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Research Report

Strategic Purchasing: Lessons from Four Country Assessments in Burkina Faso, Colombia, Karnataka (India) and the Philippines

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Strategic purchasing – lessons from four country assessments in Burkina Faso, Colombia, Karnataka (India) and the Philippines

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Introduction

Purchasing is one of the three core health financing functions, in addition to revenue collection and pooling. It refers to the allocation of resources by one or several purchasing agents to public and private health care providers for the provision of services. There is a growing consensus that a move towards more active or strategic purchasing of health services is a necessary condition for countries to make and sustain significant progress towards UHC.

The aims of strategic purchasing, broadly, are to guide the allocation of resources to contribute to improving intermediate and final UHC objectives. The intermediate and final objectives that are affected through purchasing mechanisms include: increased efficiency in the use of funds; expenditure growth management; equity in the distribution of resources; improved accountability; equitable access to health services (utilization in line with need); financial protection and improved quality of care (including continuity of care) (Kutzin, 2013, WHO 2010).

More low-and middle-income countries seek to shift to strategic purchasing, creating a demand for practical tools to assess current purchasing situations and identify options for future development. To contribute to such processes, a collectivity group[1] on Strategic Purchasing and Universal Health Coverage was launched jointly by the World Health Organization (WHO), the Institute of Tropical Medicine Antwerp, and the Communities of Practice "Performance-Based Financing" and "Financial Access to Health Services". Based on a draft provided by the WHO, the collectivity group developed an assessment guide for strategic purchasing. Four country assessments were conducted to explore how the weaknesses in purchasing set-ups affect UHC intermediate and final objectives as well as other effects on the health system. The assessments were complemented with i) literature review; ii) interviews and discussions with key stakeholders; and iii) quantitative data collection. They were conducted between March-July 2018 in Burkina Faso, Colombia, Karnataka (India) and the Philippines. Three assessments focused on the national level, while the assessment in Karnataka focused on the sub-national state level.

The final purpose of this assessment was to outline and frame key policy issues and challenges that are considered critical to the shift towards strategic purchasing in the four health care systems. This new evidence identified clearly the opportunities at the country and provincial level to facilitate reforms and dialogue on strategic purchasing to meet UHC by 2030, focusing on four key areas: benefit package, payment methods, information management and governance arrangements.

[1] Collectivity is an online collaborative forum for convening practitioners to promote collective action around development issues and solutions. The forum is hosted by ITM and funded by NORAD. Communities of practice are formed around various topics. Jointly led by the WHO, ITM and the FAHS and PBF communities of practice, the Collectivity group on strategic purchasing was launched in July 2017 with over 80 members. A subgroup of 18 individuals worked on the assessment guide and country studies from October 2017- October 2018.

This paper shares reflections on commonalities and key features of the purchasing arrangements in the four countries (section 2), outlines instruments used to move towards more strategic purchasing (section 3) successfully and identifies gaps and a way forward (section 4).

Commonalities and differences

The assessment of strategic purchasing in four very different country settings using the same framework, revealed several surprising commonalities, success factors and struggles related to the purchasing function.

General context:

Despite being at different stages of economic development and having different health system architectures, all four countries are characterized by a political commitment to move towards more strategic purchasing as underlined in policies aiming at extending coverage to the whole population and changes in purchasing arrangements. As in many countries, health coverage schemes started with health risk pooling among employees in public and formal private sectors. At the same time, free or more affordable health services were provided through a network of public facilities targeting poorer populations and, in some cases, the informal sector. E.g., in Burkina Faso coverage is provided by the Ministry of Health through subsidies to public health facilities while the Ministry of National Defence and Veteran Affairs, as well as the Ministry of Labour and Social Security, are managing insurance schemes for formal sector employees, military personnel and dependents. (Kiendrebeogo et al., 2018) In Colombia, an initial system providing health insurance to around one quarter of the population and free services at public health facilities was reformed by law in 1993. (Rivillas et al., 2018) In India, formal sector workers are covered by health insurance. Government facilities are supposed to provide comprehensive subsidized care to the whole population but often lack sufficient funding to do this. (Devadasan 2018) The Philippines had a similar setup with the formal sector covered through social health insurance managed by PhilHealth and additional subsidy provided for service provision at local level by local authorities. (de Claro 2018).

