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STRATEGIC HEALTH PURCHASING PROGRESS: A FRAMEWORK FOR POLICYMAKERS AND PRACTITIONERS

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This publication was produced for review by the United States Agency for International Development. It was prepared by Cheryl Cashin, Sharon Nakhimovsky, Kelley Laird, Altea Cico, Sharmini Radakrishnan, Tihomir Strizrep, Ali Lauer, Catherine Connor, Sheila O'Dougherty, James White and Katie Hammer for the Health Finance and Governance Project.

Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this six-year, $209 million global project increases the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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STRATEGIC HEALTH PURCHASING PROGRESS: A FRAMEWORK FOR POLICYMAKERS AND PRACTITIONERS

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ACRONYMS

AQUA	Applied Quality Improvement and Research in Health Care
AR	Australian Refined
CADTH	Canadian Agency for Drugs and Technologies in Health
CBHI	Community-based health insurance
CEO	Chief Executive Officer
CHF	Community health insurance fund
CIHI	Canada Institute for Health Information
DDH	District Designated Hospitals
DFF	Direct facility financing
DHFF	Direct health facility financing
DHIS2	District Health Information System 2
DMP	Disease Management Program
DP	Donor program
DRG	Diagnostic-related groups
eGK	Electronic health cards
EHR	Electronic Health Record
eLMIS	Electronic Logistics Management Information System
FFARS	Facility Financial Accounting and Reporting System
FFS	Fee-for-service
FMOH	Federal Ministry of Health
GDP	Gross domestic product
GOT	Government of Tanzania
GOT-HOMIS	Government of Tanzania Hospital Management Information System
HBF	Health Basket Fund
HCC	Health Council of Canada
HFS	Health Financing Strategy
HIC	High-income country
HiT	Health Systems and Policies Health System Reviews
HMIS	Health management information system
HR	Human resources

HSS	Health system strengthening
HTA	Health Technology Assessment
IT	Information technology
JLN	Joint Learning Network
KII	Key informant interview
LGA	Local Government Authority
LMIC	Low- and middle-income country
M&E	Monitoring and evaluation
MBP	Minimum benefit package
MOF	Ministry of finance
MOFP	Ministry of Finance and Planning
MOH	Ministry of health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MSD	Medical Stores Department
NHI	National Health Insurance
NHIF	National Health Insurance Fund
OOP	Out of pocket
OTC	Over the counter
PFM	Public financial management
PHC	Primary health care
PHI	Private health insurance
POPSM	President's Office, Public Service Management
PORALG	President's Office for Regional and Local Government
PPP	Public private partnership
PPTP	Placanje po terapijskom postupku (Croatian acronym)
QA	Quality assurance
RBF	Results-based financing
RHA	Regional Health Authority
SGB	Social Code Book
SHI	Statutory Health Insurance
SHP	Strategic health purchasing
UHC	Universal health coverage
USAID	United States Agency for International Development
WHO	World Health Organization

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1. INTRODUCTION

Making progress toward universal health coverage (UHC) can seem costly to governments, whose resources and stewardship are needed to make change equitable (WHO 2010a). Expanding coverage to previously excluded populations—often poorer segments with heavier disease burdens—requires governments to address barriers to access, including financial barriers. In addition, new technologies, some of which may not be cost-effective, attract patients and providers alike (Saini et al. 2017).

Governments seeking to advance UHC have three options: (1) increase government revenue for health; (2) cut costs by limiting coverage (e.g., remove services from a benefit package, increase cost sharing, or underfund inputs); or (3) increase efficiency in the use of funds (Cashin et al. 2017). Global experience indicates that all of these options face limitations and tradeoffs. Raising new money (option 1) is limited by weak tax enforcement, a small tax base, competing public priorities such as education, and other factors, particularly, in low- and middle-income countries (LMICs). Limiting coverage (option 2), particularly when aimed at poor and vulnerable populations, contradicts the objectives of UHC. Improving efficiency of health spending (option 3) is desirable but may encounter resistance from those who benefit from wasteful spending. A combination of the three options is almost always necessary (Cashin et al. 2017).

This paper focuses on **strategic health purchasing (SHP)**, a policy lever governments can use to improve the efficiency of health spending along with equity in the health system and the quality of health care goods and services delivered. All health systems purchase health care goods and services through one or more **purchasers**. Households are purchasers when they pay providers out-of-pocket for their health care, a regressive and inefficient arrangement. **Third-party purchasers** are those paying on behalf of households/patients and include institutions such as government agencies, public and private insurance organizations, or possibly ministries of health delivering health services to their citizens using input-based budgeting. Purchasing becomes strategic or ***active*** when third-party purchasers deliberately design and use evidence-informed arrangements for selecting the health goods and services to buy, determine which providers to buy from, and pay the providers to deliver the covered services. These arrangements create financial incentives for providers to contribute to health system objectives. In contrast, ***passive*** purchasing is characterized by arrangements that are based on historical precedent, and miss an opportunity to use purchasing to purposefully improve access, efficiency, quality, and equity of service delivery (Box 1).

Box 1. Potential benefits of Strategic Health Purchasing

Efficiency:

- Prioritize cost-effective health services such as primary care
- Incentivize prevention and health promotion
- Reduce wasteful spending on unnecessary services

Equity and Access:

- Pay providers to work in underserved areas, serve vulnerable populations
- Reduce incentives to collect informal fees from patients

Quality:

- Make payment contingent on meeting accreditation standards or following clinical treatment guidelines

Many countries at all economic levels are engaged in reforms to make purchasing for health care services more strategic, but face challenges in design and implementation. There is a growing global literature and multiple guidance documents that support LMIC governments and other stakeholders through the process (see Annex 1 for an annotated

bibliography). Missing is a succinct framework for understanding the critical functions necessary for strategic purchasing of health care, and how governments and other actors improve their ability to fulfill these functions.

Led by Dr. Cheryl Cashin, the USAID's Health Finance and Governance (HFG) project and the Gates Foundation developed a framework to fill this gap. The team drew upon the existing SHP guidance documents and extensive field work on and documentation of SHP in several LMICs and high-income countries (HICs) to develop the SHP Progress Framework. The framework is intended to help policymakers and practitioners—especially purchasing agencies and health sector planners—visualize the progression from passive to active or strategic purchasing across two sets of essential functions: 1) health system functions that enable SHP, and 2) functions fundamental to the purchasing system itself. By visualizing this progression and country examples of functionality, stakeholders will be better able to design and adapt holistic, integrated plans for strategic purchasing reforms.

This report presents the SHP Progress Framework and examples of its application in both HIC and LMIC settings, including Germany, Canada, and Tanzania. It looks across the examples to identify the characteristics of mature and maturing systems. The report ends with a discussion of ways LMIC policymakers and practitioners can apply the framework and lessons from these examples to inform their reform agendas.

2. STRATEGIC HEALTH PURCHASING PROGRESS FRAMEWORK

The SHP Progress Framework is presented in Section 2.1. Sections 2.2 and 2.3 detail the structure and components of the framework. Section 2.4 recommends steps for applying the framework in country context. Section 3 provides case studies using the framework, and Section 4 offers considerations to policymakers and practitioners when implementing SHP reforms.

2.1 SHP Progress Framework

❶ REQUIREMENTS FOR SHP ACROSS THE HEALTH SYSTEM	STAGES OF DEVELOPMENT: PASSIVE TO ACTIVE/STRATEGIC PURCHASING		
HEALTH SYSTEM FUNCTIONS NEEDED TO SUPPORT THE SHP SYSTEM	STAGE A: INITIATING SHP	STAGE B: IMPLEMENTING/ STRENGTHENING SHP	STAGE C: ITERATING PROCESSES AT SCALE
1.1 Governance and Information			
1.1.1 Developing or revising regulations to strengthen systems for implementation, oversight, accountability, and quality assurance			
1.1.2 Establishing and strengthening licensing, accreditation, and other systems for quality			
1.1.3 Monitoring of interactions and aligning purchasing arrangements across schemes			
1.1.4 Strengthening systems, strategy, and infrastructure for information technology and ensuring access to and easy use of data by purchasers, providers, and other stakeholders			
1.2 Service Readiness and Provision			
1.2.1 Improving readiness of public and private sector providers to deliver services that are accessible, effective, efficient, and of high quality, including by strengthening quality improvement/quality assurance processes, infrastructure, and supply chains			
1.2.2 Giving public providers autonomy in spending and managerial decision making			
1.2.3 Increasing capacity of providers to handle active purchasing relationship with purchaser			
1.3 Sufficiency and Institutional Flow of Resources			
1.3.1 Pooled funds sufficient to undertake intended purchasing			
1.3.2 Implementing reforms to reduce fragmentation of financing schemes			
1.3.3 Monitoring of interactions and aligning benefit packages across schemes if multiple government-managed health financing schemes exist			

2 THE PURCHASING SYSTEM

PURCHASING FUNCTIONS NEEDED TO SUPPORT THE SHP SYSTEM	STAGES OF DEVELOPMENT: PASSIVE TO ACTIVE/STRATEGIC PURCHASING		
	STAGE A: INITIATING SHP	STAGE B: IMPLEMENTING/ STRENGTHENING SHP	STAGE C: ITERATING PROCESSES AT SCALE
2.1 Governance of Purchasing			
2.1.1 Articulating goals and objectives for purchasing and selecting mix of payment methods			
2.1.2 Establishing data system and IT architecture to develop, implement, monitor and adapt purchasing systems, including to facilitate communication between providers and purchasers			
2.1.3 Defining roles and responsibilities for institutions engaged in purchasing and service delivery, making them clearly distinct from the institutions fulfilling service provision functions			
2.1.4 Planning reform or refinement of purchasing systems; overseeing implementation; monitoring the gap between purchasing design and implementation; monitoring the institutions engaged in purchasing; and managing change across institutions			
2.1.5 Developing and maintaining human and system capacity for purchasing and related systems			
2.1.6 Conducting stakeholder engagement and strategic communication, including with health care providers and the public			
2.2 The Health Care Goods and Services to Purchase			
2.2.1 Defining and creating systems for updating and costing a service package, including inpatient medicines, medical devices, and supplies			
2.2.2 Defining and creating systems for updating outpatient drug benefits and prescribing guidelines			
2.2.3 Specifying which standard treatment guidelines at each level of care are a condition of contracting and payment			
2.2.4 Establishing and updating gate-keeping and referral guidelines and defining application of guidelines for contracting and payment			
2.3 The Providers from Whom Goods and Services are Purchased			
2.3.1 Establishing rules for selective contracting by linking the conditions for contracting and payment with the clinical and quality requirements (1.2.3) and regulatory systems			
2.3.2 Deciding from whom to purchase medicines, medical devices, and supplies and rules for payment to suppliers, distributors and retailers			
2.3.3 Deciding role of private providers and how they will or will not be included in contracting and developing policies to guide contracting with private providers			
2.4 How to Purchase: Contracting and Provider Payment			
2.4.1 Designing payment systems for the selected mix of methods for providers of health care services, including calculating/negotiating payment rates			
2.4.2 Designing payment systems for the selected mix of methods for providers of medicines, medical devices and supplies, including calculating and negotiating payment rates			
2.4.3 Entering into, managing, and monitoring contracts with providers, including empanelment			
2.4.4 Monitoring providers through performance management systems			
2.4.5 Monitoring tensions between central policy and local performance			
2.4.6 Collecting, refining, analyzing the routine, standardized data/information needed for purchasing			
	STATUS QUO AT ORIGIN *No government plan to advance towards SHP exists* *Purchasing systems for government facilities rudimentary (e.g. primarily line-item budgets/time-based payment* *Resource allocation less efficient, equitable, delivers lower quality care*	**CRITERIA FOR STAGE B** *Institutional role and/or home for purchasing identified* *Some service entitlements specified and linked to payment* *Introduction of at least some output-based payment* *Some provider autonomy*	**CRITERIA FOR STAGE C** *Increased provider autonomy in spending decisions and institutional separation from the purchaser* *SHP systems refined/ready to scale* *Claims or other data used for secondary purposes beyond payment to make decisions*	**STATUS QUO AT SHP MATURITY** *Productive iteration ongoing* *SHP at scale, and aligned with SHP in other schemes;* *Prices set appropriately; entitlements sustainably financed* *Seeing results from M&E systems to goals of equity, efficiency, quality*

2.2 Framework for Government Health Purchasers

The intended audience for this framework is government stewards of health system strengthening (HSS) who are interested in using SHP to shape service delivery outcomes as part of their country's strategy to progress towards UHC. The framework focuses on purchasing for government-managed or government-sponsored health financing schemes which include schemes labeled as "insurance" and a government paying for its own health facilities and medical providers to provide services (e.g. National Health Service in the United Kingdom). While the principles of strategic purchasing can and are used by private insurers, in the LMIC context, the focus on government schemes is justifiable since private health insurance typically accounts for only a small percentage of total health spending. Also, according to recent studies, private voluntary health insurance is not associated with a reduction in population out-of-pocket spending nor with coverage of underserved populations leading towards UHC (Pettigrew and Mathauer 2016).

Box 2. Key Terms

Purchaser: any entity that allocates funds to providers of health services, medicines, and other health care goods on behalf of a population. Throughout the text, we primarily use the term "purchaser" to refer to third party purchasers – i.e. all purchasers other than households paying out-of-pocket for care.

Provider: any provider of health care services and/or goods such as medicines and supplies.

Contracting: "a mechanism through which arrangements between individuals and organizations are coordinated; they specify each party's actions and rewards for a range of circumstances and contingencies."

*Source: Figueras et al ed. 2005

Ideally, this framework should apply, in line with Kutzin (2013), a health systems lens to the discussion of SHP. In other words, policymakers should consider SHP for all government-financed purchasers collectively, where multiple financing schemes exist. For example, many countries in Latin America have a social health insurance for formal sector employees, public health facilities for all citizens, and special schemes for the poor such as *Seguro Popular* in Mexico (World Bank 2015). Where multiple schemes exist, the authors recommend applying this framework across all schemes, or to each scheme in turn, to explore economies of scale and reduce fragmentation between schemes. In some cases, this approach may not be initially feasible for stakeholders; if so, they can then begin by applying this framework to the largest of the schemes—the one which pays for services on behalf of the largest number of people, or with the largest amount of funding, relative to other schemes. In these cases, it will be critical to think about function 2.3.3 (see Table 2) regarding the alignment in payment methods with other financing schemes.

