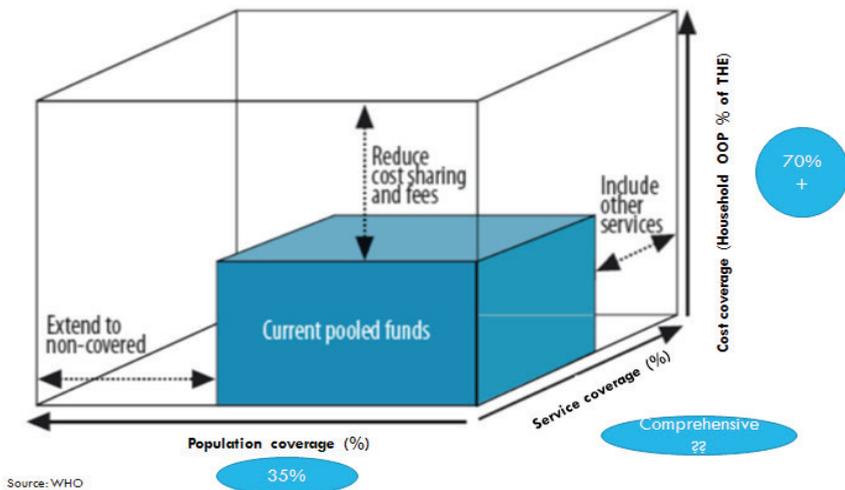
## Equity

Health indicators vary vigorously between the states. Lack of equity is also true within the states; between rural and urban areas and between different localities. Inequity of utilization of services is also significant according to income group. In case of ambulatory care, those belonging to the richest quintile utilized health services nearly four-fold greater than those from poorest quintile. The utilization of private health providers among the richest quintile is four-fold higher compared to the poorest quintile. Greater use of inpatient services by the richer populations suggests that they tend to benefit more from public subsidy.

## Progress toward universal health coverage (UHC)

As shown below, the WHO cube depicts the three dimensions of UHC including population coverage by prepayment mechanism, depth of services provided and the cost of service covered by prepayment arrangements.

**Figure 5: Three dimensions of Universal Health Coverage (UHC)**



National health insurance fund (NHIF) currently covers about 35% of population with comprehensive package of service including outpatient and inpatient services. For the provision of services, the health care sector is organized at three levels: primary, secondary and tertiary level. On the other hand ministry of health from supply side also provides free and subsidized health services through its network of facilities. According to facility survey (mapping) conducted by FMOH in 2011 about 14% of population lack geographic coverage by health facilities, with significant disparity between states. With regard to package provided; FMOH identified 5 essential components of PHC package. According to the same mapping survey, only 24% of PHC facilities provide this package of services. Ministry of health also through its hospitals spreading throughout the country

provides wide range of inpatient services. Moreover free treatment program for selected tertiary services with high risk to cause impoverishment is running.

However, financial protection is very low. According to national health account 2011, the out of pocket expenditure represents about 70% of total health expenditure.

## **Current situation of financing system**

### **Background**

The Federal Ministry of Health represented in public health institute (PHI) conducted a review of the national health financing system with the objective of identifying strengths and weaknesses as a prelude to developing a national strategy for health financing. This review of the of health financing system has indicated the decreasing level of funding in real terms counting the rising inflation, low coverage both by health services and insurance, resulting in the health system faltering in protecting the population from financial risk due to ill health. The efficiency, both economic and administrative, is an issue, while equity is eroded proven by the fact that the poorest 20% or the lowest income quintile receives only 13% of public sector expenditure on health, while the richest or highest income quintile receive 26%. Finally, institutional and organisational bottlenecks are identified through which this review may contribute to defining policy options for a robust strategy for financing health in Sudan.

