Implementing strategic purchasing to contribute to progress towards universal health coverage in Africa

Skills building through peer learning

AfHEA pre-conference workshop on strategic purchasing

11th March 2019, Accra, Ghana

Meeting report

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Introduction

The World Health Organization (WHO) in collaboration with the Strategic Purchasing Africa Resource Centre (SPARC) organized a pre-conference workshop at the 5th African Health Economics and Policy Association Conference.[1] The aim of the workshop was to provide clarifications of concepts around strategic purchasing and to highlight key areas for moving towards more strategic purchasing. This was coupled with presentations of country examples. Participants shared their own experiences in group work and discussions for peer learning.

The workshop brought together over 70 participants, including policy makers, representatives of ministries of health and purchasing agencies, researchers and students from over 15 countries, mostly African ones.

Overview of strategic health purchasing: functions and policy instruments

Introductory presentation by Cheryl Cashin and Inke Mathauer

Key messages:

- More resources alone do not guarantee reaching UHC, it is also about how the money is spent. Countries that have made sustainable progress toward UHC use strategic purchasing levers to:
  - Balance efficiency gains with
  - Improved health service delivery and better quality
- Effective strategic purchasing requires
  - Appropriate (and clear) institutional structure to allocate responsibility for the purchasing functions (what to buy, from whom to buy, how to buy)
  - Well-designed and implemented operational systems to carry out purchasing functions (what to buy, from whom to buy, how to buy)
  - Sufficient provider autonomy alongside with clear accountability requirements and sufficient management capacity
  - Evolving institutional and technical capacity of purchasers, providers and other stakeholders involved in the purchasing process
  - And political will!
- Strategic purchasing doesn't have to be achieved through a "big bang" reform; it can be achieved incrementally. Starting with feasible first steps and having a clear vision is important.

Country illustration on the introduction of capitation payments and related challenges in Ghana by Eugenia Amporfu, Kwame Nkrumah University of Science and Technology:

The introduction of diagnosis related groups (DRG) payments in both outpatient and inpatient care in Ghana had resulted in skyrocketing of cost. Capitation payments were piloted to cap cost escalation. A committee including representatives from the National Health Insurance Agency (NHIA), religious groups, experts, different providers, and the Ministry of Health engaged in an 18 months preparation phase. Capitation payments cover maternal care, outpatient services, certain essential medicines and diagnostic tests. Providers have to be accredited by the NHIA while NHIA members need to register

[1] The facilitation team consisted of: Cheryl Cashin, Fahdi Dkhimi, Anastasiah Kimeu, Aurelie Klein, Inke Mathauer, Yoriko Nakamura, Nat Otoo, Henok Yemane, Andrew Wong

with one provider as their preferred primary provider. Monthly advance payments based on the number of registered insureds are transferred to the provider. Initially only public providers participated in the scheme. Providers not offering the full benefit package can team up with other providers. They will have to find an arrangement on how the capitation payment is split between them, which in general is working well.

The new payment system allowed timely reimbursement of providers and was well understood by members and providers. However, its potential to contain costs was limited as the capitation payment was only applied to a small share of services provided, and cost shifting to DRG services occurred. The capitation payment has currently not been extended beyond the pilot phase.

The suspension of the pilot was also a political decision following complaints of decreased quality of health services by members. Private providers only joined the pilot at a later stage, after members had already chosen their preferred primary provider, and indicated that they were therefore losing market shares. Political disagreements between local authorities in the pilot region and national authorities led to additional tensions.

This experience points to the need of early engagement of all stakeholders and carefully anticipating the effects of a mixed payment system.

Country illustration: improving health facility autonomy to support strategic purchasing in Tanzania by Suzan Makawia, Ifakara Health Institute

A public financial management reform in 2017 introduced direct transfers to government health facilities' bank accounts. These allocations to the facilities are based on utilization rate and size of the catchment population. Further adjustments exist for remote facilities. The direct transfer arrangements give providers more managerial and financial autonomy. This was accompanied by the introduction of a financial accounting and reporting system as well as a budgeting and planning tool. These changes enhanced the facilities' involvement in the planning process, helped clarifying roles and responsibilities within an effective provider-payer split. It also enabled providers to use resources according to facility needs, although approval by the district treasury is still needed. Use of the new system was accompanied by IT capacity strengthening. The reform also helped to improve the quality of health services and availability of service utilization information.