Table 1 Health expenditure data for the selected countries for 2015. Source: WHO Global Health Expenditure Database

Indicators	Burkina Faso	Colombia	India	Philippines
Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	5	6	4	4
Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE)	28	67	26	31
External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)	30	4	1	1
Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure (GGE)	7	12	3	7
Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)	36	18	65	54

From a similar starting point, the four countries used different approaches to improve financial health protection of their populations. Colombia chose to make health insurance membership

compulsory for the whole population and subsidized premiums for the population entitled to social benefits. The system was designed as a multiple competitive purchaser system with some functions such as benefit package design remaining at the national level, while implementation was left to public and private purchasers as well as provincial governments. (Rivillas et al., 2018) The Philippines took a similar approach but kept PhilHealth as a single-purchaser. Membership for recipients of social benefits as identified by the Department of Social Welfare and Development as well as for persons aged 60 and above was fully subsidized by the government. In addition, the government launched a policy which funds PhilHealth coverage to those patients who cannot afford to pay at the point of service. (de Claro 2018) Karnataka, in India, identified secondary care provision for vulnerable groups as a key coverage gap and created a new publicly funded scheme to provide a very targeted benefit package to people below the poverty line at State level. (Devadasan 2018) In Burkina Faso, the formal sector coverage is complemented by voluntary schemes and free health care policies for selected services and/or population groups including financial support by external partners. A comprehensive health sector reform aims at creating a single-payer universal health coverage scheme for the whole population. (Kiendrebeogo et al., 2018)

In all the countries, this led to a multitude of purchasers. In the case of Colombia, a two-level purchasing arrangement exists. The main purchasers are the Ministry of Health, other ministries and the two major insurance schemes, which are operated by 30 sub-purchasers, which together cover around 90% of the population. This competitive purchaser market led to a reduction in the number of insurance schemes. (Rivillas et al., 2018) According to the design of the public purchasing mechanisms, PhilHealth has a strong position as a single purchaser. However, funding managed by the agency remains low as a percentage of total health expenditure and is complemented by allocations managed by national and local governments, and by private health insurance. (de Claro 2018) In Karnataka, decentralization and fragmentation along population groups and along services multiplies the number of purchasing agencies. At the same time, low level of public funding and a split into national and state-funded programs as well as health insurance schemes makes harmonization a politically difficult undertaking. (Devadasan 2018) Burkina Faso just launched an initiative to re-centralise the purchasing function under a compulsory universal health coverage scheme, but this is not yet operational. (Kiendrebeogo et al., 2018)

Provider payment methods:

The comparison of the four countries shows that the existence of non-aligned and mixed provider payment systems does not depend on features of the health system, including the level of health spending or specific governance arrangements such as a strict purchaser/ provider split. However, a purchasing arrangement with a clear division of mandates between purchaser and provider facilitates contracting of private providers. Schemes in the four countries have different mechanisms for and levels of control of provider activity. The mechanisms include general quality control of providers through accreditation, compulsory annual reporting of provider activity, pre-authorisation of treatment and patient feedback after treatment. All countries are gradually shifting towards results-based payment modalities but still lack a comprehensive approach of aligning payment mechanisms to coherent and strong incentives for service delivery by providers.

In Burkina Faso, public funding is mostly channeled to public providers, and to some extent to private doctors, primarily using line-item budgets or fee for service payments. Performance-based financing has been introduced for certain services in selected areas with external support. However, performance-based financing is not yet institutionalised and harmonized with other financial flows limiting the potential impact of the incentives set by the system and potentially allowing for double funding of services at facility level. (Kiendrebeogo et al., 2018)

Colombia uses a variety of payment methods ranging from fee for service to global budget with a clear output orientation and with a strong intention by the government to move towards prospective payments. Overall in 2017, 50% of all payments were made by fee for service, 40% by capitation and 10% by global budgets. The funding is mainly from public sources, and managed to a large extent by private health insurance agencies. The Colombia Compra Efficiente initiative provides a framework for integrating quality measures into the purchasing decision through linking payment to the fulfilment of some indicators. (Rivillas et al., 2018)