### **Tax-based healthcare financing**

The national revenue in Sudan is generated from tax and non-tax sources. Non-tax revenues are mainly natural resources, of which oil is the major contributor. Indirect taxes have been a major source of tax revenue in the Sudan, while there is a narrow base for direct taxes. Sudan economy boomed in 1999 due to the increases in oil production and significant inflows of foreign direct investment. Despite sanctions and additional safeguard policies of the west, it was one of the world's fastest growing

economies until the second half of 2008, scoring an average annual growth rate in the range of 5-7%. However, this economic growth benefited mainly the capital cities, leading to the increasing disparities between rural and urban areas as well as between states and the geographical regions of the country. With the secession of South from the mother country Sudan to form an independent state of South Sudan in July 2011, 75% of oil production was taken away by the new nation, and that had an impact on government revenues as oil contributed about 30% of the national budget. Within the tax-based system of financing, resources for health are generated through public, private and other sources. In the public sector revenue is collected through levying taxes and exploiting non-tax sources. The former has stagnated, but the latter was increasing up until the Southern Sudan separated from the mother country Sudan in 2011.

Further, this state of economy is likely to impact the future economic forecast and fiscal space and resources available for social services including health. Tax evasion is calculated by estimating the size of the underground economy and its GDP. In Sudan, the tax evasion is of substantial size. It is still increasing and currently stands at about 53% of the actual tax yield and 33% of potential tax yield.

Sudan spends almost 6.5% of its GDP on health. The main sources of GGHE are federal and state, contributing 5.49% and 20.84% of government general expenditure respectively. Total private health expenditure is 73.14% of THE, out of which 70% is out-of-pocket and translates to 84.24US\$ per capita. 4.1% households face catastrophic expenditure and 2.2% households become impoverished due to health expenses. Contribution from partners and donors was 4.5% of THE, while the public sector funding in 2011 was 22.34%, which is up by 15% compared to that in 2008 but far below government commitment of 15% at Abuja. Sudan is not a big beneficiary from external funds compared to the neighbouring countries, especially those from sub-Saharan Africa. Its health system receives only US\$3 per capita versus US\$12 for Kenya, US\$8 for Senegal and Ghana, and US\$6 for Mauritania.

The major financing schemes, in addition to the private insurance market includes: Ministries of health, National Health Insurance Fund, armed forces employees' health insurance schemes and other parastatal institutions, as well as out of pocket household health expenditures.

The major contributors to the public sector share of health care financing are the state and Federal Ministries of Finance, with the former paying a little over 39% and the latter a little less than 48%. Localities or districts contribute about 3%, while parastatal bodies like the army; police etc. contribute over 3.5% of health care financing. Zakat is the source for 4.5% and other public sector bodies contribute about 2.4%.

The federal transfer is channelled to the states, from where it reaches health facilities via the respective locality. While the national average is 11.64USD per person, the allocation of public funds between states is uneven. It ranged from 2.47US\$ per person in South Darfur to 23.40US\$ per person in (Northern) state in 2011. This disparity extends also to how expenditure is incurred. Sudan health care delivery system is biased towards curative care. Allocation to the health sector and the extent to which these resources reach health facilities is a function of the state. The amount received at facilities is 27% of what is meant in real terms for facilities. A user fee is charged at all health facilities, and is paid either out of pocket or through insurance if covered or exempted/waived, although the mechanisms and eligibility criteria are not well defined.

### **Social health insurance**

Under the National Insurance Corporation Act, 1994 membership of the NHIF is compulsory for the formal sector, while it is voluntary for the informal sector and small companies ( $\leq 10$  employees). The subscriber unit is the "family" and beneficiaries include the principal member and dependents. Over 11.8 million citizens or 37.3% of the population is covered. Out of the total covered, 30% are from the formal sector, while the informal sector represents 22.5%, and the remaining belongs to various sectors. The coverage varies between states with River Nile at 41.2% and South Darfur

with 11.3% of the population. Federal Ministry of Finance is the major contributor with about 72% of funds, followed by the parastatal organizations with 12.65%, while households contribute as premium and co-payment over 9% of revenue to the NHIF. Zakat contributes over 6.4%, with quite a little from the private sector. Collection is considered to be poor compared to the potential amount.

The main collection mechanism: is deduction from payroll for the formal sector. For the informal sector, contributions are paid to the account of the SHIF or through organized local organizations like market associations. For special groups, the NHIF is paid through Zakat, National Students' Fund, Pensioners' Fund and the MOF. In addition, 25% of the medicine cost is paid by those insured as cost sharing at the point of purchase and credited to the scheme.

The level of the current contribution is far less than it should be, thus having impact on sustainability and to achieve universal coverage. The formal sector contributes 10% of the salary, which is deducted at source, 4% from the employee and 6% from the employer. Regarding the informal sector, employers pay a flat rate, which varies from one state to another.