2.3 Framework Functions

The framework summarizes **essential functions** for health purchasing, and is not intended to be exhaustive. Each function refers to a set of activities that are fulfilled by various health system stakeholders and evolve as SHP is conceived and matures, as capacity develops, and as institutional roles and relationships change. The framework divides these essential functions into two parts: those that support the purchasing system from the health system overall (Part 1) and those that are fundamental to the purchasing system (Part 2). Within each part, there are several **groups** of functions: Part 1 encompasses groups 1.1 through 1.3, and Part 2 encompasses groups 2.1 through 2.4.

Part 1 summarizes a set of **health system functions** needed to support purchasing (Table 1). These health system functions are categorized under groups that roughly align with some of the World Health Organization (WHO) Health System Building Blocks (WHO 2010). These include governance and

information (Group 1.1), service readiness and provision (Group 1.2), and sufficiency and institutional flow of resources (Group 1.3). Including these functions in this SHP framework highlights the critical importance of broader health system performance to enable improved purchasing.

In Part 2 (Table 2), the first group of SHP functions (Group 2.1) relates to the overall governance of purchasing for the financing scheme under analysis. The other SHP function groups are:

- The health care goods and services to purchase (Group 2.2)
- The providers from whom goods and services are purchased (Group 2.3)
- Designing, processing, and monitoring payment (Group 2.4)

Tables 1 and 2 describe the activities in each function and how their execution can evolve from passive to strategic.

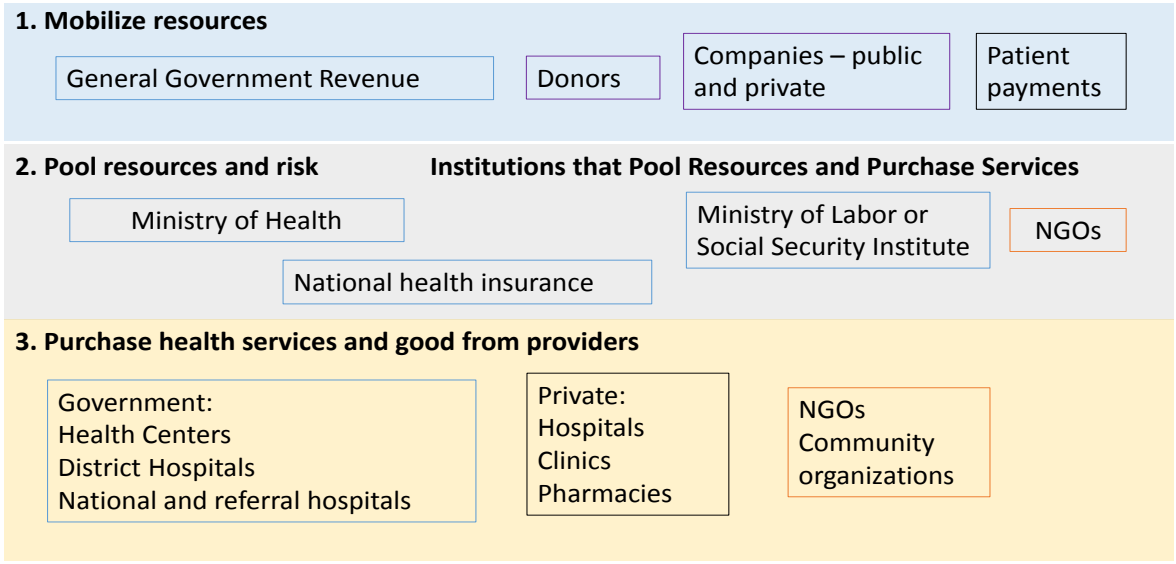
Table 1. Part 1: Description of Health System Functions Needed to Support SHP

HSS Group	Description of HSS Functions to Support Strategic Health Purchasing
1.1 Governance & Information	Function 1.1.1 concerns regulatory policies and systems as part of a broader health policy environment needed to help govern behavior across the health system and reduce asymmetry of information, a common reason for market failures in the health sector (Bloom, Henson and Peters 2014). This function involves assigning and revising roles and responsibilities for establishing, drafting, updating, and enforcing these regulatory policies and systems. Function 1.1.2 highlights the need for licensing and accreditation, systems to support quality assurance/quality improvement, ultimately linked to provider payment systems. Function 1.1.3 covers the activities associated with establishing and strengthening mechanisms for accountability, including: systems that support accountability of providers to purchasers, purchasers to the public (e.g., through statutory guarantee of benefits and patients' rights), providers to the public (e.g., through free access to information, score cards, community engagement), and purchasers to providers. Finally, Function 1.1.4 underscores the importance of the information technology (IT) infrastructure such as electronic medical records to enable and adapt with the SHP objectives over time. **To support the evolution from passive to SHP,** government actors will invest political capital and funding into improving governance and strengthening capacity for SHP over time, thus demonstrating commitment to stewardship for SHP. Stakeholders will align regulatory functions with purchasing systems, including by refining or establishing processes and actors' responsibilities for licensing, certification, registration, accreditation, Health Technology Assessment (HTA), and patient safety, etc. This often includes establishing third party verification processes to verify provider readiness and quality, and establishing applicable criteria for suspending or terminating a provider or facility's registration, i.e. enrollee feedback mechanisms or provider performance data. In mature systems, governments usually separate the functions of purchasing and providing health care services through institutional architecture to mitigate any perceived or real conflicts of interest. The capacity and sophistication of the Ministry of Finance (MoF)/public financial management (PFM) system will influence what is possible in terms of strategic

HSS Group	Description of HSS Functions to Support Strategic Health Purchasing
	health purchasing methods by a government purchaser and public providers (see Tanzania case). In maturing purchasing systems, accountability mechanisms will be specified in detail and transparent. Different levels of accountability will be defined, including for example a chief executive officer or managing director's accountability to the Scheme's Board and the Board's accountability to the Government or Parliament. The roles and responsibilities of the Board should be precisely defined including what metrics/indicators and data the Board will use to monitor performance on which basis resolutions shall be taken, what the composition will be, procedure for the appointment/disqualification of the Members, remuneration of the Members, etc. The ability of payer and provider to exchange health service delivery, patient outcome, cost, and other data is fundamental to SHP. IT infrastructure includes a unique consumer identifier which may be the same for all social welfare benefits, claims management software, national directories of providers and classifiers for health facilities, procedures and rules for their change and revision, and rules governing data exchange. The rules and standard operation procedures will be clearly defined, describing the contents, format and structure of the databases and relationships between databases, and parameters on use and manipulation of data. In more mature systems, protection and confidentiality of the data is guaranteed. Relevant government agencies ensure adequate legislation and operating procedures for data protection.
1.2 Service Readiness and Provision	Stakeholders interested in pursuing strategic purchasing cannot assume that quality health services are actually available to purchase, nor that providers are ready to respond to a new payment method. Yet, strategic purchasing requires both. Function 1.2.1 concerns improving readiness of public and private sector providers to deliver quality services covered by the purchaser (e.g. in a benefits package). Readiness includes the technical capacity of the clinical staff, provider management capacity, health facility infrastructure, and medical equipment. Readiness also includes the supply chain for medicines, medical supplies, and medical devices, as well as proper warehousing, inventory management, transport, and quantification and procurement. Function 1.2.2 concerns giving public providers autonomy to spend funds they receive efficiently. To realize the potential gains in efficiency and quality, public providers must be able to manage staff (hire/fire), supplies, repairs, and other inputs. Function 1.2.3 concerns the need for both public and private providers to have financial management skills and information systems to engage effectively with purchasers in contractual relationships. Related to all three sub-functions of Service Readiness, is the potential for SHP to encourage the development or strengthening of provider networks that integrate levels of care, optimize referral patterns, and are associated with more sophisticated financial management and medical record systems. **To support the evolution from passive to SHP**, facilities (including primary health care facilities) need to be ready to provide the service package appropriate

HSS Group	Description of HSS Functions to Support Strategic Health Purchasing
	for its level of care (primary, secondary, tertiary). New policies, institutional arrangements, and PFM systems are required to give public providers autonomy to manage funds with accountability. Evolution to SHP requires increasing the capacity of all providers, public and private, in financial and management, HMIS, and quality improvement so they can respond successfully to SHP incentives.
1.3 Sufficiency and Institutional Flow of Resources	The functions in this group pertain to the first two health financing functions of the descriptive framework for country-level analysis of health care financing arrangements (Kutzin 2001), including: 1) mobilizing resources and 2) pooling resources to do the third health financing function of purchasing health goods and services. **Figure 1**, below illustrates the relationship between the three health financing functions and the institutions typically responsible for carrying them out. Purchasing, passive or strategic, requires an institution to act as the payer with a sufficient pool of funds – the middle row in Figure 1. Purchasing systems impact and are impacted by the sufficiency of funding and fragmentation in pooling. **To support the evolution from passive to SHP**, pooled funds must be sufficient to undertake intended purchasing. Purchasing will influence service delivery outcomes more effectively when objectives for purchasing are aligned across financing schemes and with supporting systems such as PFM, information systems, and civil service.

Figure 1. The Three Health Financing Functions



Source: Kutzin 2001

Table 2. Part 2: Description of Functions Needed for SHP

SHP Group	Description of Purchasing Functions to Support Strategic Purchasing
2.1 Governance of Purchasing	The first three functions (2.1.1, 2.1.2, and 2.1.3) relate to the design phase when policy makers make high-level decisions about the purpose and structure of the purchasing system. These decisions set the direction for purchasing by specifying the **goals** purchasing is intended to achieve (efficiency, equity, quality), the **purchasing arrangements and payment methods** that will facilitate achieving those goals, the **data systems** that will support effective use of the payment methods, and the **institutions** that fulfill functions for purchasing and related systems. The next three functions (2.1.4, 2.1.5, 2.1.6) relate to implementation and refinement as part of overseeing the fulfillment of purchasing functions. 2.1.4. **Planning for implementation** or refinement includes sequencing of steps, potentially beginning with pilots, and assigning responsibility for completing them. In some cases, this might involve establishing new institution(s) (e.g., a health insurance fund, accreditation agency), and assigning roles, responsibilities, and relationships across all institutions that play a role in SHP. **Overseeing progress** occurs by comparing design with implementation and monitoring the institutions to ensure they fulfill their intended roles and responsibilities, and that they are managing the changes implicated through reform. 2.1.5. A related function is ensuring that institutions and staff have the required capacity (or are building them) to fulfill their functions. 2.1.6. Another function is communicating and engaging with a broader group of stakeholders, including (a) health care providers to ensure they understand the intended incentives of SHP and to increase their willingness and capacity to participate in an active purchasing relationship with the purchaser and (b) the public to ensure consumers and patients understand the goals of SHP, service package(s) to which they are entitled, and any co-payments. **In passive systems**, decisions about goals, purchasing arrangements and payment methods, data, and institutions may be made implicitly and are continuation of the status quo. In systems that use input-based budgeting to pay for health care providers, infrastructure, medicines, etc., purchasing goals may be related to compliance and convenience. These payment methods allow governments with limited capacity to maintain strong administrative control over spending in a historically accustomed manner. Passive systems may also feature a lack of clarity over roles and responsibilities by and across institutions as change occurs within and outside of the health system (e.g., decentralization). Few analytics are available and used to monitor and adapt purchasing systems. **As purchasing becomes more strategic**, goals and payment methods become aligned with health system goals (equity, efficiency, quality). Also, provider payment methods are harmonized across different risk pools, leading to coherence across policies. Payments methods based on outputs and outcomes (performance-based) may be developed or refined. Mixed provider payment methods may be considered as a way to increase desired provider behavior and minimize negative behavior, i.e. over provision of care, high referrals, etc. Roles and responsibilities for each participating institution (for example, MOH, Ministry of Finance, Ministry of Justice, local government authorities, labor or trade unions, civil society, third party administrators, providers, associations, etc.) become more clearly defined. The distinction between purchasing and provider roles are more clearly defined and understood, maximizing each for better

SHP Group	Description of Purchasing Functions to Support Strategic Purchasing
	efficiency in, quality of, access to, and effectiveness of health care delivery. There is an intentional plan for strengthening each institution's capacity to handle more complex payment methods, aligned with a strategic plan for purchasing for the health system. Data analytic plan and operational capacity for analyzing data to monitor and refine purchasing systems are in place. In mature systems, governments invest in claims management software. Better quality data and more inclusive processes are used more frequently in overseeing implementation, planning for reform and refinements, and conducting strategic communication with the broader set of stakeholders.
2.2 The Health care Goods and Services to Purchase	The first two functions (2.2.1 and 2.2.2) are related to defining and creating systems for updating the list of covered services **(service or benefit package)** and the list of covered medicines **(an essential medicines list or formulary)**. Supplies and medical devices must be included in the total costs of providing these services. Defining these lists is often done at a high-level, while updating is usually done at a technical level. The next two functions (2.2.3 and 2.2.4) focus on specifying the requirements for purchasing from health care providers, in relation to the lists established. These requirements need to include standard treatment guidelines with standards for the quality of care delivered and guidelines for referrals, including any gate-keeping policies, such that patients must first seek care at lower-levels of care. Functions 2.2.3 and 2.2.4 also cover the review and revision of associated quality standards and referral guidelines after they are established. These guidelines and policies inform the conditions of contracting and payment; are used as monitoring and quality assurance tools for the purchaser, provider, and other stakeholders; and are usually rooted in already established MOH standard treatment guidelines. **In passive systems**, routine, data-driven, inclusive systems for updating service packages or medicine lists may not exist. Without these processes, the lists will not reflect changing burden of disease, changing technology options, or new data on cost-effectiveness or population preferences. Similarly, without standard treatment and related guidelines, stakeholders will not have the specificity they need to develop effective contracting arrangements with providers. **As purchasing becomes more strategic**, processes, including stakeholder roles and responsibilities, for defining and updating services and medicines packages and using related guidelines for contracting, will become more refined, routine, data-driven, and inclusive. Through these processes, decisions will become more explicit (i.e., clearly articulated), with specific criteria established for reaching them and with stronger research and data processes supporting them. A maturing system often uses health technology assessments (HTAs) to evaluate the cost effectiveness of health services, drugs, and devices based on international benchmarks and national conditions. HTAs are largely used to make decisions about benefit package expansion, and not to define the core essential services, so should be sequenced carefully as countries mature. Often, not all services in a service package will immediately pass the HTA. Yet, the capacity to use HTAs in decision-making will be developed by reviewing services or medical technologies new in a country but with evidence from other contexts. Refining the quality standards and guidelines for referrals, prescribing guidelines, and gate-keeping help improve the precision and explicit nature of the service package (i.e. what is included, excluded, and what level of specificity is required). In maturing systems, consultative bodies are developed or strengthened, i.e. clinical