While public funding managed by national and local governments in the Philippines is allocated to public providers based on line-item budget, PhilHealth is using output-based payment methods. In 2011, the agency moved from fee for service payments to mostly case-based payments. A limited part of funding is allocated through capitation payments. With a low amount and no connection to performance indicators these capitation payments however don't encourage quality or performance improvements. PhilHealth does not only have more flexibility in the use of payment methods but contracts both public (40%) and private providers (60%). (de Claro 2018)

Traditionally, Indian governmental agencies used predominantly line-item budgets, giving little incentive for improvement of efficiency at the facility level. The state-level scheme in Karnataka targeting secondary care for poor people, known as Vajpayee Arogyashree, is an exception. The scheme is implemented by an independent trust, contracting mainly private providers. Payments are procedure-based. Across the schemes in the four countries, the Vajpayee Arogyashree has the strongest quality component, as payments are conditional of patients providing feedback. As in Colombia, pre-authorisation by the purchaser is needed for providing hospital services. (Devadasan 2018)

Benefit package design:

Primary health care services are exempted from fees or have lower co-payments, at least for vulnerable groups, across the four countries. The comparison of the country situations suggests that there is a link between independence of purchasers and providers and a clearer definition of a benefit package. A clearly defined benefit package responds to identified population needs and is less driven by service availability. A stronger split between purchaser and provider also seems to encourage individual contracting. In every setting, some form of provider performance monitoring exists but often has weak links to payments. With growing pressure for accountability on purchasers, patient feedback mechanisms tend to get stronger. The schemes in which purchasers have more autonomy require more reporting and tend to have better complaints mechanisms for patients than schemes implemented directly by the ministry of health.

Burkina Faso is an example of a setting where the purchaser and provider split is not yet very strong and mostly limited to health insurance schemes for formal sector employees run by professional associations, community-based and voluntary health insurance, with limited population coverage. The benefits provided, under schemes funded by the Ministry of Health, tend to depend on service availability, especially at the local level. As a result, the deployment and planning of human resources for health, a key condition for availability of primary health care services, becomes a main factor influencing scope and cost of the benefits. In preparation of the creation of a national agency managing the new universal health coverage scheme, costing and actuarial studies were commissioned which will provide a good basis for moving towards a more strategic definition of benefits, which is likely to be different from the service package, based on affordability and societal preferences. (Kiendrebeogo et al., 2018)

In Karnataka, benefit definition varies significantly between schemes. On the one hand, benefit packages and cost under the government-funded primary health care, are driven by service and human resource availability, similar to the situation in Burkina Faso. On the other hand, the Vajpayee Arogyashree scheme, with an effective purchaser-provider split and a clear mandate, is similar to the Colombian setting. A clear process for benefit revision exists, and individual contracting and performance monitoring of providers responds to accountability demands by members and funding agencies. (Devadasan 2018)

PhilHealth has a benefit package which is strongly oriented on inpatient services. In 2017, over 90% of its expenditures were allocated to inpatient treatment. As a result of often high co-payments and non-coverage of most outpatient drugs, including for chronic diseases, the benefits fail to provide comprehensive financial protection. The introduction of a no-balance-billing policy for vulnerable groups as well as a specific list of high cost treatments which are provided free of charge to certain groups at selected facilities aimed at reducing out-of-pocket spending. PhilHealth adds new benefits on a yearly basis which are approved by the board. The institutionalisation of a systematic health technology assessment process is ongoing. (de Claro 2018)

Colombia has well-defined benefits covering the whole population and harmonised across the contributory and subsidized schemes. The alignment of the benefit package of the subsidized scheme and the contributory scheme was accompanied by a change from an implicitly-defined package to a negative list defining which services are excluded. This favoured equitable access to services, especially to new technologies in line with the statutory law of 2015 which defines health as a fundamental right that must be protected and accessible without administrative barriers. At the same time, a standardized process for updating the package was developed. This process includes criteria for assessing new technologies as well as a strong role of the Technological Health Assessment Institute and the Institute for Food and Drug Surveillance whose role extends to negotiations and centralised procurement, price control of medicine and assessment of budgetary impact. (Rivillas et al., 2018)