There are some direct subsidies from MOF, which are increasing to compensate the deficit. The MOF also funds the premiums of civil servants, pensioners and numerous poor, reaching more than 60% of financing. In addition, the federal level supports NHIF by funding chapter one (salaries) and partial support to chapter two.

NHIF uses 13% of its resources for administration, while the payment to pharmacies exceeds 53%, followed by laboratories which receive over 15%. A negligible 0.01% of the payment goes to PHC services, whereas hospitals get over 18%, out of which 5.25% is paid to hospitals operated by the NHIF. 0.75% of the resources are used for research activities. With regard to degree of pooling in health insurance; at the national level there are five pools: NHIF, military, police, parastatal, and private health insurance. NHIF is the largest pool, organized as a head office in Khartoum and

state executive offices in all states. Some companies provide their staff with insurance schemes, e.g. Sudan Airways, or company-run health services, e.g. university clinics, Sudan Seaports Corporation, etc. Free Health Care Initiative gives the students, the children under five and pregnant women access to health services. Whereas the exact coverage is not known, uncoordinated multiple risk pools increase the risk that some people may fall in between pools, while others may have double coverage. Insurance law is silent on cross-subsidization, while there is no risk equalization arrangement, except certain expenditure is centralized like support to the patients, treatment of cases referred from states and training. In order to cover such expenses, federal level deducts part of drug profits and retains about 3% of funds transferred from FMOH as reserve which is also used to support the weaker states.

Overall the purchasing entities are many and the process is fragmented between NHIF, military, police, ministries and private insurance NHIF is responsible for purchasing goods and services from a variety of providers, totaling 1400 including 300 owned by NHIF.

The MoH policy emphasizes the importance of the Primary Health Care, making the services' pyramid broad based. Inversely, however the National Health Insurance Fund's investment is mainly in tertiary and secondary care resulting in an inverted pyramid.

The payment is based on fee for service and is not linked to the performance of the facility, and there are no criteria for performance evaluation.

Regarding quality of service, this review revealed that the quality assurance system is weak and there is no system for the accreditation of service providers and that no protocols exist against which to assess whether the services provided are good or not.

# Summary of key challenges

## Collection

- Weak organizational capacity to collect taxes (evasion rate considered to be high) especially for direct taxes and poor coordination and inter-organizational relations between entities involved in tax collection. This contributed to the current situation of limited envelop from which health is financed and by so limited population coverage. Also taxes are mainly indirect which is not progressive.
- As a result of this and also due to low priority given to health ,the health system is under financed (less than 40\$ public expenditure) resulting in considerable proportion of population with no access to services and limited coverage by the essential package, beside poor quality of services. Also allocation from the Ministry of Finance (MOF) to subsystems is inefficient, not based on pre-set priorities and skewed to curative services. This aggravates the problem of under-financing especially for PHC and inequity in allocation of fund because curative services are used mainly by rich groups and in urban settings.
- As a result of a weak decentralized system; capacity of states to generate local revenues is very weak, resulting in dependence on transfer from federal level
- Still limited coverage by HI (34%) with opting out possibility which enabled big companies and some parastatal agencies to leave the HIF. The great challenge lies in the informal sector which is big in Sudan and extremely difficult to enroll in health insurance schemes like the experience in other countries.
- In HIF high expenditure compared to collection (low premiums, ineffective collection from the informal sector which is also inequitable).
- Great majority of expenditure (70%) comes from private out of

pocket which is inequitable, inefficient and increases catastrophic expenditure.

- Inequitable transfer to states which aggravated great variation between states in per-capita expenditure and results in inequitable access to health services and poor quality of service.
- Inefficient use of external fund and other national funds like ZAKAT and endowment (AWKAF).