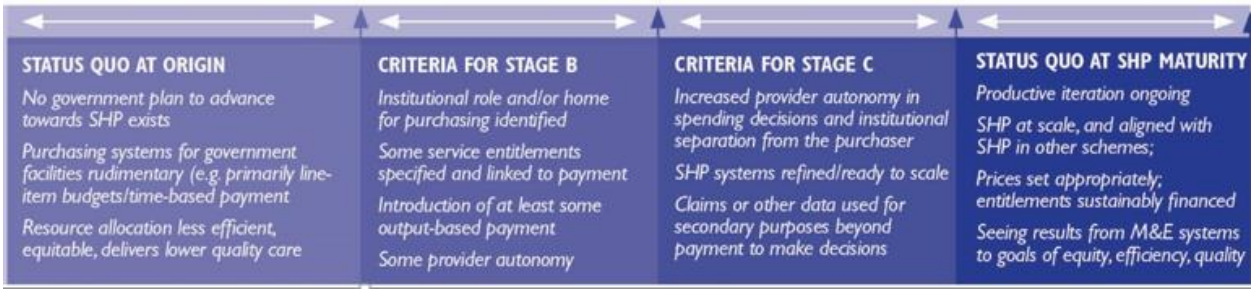
SHP Group	Description of Purchasing Functions to Support Strategic Purchasing
	classification committees, to gather health professionals' inputs in designing or redesigning these parameters. The parameters play a fundamental role in designing and implementing contracts with public providers who have increased autonomy in decision-making and private providers who are more equipped to participate in the purchasing arrangement (see below more).
2.3 The Providers from Whom Goods and Services are Purchased	Function 2.3.1 draws on the standard treatment guidelines and quality requirements of the service package to create rules that determine eligibility for providers of health care services to participate for each level of care. Function 2.3.2 is related to setting similar standards and qualifications for payment to providers of medicines, medical devices and supplies, including suppliers, distributors, and retail outlets. Function 2.3.3 is related to deciding whether and how to purchase services from private providers (including private for profit, not-for-profit, faith-based), and adapting and evolving rules for payment from 2.3.1 and 2.3.2 to their context. **In passive systems**, standards and qualifications for participation are not clearly articulated. This may be influenced by weak governance and information systems (e.g., for licensing and accreditation) and by poor quality delivered by public and private providers (weak service delivery systems, see health system groups 1.1 and 1.2). With passive purchasing in this environment, private providers are often excluded from government-managed schemes (either deliberately or due to concerns about higher costs or lack of mechanisms or incentives for them to participate), even in contexts where they account for a large share of service utilization and medicine purchases. In this situation, the purchasing system does not leverage full market resources. It may foster unfair competition and mistrust across sectors. **As purchasing become more strategic** and service delivery readiness (Function 1.1) become stronger, public and private providers may either compete or coordinate care with incentives for cross-referral helping improve continuity of care. At first, governments may establish standards and qualifications for participation; in many cases, additional reforms will be needed to ensure quality and eligibility standards are equally applied across public and private providers. In the majority of mature systems, selective contracting rules for payment with the purchaser are comparable for public and private providers, with appropriate adjustments to account for supply-side subsidies given to public providers. The relationship between purchaser and providers is regulated by the contract, defining the obligations between both parties, using empanelment or registration processes to specify the indicators for organizational efficiency, access to care, performance targets and quality (i.e. accreditation and licensing status), and clear instructions claims submission, processing, monitoring, and reporting. Institutional capacity in commissioning and contract performance management will be developed, often including capacity building of facility managers to prepare and negotiate, manage, and control contracts. In mature systems, contracts will be executed and/or renewed on a regular basis using defined performance indicators.
2.4 How to Purchase: Contracting and Provider Payment	Functions 2.4.1 and 2.4.2 apply rules set in the functional group 2.3 (above) to detail the design of the payment methods for purchasing health goods and services. Through negotiations with providers, purchasing institutions need to establish the type of contract and its time period; the basis of payment (fee-for-service, per capita, per case, per inpatient day); the payment rate/amount; and how to hold the provider accountable for delivery. When designing the purchasing system for products (medicines, medical devices, and supplies), purchasing institutions must ask questions including: Does provider payment (e.g., for an episode of care, or an

SHP Group	Description of Purchasing Functions to Support Strategic Purchasing
	individual, depending on the design) already cover the costs of medicines, devices, and supplies? Are these inputs purchased separately? What pricing policies (e.g., free pricing, internal reference pricing, conditional pricing) will we use (Maniadakis et al. 2017)? Are there limited wholesale suppliers pre-qualified by the government? Once the purchaser(s) has a detailed design of the purchasing methods and contract terms, it needs to enter into, manage, and monitor contracts with providers of services and products (Function 2.4.3). Functions 2.4.4, 2.4.5, and 2.4.6 concern oversight of implementation across providers. It is distinct from 2.4.3, which includes management of individual contracts, since it requires aggregating information across multiple contracts and analyzing trends. This function, providing oversight over providers, is also distinct from 2.1.4, which is about oversight over purchasers. **In passive systems**, contracts don't exist or they are informal and less specific and have weaker data systems to support monitoring provider performance. As a result, contracts will be harder to monitor and thus will be less effective in shaping service delivery, and may allow for fraud and gaming. With insufficient data on costs of service delivery, payment design may not account for important differences by region, condition, or level of care, and prices will not accurately reflect actual costs. Without needed data, purchasers may not be able to aggregate performance data and discern trends, and thus lack opportunities to engage in routine learning and adjustment. **As purchasing become more strategic**, parameters on what data will be needed to monitor the purchasing system, and how data will be used to make adjustments or changes in the system will be clearly defined. Data including for costs and patient encounters (outpatient visits, diagnostic tests, hospital admissions) will improve and be more tightly linked to payment design (for example an electronic medical record that documents compliance with clinical guidelines as required for payment). A collaborative process, drawing from a myriad of health professionals including physicians, nurses, and hospital managers to economists, lawyers, and IT specialists will be established to design, review, and refine payment design. Payment rates will better reflect real costs and include risk adjusters for cost differences across geographic location, level of care, age, and gender. Accurate encounter data through use of effective claims management software and electronic patient registers will help improve provider performance monitoring systems, which purchasers use to routinely monitor individual contracts and analyze trends across them. A usual step as countries mature is to adopt internationally recognized systems for coding of diagnoses (ICD-10) and procedures (ICPC-2, ICPM, and ICHI) to operate and monitor the purchasing system. An investment in developing a culture of and building capacity for coding will be required. This is also often a precursor to using advanced claims management systems. When first established, contracts between purchaser and provider may not be strong enough to drive specific service delivery objectives. As processes (including price setting) and relationships strengthen, contracting will play a central role to use purchasing to shape service delivery.

2.4 Characteristics of Stages and Progress

The framework shows a progression from a health system with passive purchasing to one with strategic purchasing. This progression has been simplified into three stages based on analysis of SHP in two 'mature' countries (Canada and Germany) and one at an earlier stage (Tanzania): ***A) Initiating SHP, B) Implementing and strengthening SHP***, and ***C) Iterating SHP processes***. Users of the framework can assess in which stage the purchasing system(s) under analysis is in by comparing the purchasing system in question with the characteristics of purchasing at origin and maturity (stage C) and the criteria for advancing from one stage to the next (Figure 2). These criteria highlight baseline characteristics and milestones that stakeholders must achieve along a pathway to SHP maturity.

Figure 2. SHP Progress Framework - Criteria for Each Stage



Note that these criteria are illustrative and not all of them need to be present for users of the framework to classify a purchasing system in a particular stage. For example, a government might have a plan for advancing SHP, but it might be too general to stimulate action or be blocked politically. In this scenario, a purchasing system might still be considered to be "at origin" even though a plan exists. While progression appears to be a simple linear pathway from passive to strategic purchasing, in reality, countries' progress has the following characteristics:

2.4.1 Progress is non-linear

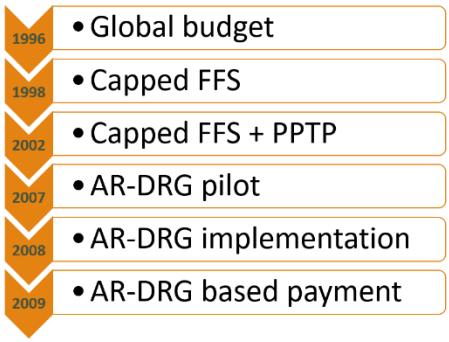
As the arrows between the stages indicate, progress from stage A to stage C may occur in fits and starts, as steps are taken to introduce new functions, improve existing functions, and as systems adapt. It is common, for example, for many country governments to get stuck at rudimentary levels of strategic purchasing methods for many years due to low technical capacity, political economy obstacles, rigidities in PFM systems, and low awareness or political will.

It is also possible to move backward in some functions. For example, a government may change and usher in massive reforms that alter the foundation of the scheme(s). For example, Vietnam's plans to implement capitation payment for primary health care (PHC) were blocked by a separate piece of legislation that did not allow patient choice to be limited. Since capitation requires that each person be linked to a preferred PHC provider for a fixed period of time, the payment system was not supported under the new law. In these cases, purchasing systems development will appear more linear, with some progression from A through B to C, only when considering larger time units.

In other settings, the progression might be linear. In Croatia, for example, hospital financing reform occurred incrementally, with each step building on the previous one (Figure 3). The Croatian National Health Insurance began first transitioned from global budgets to capped fee-for-service (FFS). This is a global budget with FFS invoicing up to a ceiling or cap. The purchaser then transitioned to diagnostic related groups (DRGs) incrementally, beginning with pilot testing before scaling up DRGs nationally.

Figure 3. Hospital Financing Reform in Croatia

Source: Strizrep n.d.



2.4.2 Pace will vary by country

Stage A, for example, can be long or short. In some countries, Stage A can occur in perpetuity. Less centrally-planned governments may make significant progress in SHP through bottom-up strengthening, and others may have plans that are never implemented.

2.4.3 Purchasing functions interact as they evolve in tandem

The purchasing and health system functions presented in the framework will evolve as each one strengthens and interacts with the other. ***Importantly, there is no recommended sequencing of steps to progress across the groups of functions, based on theory or country experiences.*** In some cases, purchasing functions will strengthen after progress in other parts of the system occurs. For example, with revisions to PFM systems that allow for activity-based contracts, government health agencies may have more purchasing methods that are feasible to implement.

At the same time, progress in purchasing can also stimulate improvements elsewhere and can overcome seemingly prohibitive barriers. For example, stakeholders may believe that fragmentation in pooling prohibits the ability of a government to pursue strategic purchasing. Instead, in some cases (as in the Tanzania case described in Section 3.3), purchasing can help consolidate pools of funds and reduce fragmentation. In another example, when Ghana's National Health Insurance Authority began implementing capitation to purchase a package of primary care services, it exposed large service delivery gaps. Many providers were not able to deliver all the services in the package. The gaps are now being addressed outside of the purchasing function. These gaps were always there but SHP brought stakeholders together to earnestly address them (Ghana MOH and Ghana Health Service 2015) These examples highlight the flexibility of the framework and the importance of country context in making any judgements or recommendations about how to advance systems forward.

2.5 Applying the Framework

The SHP Progress Framework is a way to document a country's past efforts and current status along the seven functions in order to judge its progress to date and identify the most promising next steps. Policymakers and practitioners who have a tacit understanding of their country's reform efforts, and understand the successes and challenges are best positioned to use the framework. Users apply the framework in several steps:

1) Identify a large government-managed health financing scheme for which an analysis of SHP would help stakeholders assess the current purchasing system and consider alternative methods to improve efficiency, equity, and quality. This can include the ministry of health, in its capacity as a third-party purchaser purchasing services for their citizens, as they oversee payment to providers.

2) Provide details—for each group of SHP functions—about the current purchasing system, including which actors fulfill which function and their roles, responsibilities and interrelationships with other actors. In the case of previous and/or on-going efforts to shift to strategic purchasing, describe how the purchasing system has evolved since a time when it was at "Origin," i.e., before stakeholders began planning for SHP (Stage A). Reviewing past efforts, progress and failures, will reveal lessons about weaknesses and opportunities that should be useful for next steps.

3) Provide details—for each group of health system functions—about ongoing activities and systems, highlighting how they are facilitating or hindering progress towards SHP. Feel free to work outside of the table as in the case study examples. Be flexible with the narrative order and combination of functions. Each country example below uses a slightly different narrative order for their SHP story.

4) Assess where the country is—for each group of purchasing and health system functions—by comparing the purchasing system in question with the characteristics of purchasing at origin and maturity, as well as the criteria for advancing from one stage to the next.

5) Use results from this analysis to inform discussions about developing or revising country plans for advancing SHP across each functional area.

In the next section, we apply the SHP Progress Framework in three different countries that are on different paths to UHC. In one case (Tanzania), we capture the evolution in health system and purchasing functions, making best use of the framework. In the other two (Canada and Germany) we simply present a snapshot or status of the functions, due to methodological limitations.

3. APPLYING THE FRAMEWORK TO VISUALIZE SHP PROGRESSION IN CANADA, GERMANY, AND TANZANIA[1]

3.1 Canada

3.1.1 Introduction

Canada's health system is designed to meet the standards of health service availability, quality, and equity as outlined in the Canada Health Act of 1984 and protects access to timely healthcare as a human right in the Canadian Charter of Rights and Freedoms of 1982 (Canadian Parliament 1984, 1982). Thirteen separate provincial and territorial health insurance plans, collectively referred to as 'Medicare', operate to ensure all Canadian residents and permanent residents have reasonable access to medically necessary hospital and physician services without paying out-of-pocket. Responsibility for health care services is shared between provincial/territorial governments and the federal government (Government of Canada website 2018). However, each province or territory is ultimately responsible for the management, organization, and delivery of health care services. The Federal government is responsible for setting and administering standards via the Canada Health Act, providing federal financial transfers to support the cost of provincial and territorial health services, and supporting the provinces in delivering health services for specific or underserved groups. Provincial and territorial plans must adhere to the principles of comprehensiveness, universality, portability, and accessibility as outlined in the Canada Health Act. Medicare therefore comprehensively covers the costs of medically necessary primary and acute care services provided by hospitals, physicians, and hospital-based dentists.