Information management system:

In the four countries, health information systems are fragmented. Health insurance agencies or ministries of interior might collect general patient or demographic data. Public health information systems, often under the ministry of health, might collect information related to population morbidity. Ministries of finance require reporting on provider income and expenditure. Finally, hospitals once they reach a certain volume of service provision, have their internal management systems. In addition to this functional fragmentation, a geographical fragmentation in which data is collected at local or provincial level but not accessible at national level also exists in the four countries. Adequate systems ideally collect information on patient treatment, including cost, extract the required information and report to other existing systems. A pre-requirement for this capacity is the standardization of data collection which allows for exchanging information between systems, as is the case in Colombia. Strong information management systems require leadership from outside the health sector, either by an entity specifically in charge of information technology, collection of statistics, or registration of citizens.

In Karnataka, a high number of information systems are in place to store health service related data by different ministries and sub-national governments to monitor program implementation and accounting, rather than performance of providers. As a result, insurance schemes tend to develop

their own patient databases. The only scheme using data for performance monitoring is the Vajpayee Arogyasharee. (Devadasan 2018)

In Burkina Faso, a reliance on external funding further adds to the fragmentation. The main information systems include a national system collecting aggregated patient data, the financial reporting systems of the government, the management system for provision of free services, the information management system of the performance-based funding scheme and the health information management system of the Ministry of Defence which is in charge of providing health services to military personnel and dependents. The development of a patient-centred hospital information management system, which started in 2017, should improve data availability on the medium term. However, capacity limitations and a weak information technology infrastructure limit progress. (Kiendrebeogo et al., 2018)

The Philippines have developed an eHealth Strategic Framework and Plan 2014 – 2020 which provides a roadmap towards a more integrated health information system. However up to day, data collection remains fragmented. PhilHealth collects what can be considered the largest health-related information in the country. However, it has not yet adopted the technology and developed the capacity which would allow to process "big data". The fragmentation combined with a limited strategic approach on data collection, means that access to timely, reliable and complete health information remains a challenge for policy makers. (de Claro 2018)

Since 2012, the Ministry of Health and Social Protection of Colombia has been centralizing data related to health service delivery in a data warehouse by developing standards allowing different information systems to be interoperable. The National Information System for Social Protection offers a unique opportunity for interaction between population heath data and data required by payment systems. Health outcomes and vulnerable population data is available, disaggregated by geographic levels. The development of such a data repository is a significant achievement but does not yet provide standardized reporting or assessments of quality of data. In addition, financial data and information collected at the sub-national level are not yet included. (Rivillas et al., 2018)

Governance arrangements in strategic purchasing:

All four countries have clear policies towards attaining universal health coverage. This objective is reflected in purchasers' goals but tends to be less explicit in more decentralised settings. The country studies show the importance, as well as the difficulties, of developing an overarching governance and coordination mechanism and of ensuring sufficient skills and capacity of the different actors to fulfill their mandates effectively. The lack of a coordination and steering mechanism also makes it more difficult to evaluate the combined incentives set by multiple purchasing arrangements on providers and how these affect progress towards UHC. Coordination should also reach beyond the health sector as in all four countries it is recognised that health agencies will not be able to become strategic purchasers without working with ministries of social welfare, ministries of finance, or even ministries in charge of regulation of private providers and purchasers. Coordination is important because for most purchasers, the overall budget is determined by the government, the ministry of finance or a cross-sectoral steering body. The regulatory framework applicable to purchasing of health services tends to reflect the overall regulation of the public sector and private markets of the countries. Finally, building awareness and understanding of strategic purchasing remains challenging in all settings.