### **Pooling:**

- Absence of risk equalization in NHIF, and relationship between national and states health insurance is not well identified
- Fragmented pools within tax system with poor coordination causing great inefficiency. The situation is worsened by the decentralized system which inherently causes fragmentation
- Contradicting schemes (free treatment, coverage of poor by HI) which deteriorates efficiency
- Under financing of free treatment policies and poor targeting process resulted in unavailability of services

### **Purchasing:**

- Fragmented and inefficient purchasing at all levels and. Also, lack of split between purchaser and provider created inefficiency in management and compromised quality of services.
- Pricing mechanism is not clear.
- Inefficient management of HFs especially hospitals (input based and rigid budgetary rules).
- BP is not well identified and costed, not unified for HIF and MOH, not based on actual resources available and contribution of different groups in HIF. Access is limited.
- Utilization is inequitable both between urban/rural and rich/poor

- Payment doesn't promote provision of quality services.
- Payment in HIF offers incentive for overprovision and management of claims is inefficient.

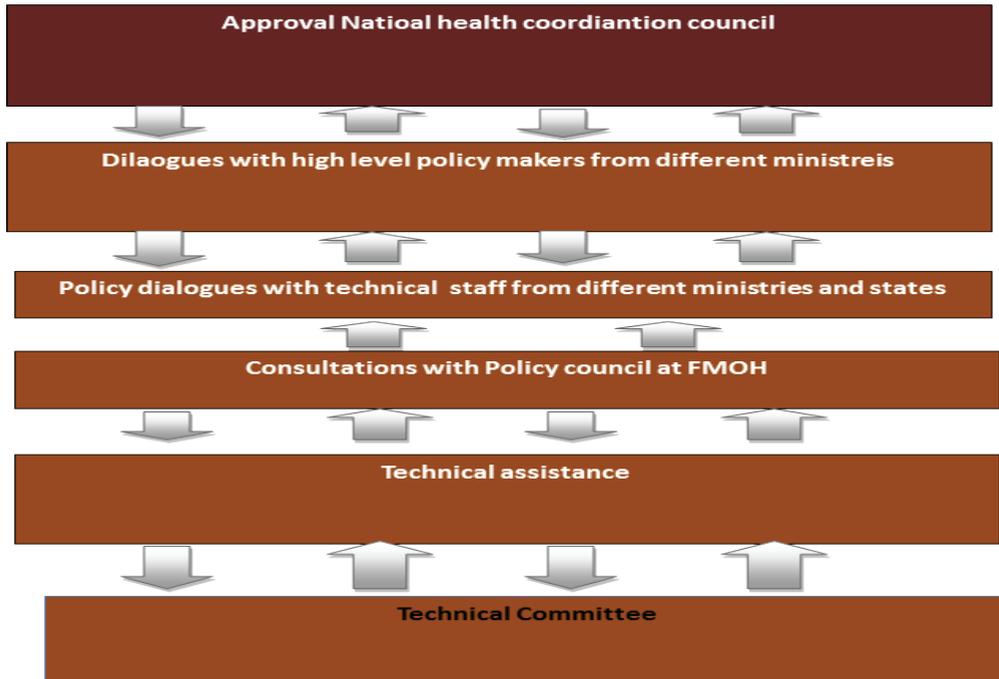
### **Stewardship**

- Weak governance of MOH (about 22% of public expenditure)
- Poor accountability at all levels
- Weakly regulated private health insurance
- Distorted implementation of decentralization
- Weak and fragmented information system

# Process of development of health finance policy

The policy development process of this policy started early in 2014 with evidence generation, followed by a long process of wide participation and consultation with key stakeholders. The figure below illustrates the steps of the process of health finance policy development

**Figure 6**



- The process started in 2014 with development of a national task-force representing main stakeholders for assessment of health finance system.
- During the assessment a series of meetings with key persons at Federal Ministry of Health and other ministries and national councils were conducted.
- Results of the assessment were presented to the Federal Ministry of Health
- Governance was identified as one of the fundamental areas for improvement, a policy dialogue for key stakeholders for discussion of

governance arrangements was organized with participation from WHO- HQ and EMRO.