The Canada Health Act does not explicitly outline medically necessary services, but instead directs that provincial and territorial health plans consult with physician colleges and groups in outlining medically necessary inclusions for provincial insurance purposes. For example, specific services or commodities may be included in provincial plans to address certain needs for prescription drugs, general dental and vision care, or services for specific populations or groups, including seniors, social assistance recipients, and eligible First Nations health service users. Provincial and territorial plans must also be universal (covering all residents) and portable (honored in provinces across Canada). All plans must be accessible, ensuring access based on medical need and not ability to pay. At present100 percent of recurrent Medicare expenditures are covered by national and provincial government revenues through the Canada Health Transfer system (Department of Finance, Government of Canada website 2018).

Although Medicare inclusions are generally comprehensive and ensure all residents timely access to medically necessary care, there are several individual health costs or preferred expenditures that are excluded from most provincial health plans (e.g., dentistry, physiotherapy, prescription drug costs, rapid access to specialize care, etc.). As a result, nearly two-thirds of Canada's population hold some form of supplementary coverage through private insurers to cover the costs of additional or excluded services.

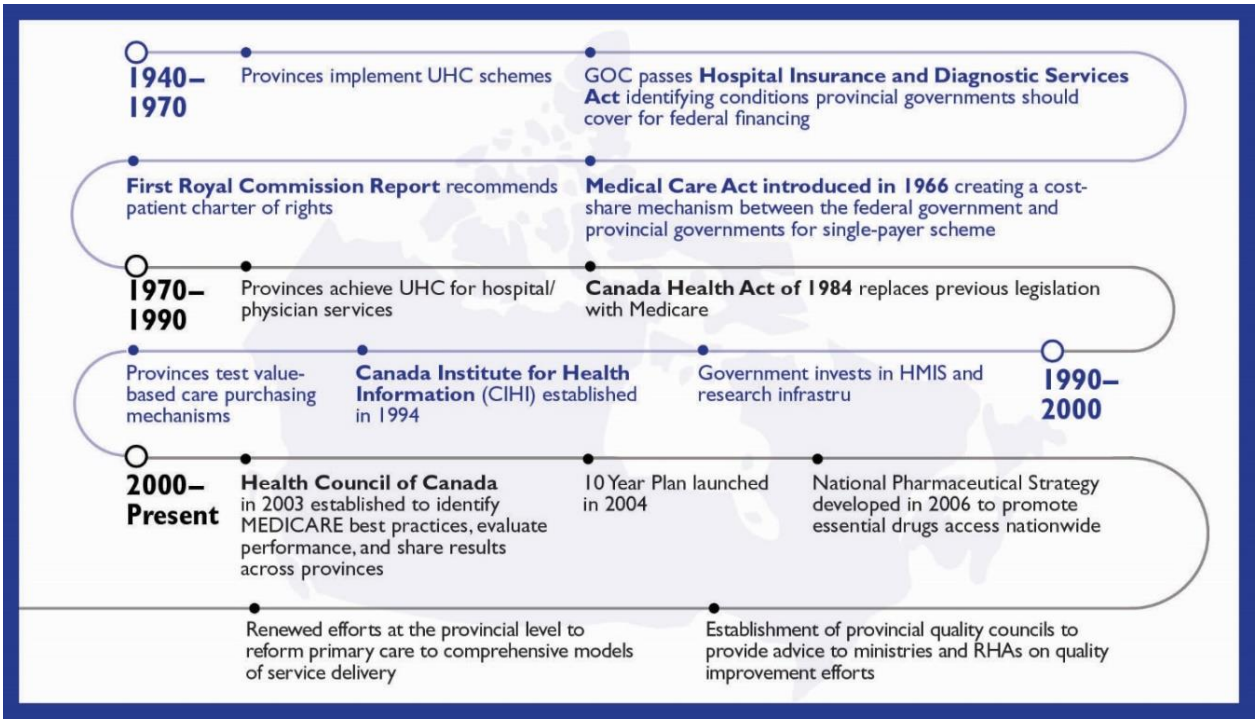
[1] Content for Case Studies, unless otherwise cited comes from the most recent Health System Review (HIT) reports from WHO

For example, OOP and private health insurance spending on prescription drugs comprised 53.9 percent of total national spending on prescription drugs in 2008.

Provincial governments implementing Medicare predominantly use FFS payment mechanisms to reimburse providers, though provinces do use alternative methods to target specific services or patient groups, including capitation, value-based bundled payments, and incentives for physicians to work in rural areas. In each province, facilities are operated by regional health authorities (RHAs) acting effectively as both purchaser and provider, but the relationships between the RHA, individual physicians and health providers, and provincial health authorities are nuanced, including agreements with providers and accountability requirements to the provinces to stay within established global budgets.

Ultimately, Canada's Medicare program operates in a highly devolved and decentralized fashion, where individual provincial and territorial plans are in various phases of maturity and functional efficiency and where supporting systems are also still progressing. For example, provincial health authorities are making efforts to redesign payment systems to improve efficiency and quality, including an integrated service delivery and payment approach for primary care, strengthening data interoperability, pursuing value based financing, and advancing community-focused PHC efforts. Long wait times and other access issues in urban centers and other locales are also reinvigorating discussions associated with scaling the provision of privately delivered options in ophthalmology, physiotherapy, mental health, and other supplemental health services. Figure 4 illustrates a brief timeline, capturing Canada's progression toward SHP and UHC over time. In the following pages, we use the progress framework to better understand the current status of each function, illustrating elements of a mature SHP system and priority areas for further reform and improvement.[2]

Figure 4. Timeline of Progressing Strategic Purchasing Functions in Canada



[2] A country stakeholder's application of the progress framework should include major historical and evolutionary data points that give details on how various reforms took place, including stakeholder engagement, negotiation, etc.

3.1.2 Canada's Purchasing Functions, Moving from Passive to Active Purchasing

Governance and information

Box 3. Canada Case Study Acronyms

RHA	Regional Health Authority
HCC	Health Council of Canada
CIHI	Canada Institute for Health Information

Canada's Medicare system, implemented separately across the 13 provincial and territorial plans, is a highly devolved and decentralized system. The provincial and territorial governments are responsible for administering a single-payer system for universal hospital-based, primary physician, and supplemental diagnostic services for their residents. Provincial and territorial governments have created RHAs, which operate at an intermediate level between provincial health ministries and individual providers. Provincial and territorial health ministries each set a broad strategic direction, while the RHAs carry out detailed planning and coordinate with a range of health care organizations and providers within a defined geographical area. RHAs set their priorities through annual budgets (occasionally supplemented by multi-year plans) that are submitted to provincial health ministries.

Since 2005, there have been no major national health reforms. However at the province and territorial levels there have been two categories of reform impacting service providers: 1) reorganization of RHAs and 2) quality improvement initiatives for primary, acute and chronic care. The RHA reorganization resulted in some consolidation of RHAs to capture economies of scale and scope in service delivery as well as reduced infrastructure costs.

Because of the devolved and decentralized nature of Medicare, there is currently no national policy to promote SHP outside the Federal 'Canada Health Transfer' (Department of Finance, Government of Canada website 2018). However, in pursuit of service delivery efficiencies and extension of services to alternate providers, all provinces are using some form of alternative payment mechanisms in addition to FFS contracts. In most provinces, RHAs act both as providers and purchasers of hospital care in public hospitals and manage other services as delegated by provincial law. Agreements between the RHA, providers, and provincial health authorities set accountability requirements that financially motivate RHAs to stay within their global budget.

There have been ongoing efforts to improve the efficiency of Medicare. Most ministries and RHAs have implemented some aspects of performance measurement in an effort to improve outcomes and processes. Both the Health Council of Canada (HCC) and Canada Institute for Health Information (CIHI) monitor quality indicators, identify best practices, and analyze administrative data to evaluate provincial/territorial health systems. Some provinces are also making efforts to move away from the FFS and have established institutions and mechanisms to improve the quality, safety, timeliness, and responsiveness of health services. However provincial ministries have been reluctant to use performance indicators as a tool in managing the delivery organizations in their respective health systems and to facilitate systematic comparisons of the performance across provincial health systems.

The Canadian Agency for Drugs and Technologies in Health (CADTH) is responsible for carrying out HTAs at the national and provincial levels to support health quality and synthesizing and sharing data for decision-making. Canada's Institute for Health Information (CIHI) and CADTH both have mandates to review and harvest various data sets in an effort to disseminate best practices and relevant lessons for implementing Medicare to provincial stakeholders and health system users. To date, more national/provincial disease registries have been established, though patient-reported outcome measures

have not yet been successfully integrated into existing government datasets (Economist Intelligence Unit 2016).

Healthcare goods and services to be purchased

The Canada Health Act (1984) set nationwide standards for hospital, diagnostic, and medical care services with the aim of ensuring that Canadian residents have reasonable access to medically necessary services on a prepaid basis. Medically necessary hospital, diagnostic, and physician services are free at the point of service for all provincial and territorial residents.

The typical patient pathway starts with a visit to a family physician, who then determines the course of basic treatment, if any. Family physicians act as gatekeepers; they decide whether their patients should obtain diagnostic tests and prescription drug therapies or should be referred to medical specialists. However, provincial ministries of health have renewed efforts to reform primary care in the last decade. Many of these reform efforts focus on moving from the traditional physician-only practice to inter-professional primary care teams that provide a broader range of primary health care services on a 24-hours, 7-days-a-week basis. In parallel, there are efforts to reduce reliance on tertiary/hospital-based services.

Currently a debate persists about whether prescription drugs should be covered for all residents as part of the basic package of Medicare goods and services. For example, in 2017 the province of Ontario's health budget included the full cost of all prescription drugs for all residents under the age of 25. However, broader implementation of this policy in Ontario and/or other provinces and territories is unlikely to occur without significant new fiscal transfers from the federal government to the provinces and territories.

Health Services covered by provincial or territorial Medicare plans typically include the total cost of:

- Primary and preventive health care
- Most acute care (provided in public or non-profit private hospitals)
- Mental health care provided in hospitals or by physicians
- Prescription drugs (covered for designated populations, e.g., seniors and social assistance recipients, eligible First Nations and Inuit)
- Inpatient rehabilitation
- Medically necessary home care and rehabilitation services
- Chronic care facilities with 24-hours-a-day nursing supervision (older adult/individuals with disabilities)

Services not generally covered by Medicare:

- Prescription drugs (if patient does not meet requirements of prescription drug plan)
- Dental care
- Vision care
- Mental health care from non-hospital/physician providers (e.g., psychologists)
- Residential care with some assisted living services (older adult/individuals with disabilities)
- Home-based long term care (coverage varies significantly by province)
- Home-based palliative care (coverage varies significantly by province)

- Non-medically necessary outpatient rehab services
- Complementary and alternative medicine (with a few exceptions e.g., chiropractors in some provinces)
- Non-medically necessary physician and hospital services
- Some specialized ambulatory and advanced diagnostic services.

Providers from whom goods and services are purchased

In many provinces, the majority of hospitals are now owned and operated by the RHAs, and the remaining independent hospitals are contractually obliged to provide RHA residents with acute care services. To the extent that hospitals are integrated in RHAs in Canada, there is no separation of purchaser and provider. However there are agreements between the RHA, providers, and provincial health authorities that set accountability requirements and help the RHA stay within their global budget and create clear purchaser and provider roles and responsibilities.

Primary health services in Canada are largely delivered by private primary healthcare physicians, nurse-practitioners, or other team-led PHC facilities. These entities are typically registered as private 'independent contractors who are not directly employed by either the RHAs or provincial ministries of health. Yet, for the most part nearly 100 percent of their income comes from provincial reimbursement for FFS rendered, though alternative payment mechanisms like salary, sessional fees, and capitation are being explored in many provinces (Picard 2018). Specialist physicians, who are registered as private independent contractors, also largely deliver services paid for by provincial ministries. In the case of those hospitals that contract with RHAs, for example, all hospitals in Ontario and Catholic hospitals in Western Canada, most payments are generally made on the basis of the previous year's allocation adjusted for inflation and budget growth. However, some RHAs have introduced or experimented with other modes of payment, including activity-based, patient-centered, and incentive-based payment models. To date, no comprehensive evaluation comparing these hospital-payment mechanisms has been conducted.

It should be noted that services outside can be provided and billed to private insurers where PHC providers or specialists are not allowed to charge fees or services covered by the Canada Health Act. Some supplemental health services are only partially covered by provincial Medicare plans, including ambulance costs, complex diagnostic laboratory services, and private beds or non-essential ancillary hospital services. These costs are typically covered by a private insurance plan or paid for OOP if deemed non-essential or not medically necessary. Services such as dental care, vision care, and psychology and rehabilitation services are minimally covered by Medicare and are typically delivered by independent contractors to those with private insurance or means to pay OOP.

Health organizations, including RHA-managed and independent health facilities, are accredited on a voluntary basis through Accreditation Canada, a member-based, non-governmental organization. All healthcare providers including physicians, nurses, pharmacists, dentists, optometrists, chiropractors, physiotherapists, and occupational therapists are required to register with their respective professional governing association at the provincial level, and all health professions are organized as self-governing professions under provincial and territorial laws.

While the specific regulatory approach for provider groups can vary considerably across provinces and territories, there is remarkable consistency in approaches among certain professions such as physicians, nurses, and dentists across all jurisdictions. Moreover, there have been considerable intergovernmental efforts to address the issue of portability of qualifications among provinces due to each registered health profession having its own rules concerning the registration of its members within a province or

territory. The self-regulated professions are expected to ensure that members are properly educated and trained and enforce minimal quality of care standards.

How to purchase: Contracting and provider payment

Most hospitals are paid through global budgets, either directly (by ministries of health), or indirectly through budget allocations to RHAs. The global budget may be determined by a variety of means (e.g., based on needs/volume, or by adjusting for risk factors), and not just by adjusting historical budgets for inflation. In recent years, some jurisdictions in Canada have begun to experiment with alternative forms of payment mechanisms for hospital care, including activity-based payment.