However, providers had difficulties in understanding the instructions related to their new responsibilities. Facilities still have to report to each and every single purchasing agencies separately. This creates an important administrative workload, which is not easy to cope with for providers. Limited internet connection further hindered reporting.

Regulations, including reporting requirements, function as checks and balances to improve quality and efficiency in service delivery. While a formal tool for quality assessment does not exist, feedback from patients is positive overall.

Payment systems: aligning mixed provider payment systems

Introductory presentation by Cheryl Cashin

Key messages:

- How purchasers pay providers is a very powerful tool, but there is a need to be aware of the incentives created by payment methods and to ensure the alignment of payment methods with health system objectives.
    - In most countries providers receive several funding flows using different payment methods which create a mixed provider payment system
    - Payments methods include capitation, case-based payments, line item budgets, fee for service payments, global budgets and per diems which all create their own incentives
    - The combined incentives signaled to providers through a mixed provider payment system might lead to undesirable behavior by providers
- Aligning a mixed provider payment system is a long-term endeavor — a payment system must be reviewed on a regular basis to adjust or revise incentives.
- Reforming a provider payment system is challenging, but it is always possible to start somewhere by looking for an entry point to initiate a dialogue on how to harmonize misaligned payment methods.
- It is important to bring different stakeholders together, including across levels of the system to have a joint understanding and diagnosis of the problems in the payment system.

Country case study Rwanda: Mixed provider payment systems
by Pascal Birindabagabo, Ministry of Health, Rwanda

In Rwanda, health service providers receive several funding flows: line item and global budget payments for salaries of health workers and earmarked transfers to cover facilities' operational cost, direct transfers, such as performance-based financing for preventive services, from development partners, fee for service payments by the health insurance and out-of-pocket payments by patients. These different funding flows result in a mixed payment system.

The need to address inefficiencies in the use of funds, including overprovision and over prescription by providers incentivized by fee for service payments, led to changes in PFM rules and to strengthened verification of provider claims. Verification ensures that provider claims are reduced when they send in claims for services not included in the benefit package or when they claim for patients whose insurance cards turned out to be invalid. Another challenge is the long time for claim processing. There is also need to address inequities in resource allocation across different regions, but a system approach to do so is still missing. Harmonizing donor funding persists to be a problem, with donors tending to invest according to their own priorities.

Group exercise:

In the group discussion, participants discussed how to better align payment methods in a fragmented health financing and payment system and how these changes would alter the incentives for providers. Based on their country experience, participants also explored what practical steps could be taken to move in the proposed direction. They reflected on the institutional challenges, stakeholder opposition,

or other unintended consequences that can be expected and how those could be managed. The following points were suggested:

- Harmonize payment systems around a common PHC benefit package
    - Link payment to one package, with a coherent set of incentives
    - Use performance-based financing to improve utilization of certain services like antenatal care
- Harmonize and better pool funding flows:
    - Merge purchasing agencies to become a stronger purchaser with more leverage
    - Verse donor funds into the budget of the MOH, who should be responsible for allocating donor funds
    - Encourage the population to enroll in a national health insurance system as a way to reduce out-of-pocket expenditure
- Contract private providers
    - Need to think about financial and non-financial incentives
    - Set up and strengthen accountability mechanisms among private sector providers in light of their larger degree of flexibility compared to the public sector
- Harmonize accountability mechanisms and information systems to reduce fragmentation of how information is reported back
    - Unify information systems as a first step

Governance for strategic purchasing: why does this matter and what are the issues?