- Dissemination workshop was organized with participation from states representatives
- A taskforce was formulated for development of the health finance policy that included representatives from FMOH, NHIF and MOF.
- This was accompanied by consultative meetings with policy makers at FMOH to explore the possible options for improving health finance system.
- Technical assistance from World Bank was obtained to assist in development of policy options for health finance.
- A series of meetings was held with policy makers at FMOH, NHIF, Ministry of Finance, Ministry of Social Welfare, ZAKAT and SHEIKAN private insurance company to understand the context and key challenges.
- A workshop was organized with participation of various stakeholders for discussion of the proposed policy options with facilitation from a World Bank consultant.
- Meetings were held with policy makers at FMOH and NHIF to discuss key issues in the finance policy and build consensus on possible policy options.
- Further technical assistance was obtained from World Bank and WHO jointly
- A workshop for endorsement of the health finance policy was organized
- Ministerial meeting (health, finance, social welfare and international cooperation) was organized to discuss the policy document and get their approval

# Policy vision, objectives and guiding principles

## Policy vision

All Sudanese are covered by a prepayment arrangement for an essential health package of services and are financially protected

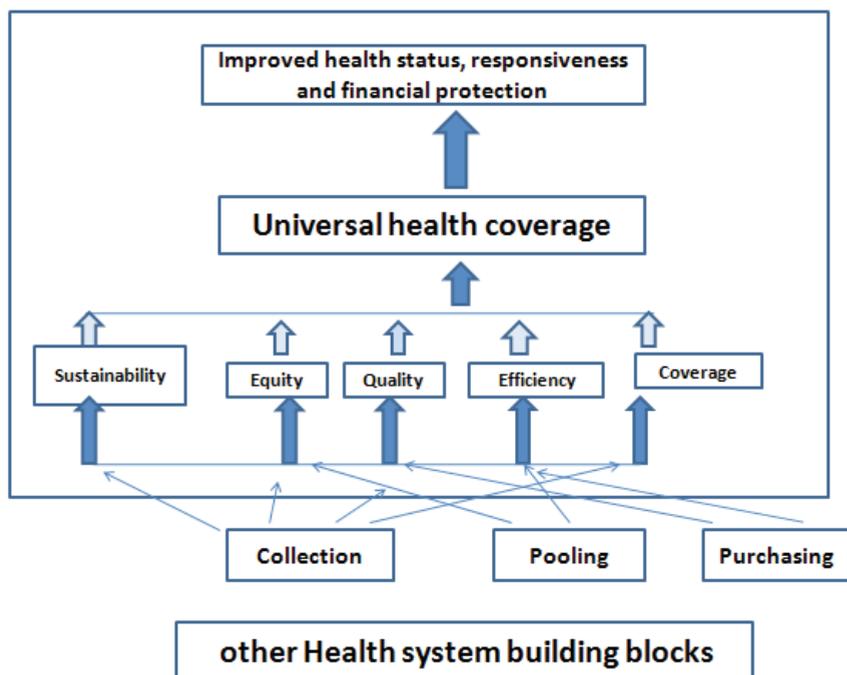
## Policy objectives

### Goal and objectives

Overall goal is to improve health status and achieve financial risk protection to all population.

The objectives of the policy as illustrated below is strengthening the functions of health financing system to enable and facilitate the move towards universal health coverage

Figure 7



## Policy directions

- Moving toward universal coverage
- Focus on poor and near poor and vulnerable populations
- Achieving equitable decentralized health system
- Overcoming fragmentation in healthcare finance
- Moving toward demand side financing
- Redesign the BP
- Improve efficiency to gain resources
- Single purchaser, strategic purchase, split provision and purchase

## Policy options

Policy statements were developed considering the health finance system in term of governance, revenue generation, pooling, purchasing including Provider payment systems, Contracting and Accreditation of Providers.

## Governance

### National health coordination council

Implementation of health finance policy requires horizontal coordination between actors at federal level (FMOH, NHIF, FMOF and other relevant ministries and institutes), as well as vertical coordinating between federal and states levels. As mentioned above, currently there are multiple policy makers in the finance system with out effective coordination between them. This affects the overall performance of HF system and results in fragmentation, contradiction of policies and absence of strategic direction and common goals. To overcome this problem, national health coordination council should be activated and strengthened for ensuring successful implementation of health finance policy by undertaking its role in gover

nance and oversight, improving coordination and holding all stakeholders accountable.

### **Developing a universal health coverage technical committee**

A universal health coverage technical committee will be developed. The main purpose of this committee is to improve policy coherence and coordination between the different actors by leading development of policies and technical guidelines needed for universal health coverage. This committee will be chaired by FMOH and includes all concerned stakeholders, and will provide regular reports to the national health coordination council.