The majority of physicians continue to be remunerated on the basis of FFS, although alternative payment methods including capitation, blended (salary and fee) payments, and contract-based payments are also applied most commonly salary and fee or capitation and fee. Blended payments are most commonly used in primary care and inpatient specialty care. Fee-for-service remains dominant in outpatient specialist care. The most recent innovative payment reforms used in Alberta and Ontario include add-on payments (e.g., pay-for-performance), bundled payments (e.g., for episodes of care or managing chronic conditions) and population-based payments (e.g., groups of healthcare providers receive payments based on the population covered) (Mattison and Wilson 2017).

Many health policy analysts have been critical of the incentives created by FFS, including the incentive for overprovision of medical services, but the system remains popular among many physicians. Physician contracts are periodically renegotiated by the provincial medical associations with provincial ministries of health. They negotiate the FFS rates as well as other rates and incentives (salaried and sessional rates, northern and isolation allowances, lab fees). In the past, provinces have sometimes temporarily frozen or reduced rates, usually during a period of fiscal austerity. This can be done variously with emphasis on specific objectives (e.g., reducing the income gap between family medicine and some specialties). Typically some kinds of specialists get paid less if they provide services without a family practitioner or other specialist referral.

One advantage of FFS is that it generates lots of detailed data on individual physician patterns of practice, the relationship between price and volume, and regional and specialty variations. There is also a lot of claim adjudication (i.e., not every physician can bill every fee item, and if a practice seems abnormal this can be reviewed.) Provinces regularly review and adjust prices. For example, when a new service or procedure is first introduced it might be quite low volume and limited primarily to a few specialists. Over time the use may become more generalized and less sophisticated, and the price might be reduced. Also, some procedures that are not popular with physicians but which are efficient and effective might have their price raised if they are priced to low.

Most non-physician health care personnel (at both public and private facilities) are paid a salary to work within hierarchically directed health organizations. Within this group, regulated nurses are the most numerous. Most nurse remuneration and conditions of work are negotiated through collective bargaining by nurses' unions and province-wide employer organizations, often with provincial governments setting broad fiscal parameters.

Historically, concerns about public health care were either expressed to provincial and territorial ministries of health and their ministers or to members of opposition parties, who would then question the governing party through the media and in the legislature. Pressure mounted on governments to establish less difficult complaints procedures. As a consequence, some provincial and territorial ministries of health (through external ombudsmen offices or a ministry office), RHAs, and hospitals have established internal complaints procedures. Though, complaints continue to be adjudicated mainly through private professional regulatory authorities at the provincial and territorial levels of government. These complaints can range from concerns about the poor bed manners of some health professionals at one end of the spectrum to allegations of life-threatening medical errors.

3.1.3 Canada's Health Systems Functions, Moving from Passive to Active Purchasing

Governance and information systems

Provincial governments have invested in health information and communications technologies infrastructures with plans to create interoperable electronic health records (EHRs) for all provincial residents to support system-wide planning. Canada currently has several information systems in place for the collection, reporting, and analysis of health data.

Most ministries and RHAs use at least some indicators and measures to identify poor performance and improve both processes and outcomes. The HCC identifies best practices and evaluates performance in key health reform areas nationwide and disseminates the results to all provincial/territorial governments as well as the general public via its website.

Provincial and territorial governments have been collecting detailed administrative data since the introduction of universal hospital and medical insurance plans. By the mid- to late 1990s, governments were beginning to invest time and resources in their health information, research, and data management infrastructures. In 1994, the federal and provincial governments established the CIHI to hold, improve, use, and disseminate administrative data from the provinces and territories as part of a larger effort by governments to better understand and evaluate their respective health systems. CIHI works with federal, provincial, and territorial governments in establishing and maintaining data definitions and quality standards. The agency also works with provider organizations in maintaining databases, including physician and hospital discharge databases. While health data systems are not yet fully interoperable, efforts are being made towards this goal.

These improvements in the collection, organization, and dissemination of health system data were spurred by the recommendations of arm's length commissions and ministerial task forces.

Canadians have benefited from more public reporting on indicators and performance measures, an outcome of governments and other public actors being held accountable for the management of health systems at the national, provincial, regional, and local levels. The work of the CIHI and HCC have facilitated this type of public accountability.

Service readiness and provision

As previously discussed, most acute care in Canada is delivered in public or private non-profit hospitals that recoup costs almost exclusively from provincial public financing. In several provinces, most hospitals are owned and operated by RHAs serving as both purchaser and provider. The remaining privately governed hospitals are contractually obliged to provide RHA residents with acute care services defined in the Canada Health Act. Both primary care providers and specialists operate as independent contractors, though revenue is largely driven by provincial funding sources. Health facility personnel are incentivized financially, distinctly from these agreements, to encourage the provision of services in rural or inhospitable areas.

The provincial colleges of physicians are responsible for licensing physicians. They also enforce standards of practice and investigate patient complaints against members for alleged breaches of ethical or professional conduct. As is the case with most professions in Canada, physicians are responsible for regulating themselves within the framework of provincial laws. The Royal College of Physicians and Surgeons of Canada oversees a continuing professional development program for physicians and other healthcare professionals that requires a minimum number of credits per 5-year cycle.

Sufficiency and institutional flow of resources

The provinces raise the majority of funds through tax revenues. They also receive less than one-quarter of their health financing from the Canada Health Transfer, an annual cash transfer from the federal government. The transfer payments are made on an equal per capita basis, and the total transfer amount grows in line with a three-year moving average of nominal gross domestic product (GDP). Historically, the federal government has played an important role in the Canada Health Act of 1984 by encouraging the introduction of the provincial/territorial health insurance plans, discouraging the use of user fees, and maintaining insurance portability among provinces and territories by tying contributory transfers to the upholding of these conditions.

Out-of-pocket payments and purchases of private health insurance are responsible for most health expenditures on goods and services not covered by Medicare, including prescription drugs, dental care, and vision care. OOP payments and PHI comprise 15 percent and 12 percent of total health expenditures, respectively. Medicare goods and services do not require any OOP payments and are not covered by PHI. The vast majority of PHI is employment-based insurance and only covers non-Medicare goods and services.

Budgetary allocations for health expenditures are made at three levels: (1) the federal government (2) the provincial and territorial governments, and (3) RHAs. At the federal and provincial levels, budgetary allocations are decided in cabinet and then reviewed and passed in the respective legislative chambers. Once ministries of health receive their budgets, they allocate among numerous health services and sectors based on the historic needs and demands of the sector as well as health policy and reform priorities as communicated by the cabinet. In regionalized jurisdictions, the majority of ministry funding is distributed to RHAs based on a variety of methodologies, including population needs-based formulas, activity-based calculations, historically-based budgeting, and the government's immediate policy priorities. However, there have been few empirical comparisons of these different methodologies.

3.2 Germany

3.2.1 Introduction

The German Statutory Health Insurance (SHI) system, first established in 1883, is the world's oldest social health insurance system. The core principles of solidarity and self-governance (Busse et al. 2017) have defined the evolution of the German system (as demonstrated in Figure 2) and are evidenced by a comprehensive UHC system offering an increasingly expanding benefits package. It is mandatory for all German citizens to hold some form of health insurance; 96 percent of the population is covered either through SHI (85%), private health insurance (PHI) (11%), while the remaining 4 percent are covered by other schemes. Public sources of funding accounted for 85 percent of total health expenditures in 2015 (OECD 2018). Within the German health care system, most of the decision-making power has been delegated by the federal and state governments to self-regulated organizations of health care providers and payers. More than 100 sickness funds (purchasers) exist within the SHI system, organized in regional (state-level) and federal associations. In the past, German government policy has focused on containing costs and achieving sustainable financing in health care. Recently, the focus has shifted towards quality.

Germany boasts a mature and effective strategic health purchasing system (outlined below). However ongoing efforts to improve the effectiveness of health policy, service readiness and provision, and purchaser financing arrangements demonstrate an emphasis on quality as the German social insurance mechanism continues to evolve. See brief timeline below (Figure 5). In the following pages, we use the proposed framework to better understand Germany's approaches to SHP and the country's progress toward quality UHC.

Figure 5. Timeline of Progressing Strategic Purchasing Functions in Germany

3.2.2 Germany's Health Systems Functions, Moving from Passive to Active Purchasing

Governance and information, and governance of purchasing

Goals and payment methods; stakeholder engagement

Cost-containment (i.e. cost management) in Germany has been articulated as a main goal within the SHI system since 1977. Several legislative measures have been undertaken to contain costs and increase efficiency by encouraging competition and simultaneously maintaining quality and equity of access.

Decision-making power within the German health system is mostly delegated to self-governing or self-regulated organizations (i.e., federal and regional sickness funds associations and provider groups). The

highest decision-making authority is the Federal Joint Committee, formed with representation from the various associations of providers and sickness funds. These organizations operate within a regulatory framework set forth in the Social Code Book (SGB/ *Sozialgesetzbuch*). The Federal Ministry of Health (FMOH) and state-level authorities play primarily a supervisory role. However, in certain occasions the FMOH has played an important role where the self-governing organizations were not able to deliver on their responsibilities (e.g., this was the case at the time of the introduction of the DRG payment system for hospitals in 2003, where the FMOH stepped in to define the basic characteristics of the system). Since 1972, the roles of the various actors (i.e., the federal government, the states, and the sickness funds) in financing hospitals were clarified by law. The roles of the provider and sickness fund groups and their interactions with each other are also defined by law. One important characteristic of the German system is the full autonomy of providers, who are self-governed through the federal- and regional-level organizations mentioned above.

Box 4. Germany Case Study Acronyms

FMOH Federal Ministry of Health
PHI Private Health Insurance
SGB Social Code Book/ Sozialgesetzbuch
SHI Statutory Health Insurance

The SHI Modernization Act, passed in 2003, has regulated the participation of patients in the SHI system. Multiple stakeholders, including professional associations and patient organizations, are granted formal rights to participate in health care decision-making. Patients, represented by various organizations and groups, are increasingly participating in key decision-making bodies of the system including the Federal Joint Committee.

The gradual implementation of reforms in Germany has been recognized as an innovative governance approach by international organizations. The introduction of DRGs at the hospital level by the self-governing organizations and the FMOH was one of the most important purchasing reforms. The DRG payment system was introduced in a stepwise fashion over a five-year period—an approach which allowed for iterative learning and continuous refinement of the system, including sufficient time for providers to adapt to changes in invoicing and payment mechanisms.

Information and reporting systems

The policy-making process is driven by robust information and reporting systems. Federal Health Reports, published on an annual basis since 1998, are comprehensive reports containing data on epidemiology, public health, and health care in Germany. Additionally, the Advisory Council for the Assessment of Developments in the Health Care System produces bi-annual reports on health system developments, highlighting, among other things, the economic impact of trends in health care provision. HTAs are conducted on a regular basis, and a database of HTAs is in place to aid with decisions related to SHI benefits package updates. The Federal Association of Sickness Funds and the Federal Association of SHI Physicians are also legally required to publish information on their performance and activities.

Hospitals are required to have established patient complaint management systems. In addition, other types of providers, state-level groups of providers, and sickness funds have mechanisms in place to address patient complaints.

The Federal Office for Quality Assurance was founded to help sickness funds and providers develop and monitor quality indicators, publishing annual hospital quality reports made available for public consumption. Now, its role has been outsourced to the Institute for Applied Quality Improvement and Research in Health Care (AQUA Institute). Hospitals are required by law to publish biannual standardized quality reports and make them accessible to the public. Systems for both measuring hospital quality based on routine data and of developing standard quality indicators for ambulatory care also have been designed.

Service readiness and provision

In the past, public health, outpatient, and hospital services were clearly separated within the German health system by scope and available service package, with hospitals providing only inpatient care. Integrated care was introduced in 2000 to enhance coordination between outpatient care providers and hospitals. In 2003, structured treatment programs (Disease Management Programs) were introduced with the purpose of coordinating the multiple outpatient care services provided to chronically ill patients by various outpatient health care providers. These efforts enabled stronger and more integrated contract agreements between the sickness funds and provider groups within a region. More recently, the SHI Care Structures Act (2011) was enacted to improve equity in the distribution of and access to health services throughout the country, particularly in rural areas. Current law requires provider groups to ensure adequate access—geographic distribution according to population needs.

Investments in hospital infrastructure are primarily made by state governments but such investments have declined over time and have not been equally spread throughout the country. More recently, the sickness funds have also taken a role in infrastructure investments as part of quality improvement efforts, specifically those associated with repairs and maintenance of buildings.

State-level professional groups are responsible for the accreditation and continuing education of health care professionals. Current German law requires specialization (secondary professional training) in order for physicians to become SHI-accredited. All health care professionals providing outpatient care to SHI beneficiaries are required to engage in continuing education, and provide evidence of professional development every five years. SHI-accredited physicians that do not provide evidence of professional development may have their SHI reimbursements reduced.

In training new health providers, The Hospital Financing Reform Act of 2009 introduced a support program to address the shortage of nurses in hospitals. Sickness funds also finance the practice-based training of health care professionals in hospitals, in addition to financing nursing schools. Purchasers and regional physician associations are required by law to pay half of the salaries of general practitioner trainees.

Sufficiency and institutional flow of resources

Sufficiency of funding

Health financing policy has traditionally relied on basing expenditures on revenue, given the long-term focus on cost containment and sustainable financing. Therefore, pooled funds have historically been sufficient to undertake the intended purchasing.

Pooling/Fragmentation

Previously, individuals were not free to choose a sickness fund, but were instead assigned to specific funds based on geographic location and employment. This system created fragmentation of risk pools, with variation in income and disease profiles among the sickness pools.

The system was reformed in 1993 with the introduction of the Health Care Structure Act, which gave individuals the freedom to choose among sickness funds. The first risk-adjustment scheme, based on gender, age and disability, was also introduced in 1994. That risk adjustment scheme also adjusted for income disparities. A country-wide uniform risk-adjustment mechanism was then introduced in 2001 to address concerns about increasing funds needed for redistribution. The reformed scheme also introduced a better mechanism for adjusting for differences in morbidity among sickness funds.

Since 2009, all German residents are required to have health insurance, which in turn increased the size of the SHI risk pool due to mandatory enrollment. The Central Reallocation Pool, the current

morbidity-based risk adjustment scheme, was also introduced in 2009. Contributions collected by the various sickness funds are transferred to the Central Reallocation Pool, and from there they are distributed back to the sickness funds based on a morbidity-based risk-adjustment scheme managed by the Federal Insurance Authority. The sickness funds do not set the contribution rates; a uniform contribution rate is set by law. However, if expenditures exceed the available funds, a sickness fund may charge its members a supplementary premium. Contributions are based on income.