Introductory presentation by Inke Mathauer and Aurélie Klein

Key messages:

- Governance is an overarching health systems function and is about "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability" (WHO 2007).
- Governance for strategic purchasing can be thought of at two levels:

    (1) Governance at the level of the health care purchasing system, i.e. the active management by policy-makers and governance actors of the roles and relations between different health purchasers and between the governance actors and purchasers

    (2) Governance arrangements at the level of the purchasing agency, i.e. rules, regulations and relationships that ensure accountability of the purchaser towards the broader government and towards beneficiaries.

- Weaknesses in governance affect strategic purchasing, when purchasers are not held to act as strategic purchasers
- A certain degree of autonomy and a clear mandate for purchasers and for providers are critical to purchase and provide services in an equitable and efficient manner
- Entry points to strengthen governance include:
    - Mapping stakeholders and their interests
    - Clarification and alignment of accountability lines and decision-making processes
    - Analysis of capacity gaps related to reform implementation

- More focus by a ministry of health on the governance function and staff recruitment with the respective competences (e.g., regulation, oversight)

Country case study Egypt: The case of Egypt's Universal Health Insurance law
by Ahmed Yehia Khalifa, WHO Egypt

The new Universal Health Insurance (UHI) law in Egypt makes coverage for all Egyptians compulsory through family-based enrolment and provides for subsidization of poor and vulnerable groups. The new UHI system will be implemented through a single payer agency, which operates a purchaser-provider split and contracts with both public and private health providers. The Ministry of Health and Population will maintain its role as principle regulator of national health policies and steward for the whole health system, however, it is yet unclear how and with which instruments this will happen under the new governance framework.

An assessment of the governance arrangements related to purchasing reveals several strong points, for example: As per the new UHI law, the new UHI organization is given a clear mandate to operate as a strategic purchaser, it will have a credible budget constraint, and a clear oversight arrangement is foreseen. However, participation of beneficiaries in decision-making is not guaranteed yet, and there are multiple, not necessarily coordinated accountability lines. Capacity of the UHI organization might need to be further strengthened. Further finetuning of the institutional and governance arrangements will therefore be needed over the next years and might include the organization of citizen consultations, further specifying the mandate of the UHI organization and strengthening the role of the Ministry of Health and Population.

Country case study Ghana: Governance arrangements of the National Health Insurance Agency
by Francis Asenso-Boadi, National Health Insurance Agency

Ghana's National Health Insurance Authority (NHIA) operates as a single purchaser and pools a large part of public funds. Several critical governance arrangements are in place that contribute to making NHIA act as a strategic purchaser. It has a clear mandate and objectives to act as a strategic purchaser, and it has sufficient autonomy on purchasing decisions. However, while it is the biggest purchaser of medicines in the country, it does not play a role in procuring medicines into the country. This limits its negotiation power on medicine pricing.

NHIA is overseen by an oversight board that ensures broad and meaningful stakeholder participation. Represented in the board are the Ministry of Health, the Ministry of Finance, the Ministry of Gender, Children and Social Protection, the Ghana Health Service, the National Insurance Commission, the Social Security and National Insurance Trust, medical & dental professions, pharmacy professions, legal professionals, two health professionals, organized labour, the chief executive officer of NHIA, and two persons representing NHIA members of whom one is a woman. This wide stakeholder participation is also reflected in the formal process of revising tariffs for specific services as well as for the list of medicine to be covered. Both processes are based on consultations with stakeholders, technical meetings, data collection and analysis and final approval by the National Health Insurance Authority Board.

Four themes were further explored in the following group discussions:

- *Which governance arrangements are effective to coordinate multiple purchasers in your country? What are common challenges and how can these be overcome?*

There is often no clear role for the overall coordination of purchasers. Ideally this should be ensured by the government as a whole or a multi-stakeholder body. The implication of many different stakeholders without clear roles and responsibilities potentially leads to incoherent policies. Several countries have therefore created a coordination body. But this requires capacity strengthening to operate effectively.