In Colombia, one of the main difficulties for coordination arises from the multiple purchaser market. The establishment of an agency in charge of the management of health financing, including funding for medicines and supplies, at national and sub-national level, contributed already to better coordination and reduced operational cost. Accountability of purchasing agencies is further strengthened through general regulation applying to Colombia Compra Eficiente as well as through the National Superintendence of Health who is in charge of supervision of both public and private health insurance agencies. (Rivillas et al., 2018)

Fragmentation in the purchaser market in the Philippines results from overlapping mandates between the Department of Health and PhilHealth, a government owned corporation. The PhilHealth Board of Directors, chaired by the Secretary of Health, has a broad mandate which includes decisions on provider payment mechanisms, benefit package design, and approval of the annual budget, but it is struggling with providing technical directions for more strategic purchasing. The development of a Universal Health Care Bill aims, among others, at improving the purchasing function. The key points of the law propose to clarify roles and responsibilities, to move towards global budgets, to mandate income retention and specific use for facility or service improvement of PhilHealth reimbursements by public providers, to expand the no balance billing policy and to improve the selection criteria for members of the Board of Directors of PhilHealth. (de Claro 2018)

In India, and more specifically in Karnataka, a limited regulatory framework exists for providers as well as purchasing agencies like the trust that operates the Vajpayee Arogyashree scheme. As a result, the trust does only have financial incentives for directing the behaviour of providers. It develops its own regulatory framework which providers have to accept if they want to be contracted. This includes development of clinical guidelines, accreditation mechanisms, reporting and accountability mechanisms as well as case-based payments. The trust itself is accountable to the Department of Health and Family Welfare of the State of Karnataka. (Devadasan 2018)

The governance arrangements for the purchasing of health services in Burkina Faso are undergoing significant changes under the guidance of an overall health sector reform. A new universal health coverage scheme and agency have been created. There is a technical secretariat within the MOH in charge of policy coordination towards UHC, which also hosts a technical working group focusing on resource mobilization and allocation. Once these mechanisms are operational, it is expected that existing coordination gaps will be closed. (Kiendrebeogo et al., 2018)

Successful instruments to move towards more strategic purchasing

In the four countries, a strong political will existed for moving towards more strategic purchasing as shown by current initiatives to improve governance arrangements, legal frameworks, and/ or capacities of purchasing actors. In every context, it was possible to identify policy instruments which allowed putting this political vision into practice. These instruments are described below and grouped according to the four areas of strategic purchasing.

Provider payment methods

Autonomy of purchaser to enable selection of strategic payment methods and selective contracting including with private facilities

When the state of Karnataka launched a new state budget funded scheme for covering secondary health services for the poor, a separate and independent purchasing agency, a not for profit trust, was created to manage the scheme. It is headed by a senior government official, has senior government officials on its board and is supervised by the Chief Minister, but there is sufficient autonomous decision-making space. For example, the executive director set up a competitive purchasing mechanism by allowing all providers, private and public, to be contracted if they fulfill the scheme's criteria. Being a non-governmental entity gave the trust autonomy to use case-based payments and contract the most suitable providers. This led to a significant amount of public funding going to private providers. (Devadasan 2018)

Strong willingness to move towards prospective payments

The purchasers in Colombia use a mix of different payment mechanisms including capitation, output-based payments such as DRGs as well as DRG based global prospective payments. Political willingness to move towards prospective payment can further encourage providers to use funds efficiently. How strategic prospective budgets will be used as a purchasing tool, will depend on the information used to determine the budget. (Rivillas et al., 2018)

Strong involvement of patient feedback in the payment process

The Vajpayee Arogyashree scheme in Karnataka, is the only scheme in the three countries which puts a very strong emphasis on patient feedback. To get their payment claim approved, providers do need not only a pre-authorization and submission of all the clinical documents but also feedback from the patient. Even though patient feedback is not necessarily an indicator of the clinical quality of the services provided, it is important to increase users' trust in the system. Especially for schemes targeting vulnerable population, strong engagement of the stakeholders will be important to improve equity in access to services. (Devadasan 2018)

Benefit package design

Alignment of benefits and moving from positive to a negative list of the benefits to increase equity

One objective of the Colombian health sector reform of 1993 was to increase equity in access to health services through ensuring entitlement to a harmonized benefit package for the whole population. Difficulties in harmonizing the packages for the contributory and the subsidized schemes led to a revised definition of the package. Instead of listing all services covered, packages were defined by a negative list of services not covered. Excluding new technologies and treatments from the list of benefits covered instead of including them in a positive list would facilitate access by all population groups to these services. (Rivillas et al., 2018).