### **Roles and responsibilities of Ministry of Health and National Health Insurance Fund**

The policy adopts the separation of purchaser from provider to promote quality of service provided as well as improve efficiency and accountability. This shift requires redefining roles and responsibilities of main actors in the health system specifically Ministry of Health at federal and states and the National Health Insurance Fund. Under this new status the mandate of Federal Ministry of Health will be providing stewardship and leadership to the health sector, health oversight, health research and health development regulation. The Federal Ministry of Health also will chair the UHC technical committee to ensure coordination and wide participation of all actors in development of sector policies. Also it will retain its role in planning for and supporting provision of public health goods and responding to epidemic and disasters. Provision of health services will be the prime responsibility of States ministries of health. National health Insurance Fund will move to become the single purchaser of health services with no role in service provision.

The Medical accreditation council will be established as an autonomous body under Federal Ministry of Health. The role of this council will be to develop standards, guidelines and SOPs for service provision in addition to developing plans for quality improvement.

The Health information system is a very important component to monitor policy implementation and provide basis for provider payment. The Health information system needs to be more comprehensive to provide sets of data required including availability, utilization and quality of health services. Also, mechanisms to coordinate collection and exchange of information between Ministry of Health and Health Insurance in addition to other actors will be established.

### **Revenue generation:**

The aim of the policy is to increase resources available for health to foster universal health coverage, improve allocative efficiency by setting priorities for health and to govern the allocation of resources for health and ensure it is equitable and sustainable at all levels.

Although there was improvement in government allocation for health in the last years, still more is needed to meet the regional and global targets. Likewise public health expenditure as part of total health expenditure is very low compared to countries with similar income. For additional resources to be allocated for health, prioritizing health and increasing public sources of financing through general taxes is very essential. The government is reducing fuel and wheat subsidies (estimated to gain 1% of GDP) and some of these resources could be diversified to the health sector, especially towards pro-poor programs. There is great need to improve tax revenue collection procedures, as this would lead to more efficient collection and more predictable resources. The Government is also introducing electronic tax management. This too should generate some additional revenue (estimated to gain 2% of GDP). Although the main direction should focus on prioritizing allocation for health in the current situation, need for and feasibility of introducing earmarked taxes for health should be studied in the future. Inequitable allocation to states is one of the salient manifestations of federal transfer. To overcome this problem enforcement of need based formula of allocation must be done. Also arrangements to ensure giving reasonable share for health form this block grant by states policy makers must be introduced. Also states must be incentivized to mobilize

more local resources for health.

Enrolment of other paying members under NHIF (formal and informal), will be a source to automatically increase revenue. About 50% of the population are the non-poor either in the formal or informal sectors. However, getting informal sector workers to join and pay voluntarily is a challenge given adverse selection and difficulty in collecting premiums, as noted from global experience. Furthermore, actuarially and inflation adjusted premium rates among the formal sector and civil servants would help do the same. Further, review of the premium contribution by the pension funds is necessary as the actuaries have recommended

to increase the *efficiency* of the use of the available resources also the following measures will be introduced:

- Rectify the skew of allocation of the resources from the hospital (secondary and tertiary) to the primary health care.
- Improve effectiveness of donors' funds through coordination between them and alignment with country priorities.
- The ZAKAT Fund allocates resources for health through various means: coverage of the vulnerable population through demand side financing and overseas treatment. The first package is pro-poor, while the latter package is expected to be pro-rich. The ZAKAT Fund for overseas treatment should be moved towards demand side financing to become pro-poor and for more efficient spending for health.
- Encourage the private sector to increase its contribution to health as part of its social responsibility and put it under the health insurance pool rather than in supporting the supply side and direct provision of services.

### **Pooling of funds**

Overcoming fragmentation and multiplicity of pools within NHIF and between NHIF and other tax based pools is essential to improve efficiency and risk sharing.