The separation between SHI and private health insurance results in different risk pools and creates inequity. This is a challenge that remains to be addressed.

3.2.3 Germany's Purchasing Functions, Moving from Passive to Active Purchasing

Healthcare goods and services to be purchased

The Federal Joint Committee has the primary role of issuing directives related to determining the inclusions of benefits coverage. The Institute for Quality and Efficiency in Health Care, a foundation financed by the various stakeholders (i.e., sickness funds and provider groups), assists the Federal Joint Committee in making decisions associated with SHI benefits and inclusions by conducting research and evaluations and preparing scientific reports on various benefit options, drugs, diagnostics, technologies, guidelines, etc. A database of health technology assessments is in place, guidelines are in place for evaluating services for inclusion in the benefits package; by law, included health services must be evaluated for need, medical necessity, and efficiency. The preventive and screening services that are included in the benefits package are defined in detail in the SGB law of 1988. The curative, diagnostic, and therapeutic services included in the benefits package are defined in more detail by the Federal Joint Committee.

Germany does not have a proscriptive list of pharmaceuticals eligible for SHI reimbursement. Historically, most drugs that are licensed in the country become eligible for SHI reimbursement, although some restrictions have been introduced in the recent past to exclude certain drugs from SHI coverage. Common over the counter (OTC) drugs, for instance, are not reimbursable by SHI. Furthermore, regulations are in place to limit reimbursement for the prescription of certain drugs for specified conditions.

There is no gate-keeping[3] in the German system. Patients are free to choose their providers, including specialists.

The providers from whom goods and services are purchased

Only private providers (pharmacies are registered as private entities) offer outpatient care in Germany. Hospitals include a mix of private for-profit, private not-for-profit, and public sector registered entities. All hospitals, regardless of their ownership, provide services to SHI beneficiaries and are subject to the same regulations. Germany has the highest number of available hospital beds per capita (806 beds per 100,000 population in 2016) among European Union member states (OECD 2018), and the number of beds in registered private hospitals has been increasing over time.

Initially, in the 1980s, only hospitals needed to meet quality requirements—which were very basic—in order to be eligible for SHI reimbursement. The SHI reforms of 2000 and 2004 increased both internal

[3] Describes the role of PHC physicians or other staff authorizing access to specialist services and diagnostic tests.

and external quality assurance and management requirements for both hospitals and outpatient care providers. All health providers (public and private, hospital and/or outpatient care) are required to deliver a minimum volume of services each year in order to be eligible to enter into contracts with sickness funds the following year. Participation in external quality evaluations is voluntary, but hospitals are required to have internal quality management programs in place, and they negotiate their contracts with sickness funds based on external quality measures. Furthermore, physicians providing outpatient care have to meet certification requirements to be able to offer services. Certification and recertification, the terms of which are defined in contracts between regional associations of SHI physicians and sickness funds, are needed to be eligible for reimbursement from sickness funds.

The Pharmaceutical Market Reform Act, passed in 2010, has introduced the requirement for assessing benefits of all new pharmaceuticals. Such assessments are the responsibility of the Federal Joint Committee, which assigns to the Institute for Quality and Efficiency in Health Care (see above) or to a third party. Pharmaceutical prices are regulated by health policy through reference prices and upper reimbursement limits for drugs without reference prices (innovative drugs). Both pharmaceutical prices and distribution are less regulated in hospitals as compared to outpatient settings, and in 2003 The SHI Modernization Act significantly liberalized the pharmaceuticals market (e.g., allowing the sale of drugs over the internet). Target prescription volumes are set by sickness funds and regional associations of SHI physicians, and further regulations are in place for pharmaceutical costs reimbursed by sickness funds. These include rebates provided by pharmacies and manufacturers, discount contracts between sickness funds and manufacturers, price freezes, reference prices, reimbursement amounts, and indirect instruments (e.g., substitution by generic equivalents).

How to purchase: Contracting and provider payment

The SGB law defines the framework for negotiations between the sickness funds and providers. At the outpatient care level, regional provider associations negotiate contracts with individual sickness funds, whereas at the inpatient (hospital) care level, regional associations of sickness funds negotiate contracts with individual hospitals.

Contracting between purchasers and outpatient care providers happens at different levels. First, framework contracts are put in place at the federal level between the Federal Association of SHI Physicians and the Federal Association of Sickness Funds. Second, collective contracts are put in place at the regional level between the regional associations of SHI physicians and the regional associations of sickness funds. While these regional collective contracts are the primary mechanism of contracting, selective contracts in certain cases (e.g., for integrated care models) are also negotiated directly between sickness funds and providers.

Until 1992, hospitals were remunerated based on standard per diems, which did not account for differences in volumes or intensity of particular clinical investigations and treatments. Department-specific per diem charges were introduced in 1992 alongside base charges. Starting in 1996, remuneration based on case and procedure fees was combined with the per diem-based remuneration system. The SHI Reform Act, passed in 2000, called for the establishment of a DRG payment system, which was gradually introduced starting in 2004. The establishment of the DRG payment system was a lengthy process, which required the FMOH to step in and define its basic characteristics, given the inability of the self-governing organizations to reach a consensus. Furthermore, a gradual introduction was needed in order to allow hospitals to adjust. Ultimately, the DRG system was not fully-implemented until 2009. Currently, hospitals are financed both by states (for infrastructure investments, as described above) and by sickness funds or private health insurance for their operating costs. DRGs are intended to cover all costs except for large infrastructure investments. The self-governing organizations and hospitals have founded the Institute for the Hospital Remuneration System to develop and maintain the DRG reimbursement system, including calculating cost weights. Uniform base rates are established at the state level and should be within the "federal-reference-price" corridor (between 2.5% above and

1.5% below the "federal-reference-price"). However, some hospital general operating costs are not covered by DRGs. For instance, additional surcharges, such as those for innovative diagnostic and treatment procedures, are negotiated directly between hospitals and regional associations of sickness funds. The introduction of the DRG payment system incentivized hospitals to maintain low costs, which translated to a reduction in nursing staff (Augurzky et al. 2017). In order to address this concern, hospitals have become eligible since 2016 to receive budget support for nursing care. Rural hospitals are also eligible to receive extra payments following the introduction of a 2017 reform (Stephani et al. 2018).

For outpatient services, morbidity-based remuneration is utilized. Volume ceilings are in place for both family doctors and specialists. Sickness funds pay regional associations of SHI physicians, rather than paying individuals providers directly. The regional associations then distribute payments to the individual providers based on a national Uniform Value Scale and regionally agreed-upon fee allocation scales. The Uniform Value Scale is set at the federal level and includes all the services provided by SHI physicians that are eligible for reimbursement. Each service in the Uniform Value Scale is allotted points instead of a monetary value. The fee allocation scales specify ceilings of services for which physicians can bill in a given time period and which can be reimbursed at the standard prices. Excess services are remunerated at a graduated price, the exact amount of which depends on the overall excess services billed by all specialist and family physicians.

The Federal Joint Committee has the mandate for issuing quality assurance directives. Stronger linkages between quality directives and contracts and payment mechanisms result from housing this responsibility at the Federal Joint Committee, which also makes decisions related to contracts and payment mechanisms. The SHI Medical Review Boards regularly conduct utilization reviews in hospitals to prevent the provision of low-quality services and review the assignment of cases to DRGs. For outpatient services, claims audits are conducted.

An electronic health card (eGK) has recently been introduced with the purpose of improving the exchange of information in the health sector. An information system for SHI-covered prescriptions (GAmSi) is also in place and allows physicians to review their prescription volume as well as that of other physicians in their region, so that they can modify their future prescription behavior. This system assists physicians to contain costs, as prescriptions are subject to target volumes, and those physicians that prescribe more than 125% of the target must pay back the prescription overage.

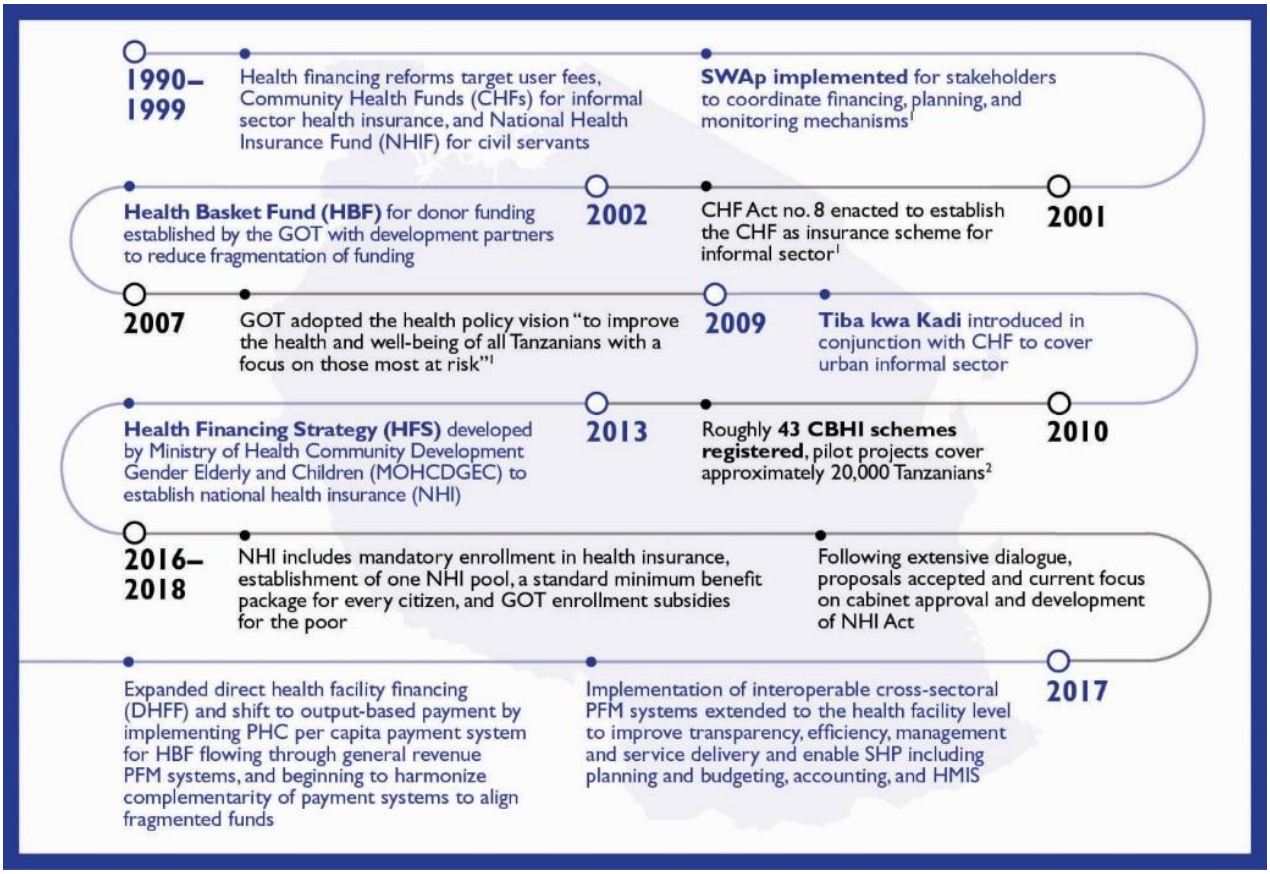
3.3 Tanzania

3.3.1 Introduction

Despite a decade of tremendous financial growth (averaging more than 6% per year GDP growth in the 2000s and 2010s), 28 percent of Tanzanians still lived below the poverty line in 2011 and continue to lack access to basic services (World Bank 2018). Persisting poverty has tremendous health consequences, and the Government of Tanzania (GoT) has significant gaps to address in realizing the goals outlined in the nation's growth and poverty reduction strategies and Development Vision 2025. Weak health system performance, high costs and inefficiencies, and critical service delivery gaps within and across the public and private health sectors instigated Tanzanian health authorities to embark on strategic health purchasing reforms in 2013. Tanzania's approach to SHP focuses on three primary areas of growth and development: 1) making discrete decisions in the design of policies, laws and regulation, health resource generation and pooling, and national health service packages; 2) initiating strategic health purchasing with a shift to direct facility financing and output-based payment in 2017; and 3) improving service provision through increased health facility visibility, transparency, autonomy, and accountability.

One primary method to their approach is to strengthen and design interoperable cross-sectoral public finance management (PFM) management systems and extend them to the provider level. Although significant work remains, the GoT has demonstrated a commitment to advancing implementation of new or harmonized payment and information systems, key components of effective strategic health purchasing approaches on the road to broadly delivered national health insurance (NHI) and universal health coverage (see Figure 6). In the following pages, we use the proposed framework to better understand Tanzania's approaches to SHP as it progresses toward quality UHC.

Figure 6. Timeline of Progressing Strategic Purchasing Functions in Tanzania[45]



3.3.2 Tanzania's Health Systems Functions, *Moving from Passive to Active Purchasing*

Governance and information, and governance of purchasing

Starting in 2013, the Government of Tanzania initiated ambitious health financing reforms to ensure that every citizen has equal access to needed health care services. The Health Financing Strategy (2013), for

[4] Government of Tanzania Health Financing Strategy 2015- 2025

[5] Sheila O'Dougherty (health systems expert with PS3), interview by Sharon Nakhimovsky, August 14 2018.

example, clearly stated the intention to establish an NHI scheme with a standard minimum benefit package (MBP) entitlement for every Tanzanian citizen.

The process of obtaining GoT and Parliament's approval of the Health Financing Strategy and associated NHI policy and laws has faced multiple delays, shifting deadlines, and an extensive process. Following elections in 2015, from mid-2016 to early 2018, the Ministry of Health Community Development Gender Elderly and Children (hereinafter MOH) developed cabinet papers and responded to comments by cabinet secretariat and the Inter-ministerial Technical Committee, consisting of the permanent secretaries of all government ministries. The MOH's four proposals from this process included: 1) making enrollment in NHI mandatory, 2) establishing one NHI pool, 3) standardizing MBP for every citizen, and 4) subsidizing enrollment in NHI for the poor (Sheila O'Dougherty (health systems expert), interview by Sharon Nakhimovsky, August 14 2018).