- *What are common governance challenges at the purchasing agency level and how can these be overcome?*

Ensuring effective oversight at the level of the purchasing agency remains a significant challenge. Fragmentation of responsibilities, i.e. between the ministry of health and the ministry of social welfare often means that the ministry not in charge of the management of the health coverage scheme is less involved in the oversight process. In fact, stakeholder representatives in the oversight board tend to have different levels of engagement, which puts accountability of the board at risk. The often very technical nature of issues to be discussed and decided is a further challenge for effective governance mechanisms.

- *How to strengthen the role of citizens, beneficiaries and patients in policy design, implementation, oversight and monitoring?*

Beneficiary participation should be encouraged both at the policy making level and at beneficiary level. Options to encourage participation include:

- Introducing a complaints mechanism
- Ensuring beneficiary representation in decision-making bodies and at health facility boards
- Organising public consultations on health coverage – this has been successful, for example, in Thailand
- Putting in place effective communication and lobbying channels with elected officials who can bring health coverage and related issues on the political agenda
- Strengthening the role of the media, civil society organizations and the parliament for communicating and disseminating existing policies as well as for collecting and providing feedback on grievances and needs of beneficiaries.

To implement these measures it is crucial that beneficiary representatives and other actors have the capacity and access to technical information in order to fulfill their role. They also need to have a clear mandate and their roles need to be formalized in relevant legislation. Providing an incentive or compensation for the time beneficiary representatives engage in consultation and decision-making bodies could help to ensure better representation. Finally, monitoring of citizen participation should critically assess whether beneficiaries' concerns are adequately reflected.

- *How to manage resistance towards strategic purchasing measures by some stakeholders (e.g., possibly providers in the case of payment reforms)?*

Resistance towards strategic purchasing measures can have multiple reasons including expected changes in resource distribution and/or in power dynamics, fear of losing influence in multi-stakeholder consultation or fear of losing benefits. A stakeholder analysis and specific communication for each group is proposed.

Participants suggested a four-step approach: (1) Grouping stakeholders within four quadrants according to their capacity of influencing decisions (low/high) and how strongly the proposed measures would affect their interests (low/high). (2) Categorizing the stakeholders into providers, purchaser, and general population. (3) Identifying the roles and potential influence of each stakeholder and if they would be expected to be supportive or not of the proposed reforms. (4) Packaging of messages and information differently to appeal to each stakeholder through transparent information which is relevant to the interest of the respective group.

Gathering information for strategic purchasing

Overview presentation by Fahdi Dkhimi

Key messages:

- Information is critical and essential for strategic purchasing. However, despite its centrality, the subject of information and information management systems does not receive much attention
    - Information collected should be able to answer key purchasing questions on what to buy, for whom, from whom, how to pay and for how much, and finally with what results. This requires granular, timely and accurate data
- A major challenge is to establish interoperable health information systems that allow for data aggregation at the system level
    - Information collected by purchasers is often underexploited despite linking clinical, administrative and financial data
    - Data availability significantly differs among population groups covered by different health coverage schemes, leading to potential inequities in access
- Defining minimum requirements and introducing incentives for data collection and reporting are the starting point of building an interoperable system
- Health information systems are undergoing digitalization, but without proper steering this is likely to result in fragmented systems, which are difficult to link with one another
- Transforming the information landscape is not going to happen overnight: it will require countries to develop a long-term vision (e.g. Republic of Korea) and to move incrementally towards it, starting with the low hanging fruits (e.g. Ghana) before moving to more ambitious reforms (e.g. Rwanda). Finally, information systems for strategic purchasing must constantly be adjusted to ensure that they collect the data needed to move towards UHC.

A group discussion encouraged participants to reflect on the following two key questions related to information needs for strategic purchasing.

Which key decisions have to be made to move towards more strategic purchasing?

- what to purchase, which services should be included
- from whom to purchase, how to engage providers
- how to purchase, how to improve quality of services, what would be appropriate provider payment methods
- how to ensure that necessary resources are available, and payments cover adequately cost of providers, if no predictable revenue the system will not be sustainable

What are the information needs and requirements, i.e. the pieces of data needed, to take these decisions and from which sources can such data be collected?