In order to ensure financial risk protection and increase prepayment; pooling mechanisms are to be improved and fragmentation is to be avoided through:

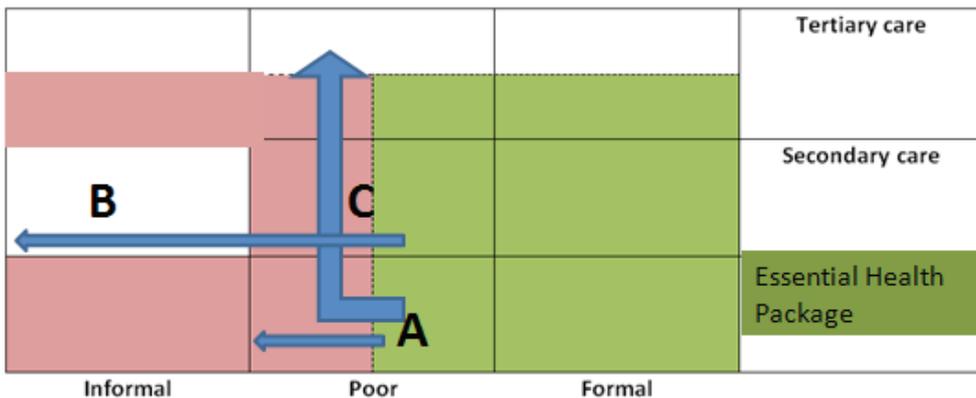
- Transfer the free treatment pools currently under Federal Ministry of Health including free treatment for under 5 and maternal health package to the National Health Insurance Fund to support purchasing of essential package for all. Moreover, donor support especially GAVI and GF need to be part of the essential health benefit package pool.
- Improve level of pooling within NHIF through collecting premiums centrally and give authority to allocate from national fund to states according to agreed formula to ensure risk equalization.
- Social support from ZAKAT for direct treatment should be moved to demand side and to be pooled under NHIF either as part of the big pool or as a separate pool.
- Prohibit opting out of the large companies from national health insurance to maintain the pool and improve risk sharing.
- Funds from the general budget which will be allocated to support purchasing of the proposed essential package will also be pooled under the NHIF either as a separate pool or merged with the existing pool funding the comprehensive package of NHIF.
- On the other hand endeavours to increase the enrolment of the poor population under NHIF will continue to complete coverage of all poor by the comprehensive package.
- Informal sector should be incentivized to join NHIF.
- Private HIS needs to be regulated, and continue their current role in providing insurance for population groups not compelled by law to join NHIF.

## **Purchasing**

The policy focuses on reforming purchasing mechanisms to promote movement towards universal health coverage by focusing on cost-effec-

tive essential health service package, improving efficiency and quality of services provided, as well as improving satisfaction of care providers.

**Benefit package:** *Given limited budgets, it is important that countries seek to understand “how” to “explicitly” select the package of services to be covered under public funds.* Three health benefit packages are suggested: the essential (basic) health package, the comprehensive package currently purchased by NHIF and the tertiary care package of services. The EHBP of services/ interventions should reflect the health needs of the population based on demographics, epidemiology, cost-effectiveness, equity and financial protection. The essential health package of services includes PHC services at PHC facilities, maternal health services and emergencies. It will be provided free of charge for all Sudanese regardless of their insurance or income status. The EHBP will be financed through general revenue at federal and states, payroll tax, social support and donors. The comprehensive package which includes additional services, such as secondary care will be provided to all insured population (contributors) in addition to poor population through government subsidies and ZAKAT. The third package of services is tertiary health care which has a high possibility to lead to impoverishment of patients such as renal dialysis and cancer treatment. The same financing arrangements currently in place will continue to provide these services for target populations. The figure below shows options for population coverage by the essential health benefit package.



## Purchasers and providers of health services

Arrangements to facilitate moving toward purchaser-provider split must be in place. The National Health Insurance Fund will be transformed to a health purchasing agency and will be the single purchaser for health services and move out from provision of service. NHIF will purchase health services from both public and private providers.

Improving efficiency and quality of services and influencing the behaviour of providers by shifting from input purchasing (which focuses on providing the resources needed for service provision) to strategic purchasing (which pays for well- defined quantity and quality of specific types of services through entering into contracts with selected providers) will be implemented.