The National Health Insurance Fund (NHIF) is currently a plan held almost exclusively by civil servants, there was extensive discussion in Tanzania regarding the number of appropriate health financing insurance pools to scale NHIF coverage to the remainder of the population. For example, would the GoT maintain the current NHIF-program for civil servants and improve Community Health Insurance Fund (CHF) options for the rest of the population?

Box 5. Tanzania Case Study Acronyms

CHF	Community health insurance fund
DFF	Direct facility financing
FFARS	Facility Financial Accounting and Reporting System
GOT	Government of Tanzania
GOT-HOMIS	Government of Tanzania Hospital Management Information System
LGA	Local Government Authority
MBP	Minimum benefit package: the package envisaged for NHI in the Health Financing Strategy
MOFP	Ministry of Finance and Planning
MOHCDGEC (aka MOH)	Ministry of Health, Community Development, Gender, Elderly and Children
NHI	National Health Insurance
NHIF	National Health Insurance Fund
PORALG	President's Office for Regional and Local Government

The GoT ultimately decided to pursue one risk pool and one NHIF plan/system for all Tanzanians. While stakeholders continue to engage in policy dialogue and develop the architecture for this future NHI scheme, the GoT has significantly progressed in planning for strategic health purchasing to better use existing resources and prepare for an NHI scheme.

A wide variety of government institutions exist with health sector responsibilities, including the development of regulations and strengthening systems for implementation, oversight, accountability, and quality assurance. Some of these include:

- MOHCDGEC—responsible for health sector policy, NHIF reports to MOH.
- President's Office for Regional and Local Government (PORALG)—responsible for implementation by Tanzania's 185 local government authorities (LGAs) across mainland Tanzania's 26 regions. Regional Secretariats are an extension of national government. Under the Tanzanian policy of decentralization-by-devolution to LGAs, health facilities and staff report to LGAs, and LGAs to PORALG.
- President's Office for Public Service Management—responsible for various public sector tasks, including human resources and management of civil servants or public workers.
- Ministry of Finance and Planning (MOFP)—responsible for revenue collection and budget formation and execution. In addition, MOFP also contains a variety of PFM systems and accountability

mechanisms including Controller Auditor General for external audit and Internal Auditor General for internal audit.

As of 2018, the GoT has initiated an extensive transformation of information systems and related improvements in access and use of information (see Box 6). Two major aspects of this transformation are extending systems to facility level (critically important to increase facility visibility, transparency, autonomy, and accountability) and making systems interoperable to increase efficiency and improve management. A key characteristic of this is strengthening cross-sectoral systems performing basic management or PFM in all public sectors (e.g. planning, budgeting, payment, accounting, reporting, and human resources management). Interoperability is achieved by pushing data through the PORALG information mediator, Muungano Gateway, and MOH Health Information Mediator.

Box 6. Tanzania HMIS systems strengthened

Relevant and newly strengthened and interoperable systems include:

- PlanRep for LGA and facility level planning and budgeting
- LGA Epicor accounting system together with integrated financial management system and MOFP-Statistical Budget Analysis Software for revenue and expenditures
- Facility Financial Accounting and Reporting System (FFARS) for revenue and expenditures
- Local Government Revenue Collection Information System (LGRCIS)
- Government of Tanzania Hospital Management Information System (GoTHoMIS) also being used in primary health care (PHC) facilities
- District Health Information System 2 (DHIS2)
- electronic Logistics Management Information System (eLMIS)
- NHIF claims management system

Service readiness and provision

Increasing health facility autonomy and accountability in Tanzania is being driven and enabled by the extension of national systems to public sector service providers (e.g., health facilities, schools). Facility codes were added to the LGA chart of accounts and this allows facilities to participate in planning, budgeting, accounting, and reporting processes. In 2017 and 2018, GoT made significant progress in two systems: PlanRep and FFARS.

In addition, since 2013, the GoT and donor partners have significantly advanced health authorities' knowledge and understanding of and interaction with a broad range of private health sector entities and corporate actors. Creation of public-private partnership (PPP) frameworks for health services (at the national and district/regional levels), advancements in contracting arrangements to designated private hospitals as District Designated Hospitals (DDH), and strengthening of public-private Alliances for specific disease areas in child health, family planning, and HIV have all enhanced multi-sectoral collaboration. Such improvements in public-private collaboration pave the way for future extension of contracting mechanisms, fee-for-service arrangements, or other reimbursement programs as public and private providers alike are brought in as providers in the NHI scheme.

PlanRep is a redesigned version of the LGA's planning and budgeting system and has been implemented since July 2018. It is used by all 185 LGAs and more than 25,000 health facilities and schools and is interoperable, country-wide, sector-wide, centralized, and web-based. Four key features of PlanRep are: 1) extension of systems to service provider or facility level including changing the LGA Chart of Accounts to increase facility visibility, transparency, autonomy, and accountability; 2) interoperability with other GoT systems to improve basic business management at LGA and facility levels; 3) introduction of service outputs to clearly define public sector products and services and begin to shift from input-based to output-based planning, budgeting, and payment; and 4) establishment of systems strengthening as a trigger for realignment of LGA and facility roles and relationships to improve

management and service delivery. These features will help PlanRep drive substantial LGA reform, efficiency gains, and management and service delivery improvement in the future. To date, PlanRep does not extend to private providers but there are plans to as implementation continues (Sheila O'Dougherty (health systems expert), interview by Sharon Nakhimovsky, August 14 2018).

The second system, FFARS, is used to manage all revenues and expenditures at the health facility level including generation of financial reports. Following an extensive and participatory design and development process, in July 2017 PORALG initiated a phased deployment and mentoring process to implement FFARS in all public health facilities and schools in all 26 regions and 185 LGAs in Mainland Tanzania (approximately 7,500 health facilities and 20,000 schools). Implementation will accelerate and management capacity will grow but the early quantitative and qualitative evidence is that health facilities have substantial capacity, willingness, and enthusiasm to perform good financial management, analyze their data, and allocate their resources to the optimal mix of service delivery inputs (Sheila O'Dougherty (health systems expert), interview by Sharon Nakhimovsky, August 14 2018). As with PlanRep, as of 2018 FFARS does not yet extend to private providers.

In addition to strengthening information systems for better management and transparency, GOT is also undertaking substantial interventions to improve service delivery directly in both the public and private sectors. Interventions include updating and standardizing clinical guidelines, strengthening quality improvement processes, and strengthening supply chain systems. These service delivery interventions will empower health facilities to make good procurement decisions on the best mix of inputs to deliver accessible, equitable, efficient, and high quality services to their patients and communities. They are complementary to the PlanRep and FFARS system roll-outs, which enable health facilities to fulfill financial management functions of planning/budgeting and accounting/reporting and thus prepare them to receive and manage output-based payments made directly to their bank account.

Sufficiency and institutional flow of resources

Sufficiency of funding limiting factor

Tanzania has experienced strong economic growth—more than six percent GDP annually—in the 2000s and 2010s (World Bank 2018). However, Tanzania's health system is still dependent on donors, including 26 percent foreign funded in FY2017/2018 (Lee and Tarimo 2018). The GoT also allocates a relatively small amount of its budget to health and disburses less of it. For FY2015-2017, the approved annual health budget in the medium-term expenditure framework accounted for about eight percent of the total government budget.

As it stands, funding remains insufficient, and the amount still falls below the range for what is needed to fund the essential service package defined in current law. Sufficient funding for operational spending is of particular concern. During the 2010 decade, general revenue allocation to personal emoluments or government salaries for health workers have increased, while recurrent costs or other charges have been reduced substantially. Increased funding is needed for the health sector, and more will need to be done to ensure a reasonable allocation of limited resources across health workforce and other inputs necessary to deliver quality health services. Funding is even further from supporting the goal of providing the package that civil servants receive under NHI to all Tanzanians.

Tanzania has a commitment to fund an equal service package for all Tanzanians under NHI with general revenue financing. However, limited fiscal space due to weaknesses in tax collection and a large informal sector, among other factors, will make it difficult to raise sufficient revenue in the short-term. Favorably with strong policies, continuing strong economic growth, and prioritization of health, GoT may be able to make significant progress in raising resources. In fact, in a modeling study, Avila and Connor (2013) suggest that if GoT achieved 15 percent spending on health/government total spending, it would be able to fund an essential service package (Avila et al. 2013).

Role of pooling to counteract fragmentation

There is substantial pooling fragmentation in Tanzania both vertically across revenue sources and horizontally across levels of government.

General government revenue consists of 1) fiscal allocations from the MOF to the MOH to pay for services at national and regional referral hospitals and specialized facilities and 2) LGAs who use allocations from MOF or PORALG and other revenue sources to finance the local government health delivery system of district hospitals, health centers and dispensaries. This revenue covers the three main budget line items of personal emoluments/government salaries, other recurrent costs, and capital investment. While both are part of an overall general revenue pool, they are fragmented within the budget and disbursement process.

MOH and LGA fiscal allocations and revenue are derived from both domestic tax and development partner health basket fund sources. While development partner funding is still fragmented, in 2002, GoT and development partners together established a health basket fund for donor contributions to help supplement national and LGA funding. Pooling multiple donor contributions in this way helped reduce fragmentation in a country where many donors were active in the health sector and gave more ownership over funding to health sector leaders. Between 2002 and 2007, the basket fund contributed US$234 million to health and became an integral component to financing government operations in the health sector (Morgan and Eichler 2013).

Donor funds, those not allocated to the health basket fund, are fragmented, especially the vertical programs (e.g., HIV, tuberculosis, malaria, family planning, maternal and child health), limiting the potential to use them effectively. GoT is aware of this problem and is attempting to mitigate it (e.g., through common or harmonized planning, budgeting, payment, information, accounting, and reporting systems) to reduce incoherent and duplicative funds flow to the extent possible. Health Financing Strategy envisions NHI with one pool in the long-term, so the relevant sequencing question is how to begin to move across the strategic health purchasing maturity framework stages of development to step-by-step reduce pooling fragmentation and/or unify or harmonize provider payment and related operating and information systems.

There are **multiple other pools** as well. First, an insurance scheme for civil servants (and individuals who purchase) that is managed by NHIF and funded through a payroll tax. Second, an insurance scheme for formal sector employees who purchase a policy that is managed by the National Social Security Fund and funded through a payroll tax. Next, an improved community health fund (CHF), Tanzania's community-based health insurance funded through private premiums along with substantial support from donors. CHF is primarily intended for rural and urban informal workers and families and its operation is currently being aggregated from LGA to regional and eventually to national level as a strategic purchasing step towards NHI and management by NHIF as health purchaser. Also, there are several small private voluntary health insurance schemes with private premiums covering anyone purchasing a policy, and a variety of other development partner-funded pools, including a results based financing (RBF) scheme to improve maternal and child health outcomes (a current strategic purchasing step is creating synergies and leveraging RBF fee-for-service payment system and other input and output-based payment systems to maximize impact).

3.3.3 Tanzania's Purchasing Functions, *Moving from Passive to Active Purchasing*

Governance of purchasing

The Health Financing Strategy and NHI institutional structure, roles, and relationships for strategic

health purchasing are envisioned as follows:

- MOHCDGEC—maintain purchasing policy functions including definition of MBP and relationship to licensing, accreditation and quality assurance in Department of Policy and Planning or enhanced MOH organizational structure
- NHIF—NHI purchaser
- PORALG—LGA and health provider management functions including planning, budgeting, procurement, accounting, internal controls, and reporting
- MOFP—budget formation and budget execution for NHI through transfer of all public funds to MOH/NHIF (on-budget but expenditure management outside of central treasury system)

Together these institutions perform many functions including planning reform, overseeing implementation, monitoring the gap between purchasing design and implementation, monitoring the institutions engaged in purchasing, and managing change across institutions. Additional roles and responsibilities include developing and maintaining human and system capacity and conducting stakeholder engagement and strategic communication including with health providers and the public.

The healthcare goods and services to purchase

Current law contains an essential health service package for the citizens of Tanzania. Essential services are consistent with the MOH-defined scheme of service for each level of care in the health delivery system including dispensaries, health centers, district hospitals, and specialized regional referral and national tertiary hospitals. The Health Financing Strategy and envisioned NHI contain a very strong commitment to equal access to one standard minimum benefit package (MBP) for all citizens of Tanzania. MBP, yet to be defined or entitlement designed, is contained in the ongoing Health Financing Strategy and NHI development process. Early expectations or indications are that the initial MBP specification will be PHC-oriented, linked to MOH health facility levels of care, and matched reasonably well with the nature of provider payment systems currently being implemented to purchase health services. The intent is to refine the MBP over time to adjust to both increases in revenue and better clinical and cost data emerging from the payment and information systems. This ongoing MBP refinement process based on continuously improving data directly related to provider payment can be an important block in the purchasing foundation and stages of development moving from passive to active purchasing.

The commitment to equal access to one standard MBP for all citizens contributes to mitigation of fragmentation, and organizing revenue sources, funds flows, and payment systems in a complementary manner. Nevertheless, issues exist now and are expected to continue especially for largely development partner (DP)-funded vertical priority programs and benefits across the continuum of care particularly specialty referral services. If not managed well, vertical program dynamics could undermine MBP specification. For example, recent statements incorrectly assert that specific diseases are not included in MBP and can be inflammatory especially since GoT funds all health worker salaries for all health services. Currently, NHIF members have additional or supplemental benefits on top of the MBP. In the near term, Tanzania cannot afford to provide these supplemental benefits for all citizens given current levels of revenue and inefficacies contained in management and service delivery. Over time, through a combination of revenue increases and efficiency gains, Tanzania expects to add these supplemental benefits received by civil servants and the formal sector to the MBP so that the informal sector and the poor also are entitled to these benefits.

The providers from whom goods and services are purchased

Health services are purchased from all 7,000+ public health facilities, including LGA dispensaries, health centers and district hospitals, and regional and national referral specialty hospitals. Under general

revenue input-based purchasing or line-item budget payment system, contracting is based on MOH, PORALG, President's Office of Public Service Management (POPSM), and MOFP regulations defining facility status, licensing and accreditation, human resource and civil service, planning and budget formation, and service delivery or clinical standards and guidelines. A shift towards strategic purchasing and output-based payment is bringing more explicit contracting processes, including NHIF accreditation and incorporating quality of care requirements into their purchasing contracts; MOH star rating or a form of accreditation delineating health facilities and linked to payment including RBF; and more clearly defining the roles and relationships of all health purchasing actors.