Development/ clarification of a basic service delivery package as an entry point for developing/ harmonizing payment rates

Which services and to what extent the cost of these services should be included in a benefit package are important policy decisions. These decisions are influenced by service availability. If providers receive multiple funding flows, these should be coordinated among the agencies managing these flows. In Burkina Faso, a process to develop a basic service package, available at each level of the health system, facilitates the definition of the benefit package provided by the universal health

insurance and the design of a strategic payment mechanism for the services covered. Strategic purchasing, in turn, will set specific incentives as a part of a larger financing architecture for providers. (Kiendrebeogo et al., 2018)

Extending benefit definition to co-payments to reduce out-of-pocket payments

Despite a high insurance coverage through PhilHealth, out-of-pocket payments continue to account for more than half of total health expenditure in the Philippines. To improve financial protection especially for the poor, PhilHealth introduced a no balance billing policy. Providers are not allowed to charge any co-payment for patients covered by this policy. A draft law currently under consideration proposes to extend this policy to 90% of the beds in public hospitals, 60% of government owned and controlled corporations' hospitals and 10% of private hospitals. (de Claro 2018)

Information management system

Development of a hospital management system organised around patient data

Burkina Faso has multiple data collection systems which include the reporting system of financial data required for all public spending, reporting of general health statistics, the reporting system of the health insurance agencies, the reporting platform for free health services, the reporting platform for performance-based financing and so on. All these sub-systems require input from health facilities leading to a significant administrative burden for providers. The Ministry of Health in Burkina Faso responded to this challenge by taking the lead in the development of a national information management system for hospitals. Discussions on the system started in 2017 to get agreement among all stakeholders on the structure of the system. (Kiendrebeogo et al., 2018)

Standardization of data to allow consolidation in a national data warehouse

Since 2012, the Ministry of Health and Social Protection of Colombia has been centralizing data related to health service delivery in a data warehouse by developing standards allowing different information systems to be interoperable. The development of such a data repository is a significant achievement but does not yet provide standardized reporting or assessments of quality of data. In addition, financial data and information collected at the sub-national level are not yet included. (Rivillas et al., 2018)

Integration of health information as a part of a broader eHealth strategy for the health sector

In 2014 the Department of Health in the Philippines adopted an eHealth Strategic Framework and Plan 2014 – 2020. It provides a roadmap towards a more integrated health information system providing an overall governance framework and underlining the need to develop standards allowing inter-operability and the necessary infrastructure. In 2015, the Department of Health and PhilHealth began to collaborate on standardizing terminologies and reporting formats and streamlining data collection. The initial focus was on PhilHealth's primary care benefits optimizing the use of various electronic medical systems utilized by health providers and providing an integrated data access via a single electronic platform called the Philippine Health Information Exchange. (de Claro 2018)

Governance arrangements for strategic purchasing

Strengthening of overall coordination for strategic purchasing through the creation of new agencies

Both Colombia and Burkina Faso aimed at improving strategic purchasing as a part of a wider health sector reform. In Colombia, where the two major schemes, covering together around 90% of the

population, are implemented through a number of sub-purchasers, coordination is crucial. The creation of the Administrator of Resources of the General System of Social Security in Health was a step towards strengthening coordination. (Rivillas et al., 2018)

Burkina Faso took a different path. The launch of a universal health insurance scheme aims at integrating existing schemes under one single payer. Given the scope of this reform and necessary adjustments in the legal, institutional and governance framework as well as the need to develop capacities, the implementation is expected to take several years. (Kiendrebeogo et al., 2018)

Getting the legal frameworks right through the development of a universal health care bill

Fragmentation, overlapping or unclear mandates, lack of systematic benefits revision and high out-of-pocket payments were key challenges for the purchasing function in the Philippines. These challenges could not be addressed by a single purchaser. The development of a universal health care bill allowed to address these points and as primary legislation, will set the basis for implementing policy measures. (de Claro 2018)