In addition to that, co-payments status need to be re-arranged to ensure removal of financial barriers against access to health services especially for the essential health package. The existing system does not have user fees or co pays for services at PHC. It however still has co-pay for drugs at PHC. This policy needs to be reconsidered in light of the new trend which endeavours to remove all barriers against accessing EHBP especially when considering current high out of pocket which amounts to more than 70%. Therefore the policy recommends removal of co pays at PHC level to remove the possible financial barrier and attract people to PHC level which in turn will reduce frequency of patients attendance at secondary level and thereby improve overall efficiency of the health system. On the other hand, not having co-pays for services at hospitals can result in moral hazard. The policy recommends considering co-pay for services and drugs at secondary and tertiary hospitals (based on income), with welfare / no co-pays for the exempt group.

## Provider payment systems

Provider payment mechanism is an important component in financing systems through which behaviour of providers could be influenced and changed by providing incentives for cost containment and improving efficiency and quality of service provided(Chapter 9 in Roberts, Hsiao, Berman, Reich “Getting Health Reform Right).

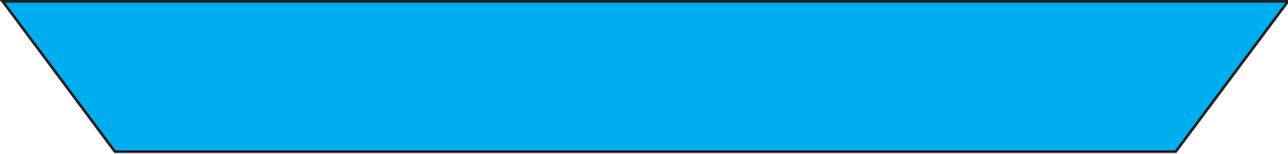
It is essential in our context in Sudan to distinguish between PHC levels, secondary and tertiary levels when designing provider payment mechanisms due to differences in the kind of incentives intended in each of these service delivery levels in order to contribute to achievement of policy objectives.

The policy aims at achieving UHC by EHBP which will be delivered mainly at the PHC level. That is why it is important to ensure mobilization of adequate resources for PHC level which is equitably distributed across all the country according to the needs of population. Therefore capitation will be adopted at PHC level. Beside the above mentioned objectives, capitation will help in incentivizing the providers to use their resources efficiently, provide promotive and preventive services beside the curative services. Capitation also will relieve the huge burden of managing claims by the purchasing agency which is one of the great challenges in the current experience. The capitation payment will be linked to key performance indicators to emphasize provision of key preventive services (vaccination, nutrition...).

Case mix based payment with fixed support budgets to control costs and improve efficiency in claim management will be adopted at hospital levels.

### **Contracting and Accreditation of Providers**

NHIS currently contracts selected public and private providers, although none of them have accreditation. The value of contracting deserves appreciation as it can improve efficiency, equity and effectiveness of reaching



desired outcomes, and improve provider performance.

As mentioned above the accreditation council will be established as an autonomous body under FMOH. All facilities need to be accredited before being contracted by health purchasing agency (HPA).

To enable entering in contractual arrangements between HPA and providers; contracting units must be defined. While hospitals will be the contracted unit by HPA after being autonomous; possibility of applying the same arrangements for PHC facilities or keeping the contract up with localities or state ministries of health need to be assessed according to the context of each state.

Gate keeping should be introduced to increase utilization of PHC services and improve efficiency by decreasing proportion of patients treated at secondary level.

Pricing proposal for health services should come from the UHC committee and endorsed by legislative councils at states. Also one of the main causes of inefficiency is the high expenditure on medicines. To overcome this challenge medicine use and price have to be rationalized by promoting use of generic medicines, changing prescription behaviour, enforcing a pricing mechanism of medicines and ensuring compliance of drug sellers.

## Policy implementation

- Implementation of the policy can be gradual and phased based on the capacity of states.
- The needed fund to achieve UHC by EHBP could be prioritized to be focused firstly on the poor population and expanded gradually to cover the entire population
- Structural reforms for HPA is needed to cope with assigned functions in the policy
- Capacity of the Ministry of Health at federal and states and HPA need to be assessed and built to empower them to undertake their roles.
- Health finance reform should be looked at as part of a comprehensive health system reform. Thereby other dimensions especially service delivery reform should be fostered and aligned with this finance reform in implementation.
- A Health finance strategic plan has to be developed to detail targets, sequencing, phasing, timelines and resources needed to implement the policy.

## References

Sudan Health Financing System Review Report (2014). Khartoum: Public Health Institute.

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