- information on out-of-pocket spending is crucial including on which diseases/ treatments are the highest (financial) burden for beneficiaries
- population information including demographics and disease burden, which are high prevalence diseases, this can be collected from facilities
- need to link clinical data with expenditure data which is needed to establish payment rates but depending on the payment method, line item budget allocations might have lower information requirements
- understanding of capacity of providers which can be collected through provider mapping
- understanding of capacity of purchasers through collecting information on processing time
- information on procurement, purchase and stocks to ensure service availability and readiness
- data is costly, need for a coalition between government, researchers, NGOs, DPs to get data. Research surveys can contribute to collecting intelligence for SP

Following the group discussion with results shared in the plenary, three country examples were presented on how information for strategic purchasing can be collected.

Ghana (Nathaniel Otoo, Strategic Purchasing Africa Resource Centre): the introduction of an identifier for each facility significantly facilitated the collection of data on service provision as well as provider performance in the whole country. It was an easy step to implement for the National Health Insurance Authority, which also led to substantial cost savings. It was also a first step to harmonize information collection. A revision of previous claims revealed many discrepancies between claims and actual medical reports. Therefore, it was decided to standardize claims. Likewise, it was ensured that facility managers can access all information.

The question of how much providers spent on service provision remains tricky. In Ghana, a certain reluctance persists among providers to share all necessary information. Moreover, facilities may not always have the capacity to collect detailed cost information. The NHIA is working with the private provider umbrella organization on costing methodologies. For medicines cost median prices are used to inform discussions on pricing.

Rwanda (Pascal Birindabagabo, Ministry of Health, Rwanda): International Classification of Diseases (ICD) codes are already in use, whereas the development of a personal identifier code is currently in process. The introduction of a personal identifier code will allow to know who received which treatment where and when. In the future this will potentially allow to know the costs of specific health services and which diseases are frequent. A uniform claim form to be used across purchasers has also been developed and will facilitate system interoperability once it is implemented. The Ministry of Health tries to convince providers to use the new form by emphasizing the advantages of a unified reporting system.

Reflecting performance of health workers in claim forms is difficult. Experience with performance-based financing in Rwanda revealed that reporting is not done for each individual health worker but as an aggregate per facility. It is up to facilities to decide how incentives are allocated between staff, whilst the Ministry of Health can only recommend facilities to allocate according to performance.

Korea (Soonman Kwon, Seoul National University): Information has always been recognized as a central lever to strategic purchasing in the Republic of Korea. From the onset the National Health Insurance Agency (NHIA) has put in place the right incentives – financial and regulatory/policy

framework – to mandate the use of standardized claim forms. However, the Korean NHIA faces serious challenges to collect information on provision of services outside the benefit package, more so as (private) providers are suspected to increasingly orient patients towards these services for financial reasons. This may be one explanation why the level of OOPs continues to remain at about 37% of current health expenditure.

While the health information system in Korea is very comprehensive, it only includes information on services included in the benefit package. Without the reimbursement incentive, providers have no interest in submitting additional information. A similar issue has been noticed under capitation payments in Ghana. When payments are transferred in advance, there is less incentive for facilities to collect and submit detailed utilization data.

Conclusion

The workshop was successful in bringing together and encouraging exchange among policy-makers, researchers and experts. The lively discussions around country examples underlined the interest and relevance of continued peer learning and collaboration. The exchange between researchers and policy makers was a useful way to bring key issues on the policy and research agenda and give more attention to the importance of understanding mixed provider payment systems, governance arrangements for strategic purchasing and information needs. The discussions also showed that processes on how to move towards more strategic purchasing tend to be well documented only in a limited number of countries. Stronger monitoring and evaluation of purchasing reform impacts should be part of the future research agenda. Finally, strategic purchasing reforms can be a gradual process with many entry points identified during the workshop, which can be a starting point for implementation at country level. The World Health Organization and the Strategic Purchasing Africa Resource Centre will continue their collaboration to facilitate cross country learning and capacity building to ensure that countries can draw on the expertise needed for their health financing reforms towards more strategic purchasing.

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