Strengthening of purchaser/ provider split and autonomy

One of the novelties of the Vajpayee Arogyashree scheme in Karnataka was that it created a semi-independent purchasing agency in charge of the implementation of the scheme. This new governance arrangement allowed for greater independence of the agency in charge of the management of the scheme from the management of providers as such strengthening the purchaser-provider split. At the same time, the creation of an oversight board including senior officials from the State Department of Health as well as the nomination of a senior government official as the chief executing officer of the implementing agency ensures sufficient control by the State Government on the use of public funding. (Devadasan 2018).

Increased competition between purchasers to reduce the number of purchasers resulting in a less fragmented purchasing market.

As part of an overall health sector reform aiming at increasing financial protection through increasing health insurance coverage, the Colombian Government made enrolment in the health insurance scheme compulsory while increasing competition between purchasing agencies and providers. Health insurance agencies were subject to rankings on quality, efficiency and scope services provided. In addition, competition among providers was increased through allowing purchasers to provide services through their network for only up to 30% of the monetary value of all services they purchased. The result of this increase in transparency and competition was a 40% decrease in the number of purchasers between 2013 and 2018 (Rivillas et al., 2018).

Capitalise on government-wide initiatives of strengthening public budgeting or procurement to support the purchasing function in the health sector

Colombia Compra Eficiente was created in 2011 to develop unified policies for public procurement to improve transparency, to allow for a better evaluation of the use of public funding, and to have a directive entity to support the national development plan. Purchasing using public funding by any ministry will follow the procedures of Colombia Compra Eficiente which includes assessments of value for money and the quality of outputs (Rivillas et al., 2018; Colombia Compra Eficiente 2018).

The Government of Burkina Faso moved to programme-based budgets in 2017. This change was preceded by policy and administrative changes including the strengthening of sector plans, adjusting responsibilities for budget execution and building management capacity of ministries. The focus on specific indicators for budgeting and monitoring is expected to facilitate strategic purchasing. (Kiendrebeogo et al., 2018)

Conclusion and way forward

The key lesson from the case studies is that at every level of development and independent of the specific features of a health system, progress towards more strategic purchasing is possible. The analytical framework used divided the analysis into the key areas of provider payment methods, benefit package design, health information systems and governance arrangements. The following four key issues, which were crucial for all four countries on their way to more strategic purchasing, also underline how the analytical categories are interwoven.

- As shown in all countries, purchasing settings are characterised by a multitude of actors and are often organised across different administrative levels. An overarching coordination mechanism is needed to ensure that the overall design of the system reflects population needs and provider performance. Also, within the various strategic purchasing areas, a coordinating actor with a clear mandate is needed. Collection of information and management of incentives set by provider payment mechanisms are only two examples where coordination is needed to move towards more efficient purchasing. This coordination also needs to be reflected in mandates of key purchasing actors to avoid overlapping functions among ministries, mandatory health insurances schemes and private bodies. The benefit package can provide a platform for coordination for all these elements.
- Moving towards more strategic purchasing is a step by step approach. Even if a country decides on a comprehensive reform of its purchasing system, examples from the four countries show that implementation of new arrangements will be a gradual process. Capacities of all actors, especially purchasers and providers, will have to be strengthened and new institutions might have to be put in place. There is a need to understand the purchasing market structures, driving forces and the interest of involved stakeholders, in particular that of health workers both in the public and private health sector. Hence, there is a need to develop training and skills in health financing at all levels of the health system.
- Payment systems rely on health information systems but can also help strengthening the later. Effective design and implementation of payment systems encourage the generation and use of new data which in turn allows to improve payment systems over time. The health information management architecture needs common standards of data collection. Systems have to be able to talk to each other. Information management was a cornerstone in each of the four country cases.
- The definition of benefit packages has broad implications. Effective alignment between benefit package review processes and the development of provider payment mechanisms is needed. The disconnection of both processes results in avoidable barriers, which in turn generate inequalities in the health care access and undermined quality and efficiency as intermediate goals of UHC.

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