As for medicines and commodities, MOH has a supply chain management system called Medical Stores Department (MSD) that serves more than 65 percent of the population (Mwencha et al 2017). The market also includes contracting with selected prime vendors and use of private pharmaceutical entities. As described in the payment group, contracting rules are evolving with a mixture of developing payment sources and systems, including national budget input-based payment to MSD which procures and distributes drugs, and health facilities which are starting to procure drugs directly from MSD and other vendors using their own funds. NHI envisions contracting with private sector over time, and private health services complement the covered range of services especially reproductive and child health services together with treatment of chronic diseases such as tuberculosis.

How to purchase: Contracting and provider payment

Tanzania is sequencing strategic purchasing interventions to mitigate pooling problems, better match payment to priority services, enable facility autonomy and improved management and service delivery, increase efficiency to extend coverage, and continuously and actively move towards NHI and universal coverage. Steps are consistent with the strategic health purchasing maturity framework stages of development, moving from passive to active/strategic purchasing, even adopting its iterative nature. Movement of the education sector to direct facility financing (DFF) enabled the first step. DFF is a Tanzanian term reflecting central authorities making payments directly to school bank accounts rather than making payments through LGAs overseen by PORALG.

In a breakthrough moment in December 2017, the health sector began DFF for health facilities with general revenue funds flowing through PFM systems and processes. DP budget support through the Health Basket Fund (HBF) was used to trigger this movement from passive to active purchasing. The HBF may face fewer PFM rigidities or barriers than domestic general revenue funds, but it is still an important step. The HBF joins CHF, RBF, user fees, and a few other small sources of funds as DFF revenue flowing directly to facilities is harmonized through payment systems. This change adds general revenue funding to essential health services for the entire population, especially in poor and underserved areas, an important step towards equitable strategic purchasing.

In addition to paying health facilities directly, DFF also shifted payment from input-based line-item budget to output-based payment required for NHI and better matching payment to priority services. The DFF HBF payment system is PHC per capita including base rate (flat facility fee) and three adjustors for catchment population (need), utilization (performance), and distance (equity). The payment formula specification is somewhat unusual in that it is composed of a base rate or flat fee per facility rather than per person. However, this formulation suited the Tanzanian environment and is effectively per capita payment, as the catchment population adjustor for need converts to per capita payment. It is also a budget neutral formula-driven payment system, meaning that payments will not exceed the HBF ceiling as base rate is set and adjustors are relative weights calibrated to 1.0 and redistribute funds according to policy objectives but do not add to total payment.

The DFF's PHC payment system was implemented for all health centers and dispensaries in Tanzania. Payments for all four quarters of FY2017–2018 were disbursed by MOFP to facility bank accounts. After extensive dialogue, agreement was reached that improved CHF would use almost the same PHC per

capita payment formula with the addition of an adjustor reflecting CHF membership. Using a similar formula will help harmonize general revenue and private premium facility and patient level incentives, thus mitigating pooling problems and reducing fragmentation across fund flows.

DFF is strategic or active purchasing in the context of sequencing moving towards NHI and the shift to output-based payment but also in its use to mitigate pooling problems by harmonizing fragmented funds flows into a unified purchasing framework. Provider payment systems were harmonized for public general revenue (HBF), private premiums (improved CHF), and some donor project support (RBF). Harmonizing payment systems doesn't mean they're all the same but rather that taken together they avoid perverse incentives or unintended consequences and stimulate health facilities to provide efficient, equitable, and high quality individual health services to their clients. Specifically, RBF fee-for-service payment targeting high priority services influences the core PHC per capita payment system under general revenue/health basket fund and private premiums/CHF. This mixed model through direct incentives of fee-for-service (i.e. fee-for-service payments for maternal and child health services) leverages the highly bundled less direct financial incentives of the PHC capitated rate payment system to drive both equity and performance in a large public health delivery system.

Health facilities will be better able to use output-based payments to procure optimal inputs to high quality service delivery to the population upon creating a new intersection of PFM and health purchasing. This intersection encompasses strengthening and extending interoperable cross-sectoral management systems to the service provider level and increasing facility autonomy and accountability. In addition, PORALG is establishing DFF management systems, guidelines, and processes to support health facilities to procure inputs (e.g., supplies, drugs, utilities, allowances) to deliver services. FFARS is the accounting and reporting system for DFF funds. To date, potential facility-level procurement barriers (e.g., line item restrictions, overly burdensome bureaucracy) are being addressed by facilities procurement authorization requests linked to their FFARS monthly financial report submission and LGA officials co-signing facility procurement plans; this is consistent with creating a new intersection and broader cross-sectoral management systems. Additional interventions are planned, including DFF management to build capacity and support facilities in all aspects of procuring inputs to deliver services to their clients under output-based payment. This front line service level buy-in and unleashing of health facility capacity for both finances and services have potential to make enormous contributions to strategic purchasing maturity, NHI, and the road to universal health coverage.

Beyond DFF and harmonization of public health basic fund, CHF, and the results-based financing scheme, NHIF is starting the process of refining its provider payment systems. Currently NHIF uses a fee-for-service system with about 900 payment groups. The specification of both the payment system parameters (flat fee or tariff vs. formula based and relative weights) and the payment categories (not bundled or grouped, largely specialty facility fees not including PHC) create perverse incentives or unintended consequences that NHIF can address in payment system refinement and preparation for its envisioned role as NHI purchaser. NHIF plans to refine its hospital and outpatient specialty payment system and adopt the PHC per capita payment system for strategic purchasing, further mitigating pooling problems and harmonizing payment and financial incentives at facility and individual patient levels.

PORALG, MOH, NHIF and DPs are also undertaking a massive exercise to harmonize and increase interoperability of health information and claims management systems to increase efficiency, effectiveness, and quality of financial and service delivery operations, processing and management. PORALG and MOH agreed that one health information system (GoTHoMIS) would be extended to health facility level. GoTHoMIS would incorporate vertical priority program information and become interoperable with DHIS2 at LGA level and with e-LMIS to improve drug ordering, delivery, payment and accounting. Further, it would become interoperable with NHIF systems so that clinical information is transferred to NHIF claims management for calculation of payment amount, processing of payments to facilities, and analysis of data for quality assurance, audits, and refining payment systems.

4. CONSIDERATIONS FOR POLICYMAKERS AND PRACTITIONERS

Developing countries everywhere face the challenge of better organizing and managing their health care systems to provide high-quality services while promoting fiscal sustainability and financial protection to the population. Strategic purchasing is an important lever to achieve the most value from the health system within limited resources. Experience from low-, middle- and high-income countries alike shows that strategic purchasing is a long-term commitment to system evolution and investment in information generation and use. Strategic purchasing requires a strong foundation of regulatory, managerial, and information capacity. The policies and approaches will evolve and mature over time as capacity grows and new challenges emerge.

The following are considerations for policymakers and practitioners as they take deliberate steps to strengthen strategic purchasing foundations, policies and approaches and put the health system on a path of continuous progress and evolution.

4.1 Improving the Structural and Functional Organization of the Health System is a Complex and Ongoing Endeavor

Strategic purchasing requires clear institutional arrangements, with roles and responsibilities defined to carry out the specific functions (e.g. which institution decides the benefits that will be included in the benefits package, and which institution decides how to pay health care providers). Countries with effective institutional arrangements for strategic purchasing allocate functions in a transparent way, with some functions separated to increase efficiency or avoid conflicts of interest or corruption. Government institutions have key roles in strategic purchasing, but just as important are health care professional associations, civil society organizations, beneficiaries, research institutes, and other institutions or organizations with a stake in the health system. The most effective institutional structure and roles for a country may change as new challenges emerge and capacities evolve, so processes should be in place for reviewing and adapting roles and responsibilities over time.

4.2 Data Analytics, Use, and Governance are Important for Mature Strategic Purchasing

Improved generation and use of information is the key factor in moving from passive to strategic purchasing. SHP approaches and instruments all require information to design and implement them. As provider payment and other purchasing approaches also generate information as they are implemented. For example, the processes required to design and implement provider payment systems often rely on and generate large amounts of data—from claims when providers bill purchasers for covered services or from other routine reporting sources. This data is a rich source of understanding where quality, access, and efficiency objectives are being met, and where adjustments are needed.

Measuring, benchmarking, and showing evidence is also a powerful way to steer activities and gain political support. Furthermore, accurate and timely data can allow policymakers and practitioners to course-correct, terminating activities that appear to be detrimental to the intended reform objectives.

Mature systems create processes for continuously monitoring, auditing, and sharing data (real-time or periodic updates) between purchaser and government stakeholders, purchaser and provider, and between providers, offering published performance scores (real-time or periodic updates) to all stakeholders, including the public. A mix of qualitative and quantitative methods should be defined to capture the results of purchasing reforms. Well-developed monitoring and auditing systems with multi-stakeholder participation should be designed to provide accurate and relevant information to decision makers on a continuous basis.

4.3 Sequencing and Phasing Reforms is Critical for Change Management

When strategic purchasing reforms are initiated, they often include several major change initiatives at once, and successful implementation requires a holistic approach to manage changes. Strategic purchasing reforms can also face serious political economy challenges, particularly when shifting functions of existing agencies and/or reallocating resources from tertiary hospitals and wealthy urban areas. When funding flows change, there are almost always winners and losers. In some environments, a strong policy and regulatory environment can help mitigate friction and opposition to change, while in others regulations introduce rigidities. Some technical tools, such as simulation models and impact analysis, can help navigate political economy challenges and inform the pace of sequencing and scale up.

4.4 Conclusion

Given the commitment in many low- and middle-income countries to UHC, even in the face of challenging macroeconomic and fiscal environments, strategic health purchasing will continue to be a necessary component of UHC policy frameworks. Innovative purchasing and provider payment strategies are particularly critical as aging populations and the burden of chronic disease is changing the kinds of services needed. Complex chronic conditions and require more coordinated preventive, curative, and disease management services that are ongoing, reach across different levels of care, and require more individualized approaches (World Bank 2013).

To overcome the implementation challenges to strategic purchasing, informed dialogue and commitment from country stakeholders must be accompanied by plans to develop institutional capacity and define and strengthen the roles and relationships that support flexible operational systems. More attention is needed to ensure that the technical capacity to assume strategic purchasing functions is deepened. More informed dialogue is also needed between national and local governments and branches of government such as health, finance, civil service, and social security authorities to ensure an enabling external environment supports strategic health purchasing objectives.

ANNEX A: METHODS

The development of the SHP Progress Framework was executed in three phases; 1) the initial mapping of high-income countries to Dr. Cashin's original Strategic Health Purchasing Framework (framework); 2) revising the framework based on findings from phase 1; and 3) mapping countries at different stages of progression to the new framework to demonstrate what progress in SHP looks like across the framework's functions as countries move from passive to active or strategic purchasing. The results of the exercise are the foundations of this report.

Phase 1: Initial Country Mapping

The HFG team held a Quality at Entry meeting to finalize research objectives and methods. Through a collaborative team process, this meeting resulted in clearly defined activity objectives, the identification of countries with mature systems to learn from, and a literature review data collection tool for phase 1.

Using the literature review data collection instrument and the European Observatory on Health Systems and Policies Health System Reviews (HiTs), along with targeted additional country specific literature, the team mapped the experience of the Netherlands, Germany, and Canada in implementing SHP to Dr. Cashin's original maturity framework. These countries were identified as more advanced 'mature' systems with sufficient literature to allow for in-depth analysis and mapping of their purchasing and systems functions.

Phase 2: Revising the Progress Framework

After reviewing findings from the three-country mapping exercise, team members led by Dr. Cashin updated the progress framework by refining the list of functions, detailing the capacities that each function should address, and defining the criteria for the three stages of progress. The revised framework reflects a comprehensive though still succinct review of the fundamental functions, processes and arrangements identified as key steps in moving towards active or strategic purchasing.

Phase 3: Mapping Countries to Revised Framework

Results of phase 1 also informed the selection of countries to focus on in phase 3. Germany and Canada were selected based on the variation of their mature purchasing systems. Tanzania was identified as the third country case study because it is currently making an intense effort to change how the government pays for health and other public services. HiTs were used as the primary source of information for Germany and Canada, with supplemental information provided through key informant interviews with Dr. Christopher Lovelace and Dr. Tihomir Strizrep; health system experts deeply familiar with the Canadian (Dr. Lovelace) and German (Dr. Strizrep) health systems. For Tanzania, the team conducted desk research, and key informant interviews with Ms. Sheila O'Dougherty, a health policy, systems, financing and management expert currently working on SHP reforms in Tanzania, and Dr. James White, a health systems expert on Tanzania. Team members developed timelines for the three countries and used the updated framework to further analyze and depict the sequencing of health purchasing reforms and improvements. The country experts then reviewed the country cases and timelines.

ANNEX B: USEFUL RESOURCES FOR MAKING STRATEGIC PURCHASING DECISIONS AND REFORMS

1. Cashin, C., Ankhbayat, B., Phuong, H.T., Jamsran, G., Nanzad, O., Phuong, N.K., Tsilaajav, T. Assessing Health Provider Payment Systems: A Practical Guide for Countries Working Toward Universal Health Coverage. Joint Learning Network for Universal Health Coverage. 2015.

This guide presents systematic strategies countries can adapt to reform their current provider payment systems. Countries can use this assessment guide to:

- Assess current provider payment systems, identify objectives for refinement or reform, and evaluate reform options;
- Establish a baseline assessment of provider payment systems that have already been selected, to aid in monitoring and evaluation;
- And contribute to an evidence base for provider payment policy across countries.

The guide is organized into four modules which can be adapted to different needs at the country, region, or institutional level. Each module is designed to be led by a range of three key categories of players: working group, facilitator, and analytical team.

2. Cashin, C, Bloom, D, Sparkes, S, Barroy, H, Ktzin, J, & O'Dougherty, S. Aligning Public Financial Management and Health Financing: Sustaining Progress Toward Universal Health Coverage. World Health Organization, Health Financing Working Paper, 17(4), 1-50. 2017. http://www.who.int/iris/handle/10665/254680

The paper considers how PFM and health financing systems can be better aligned in support of universal health coverage (UHC). Supporting productive dialogue between the ministry of health and the ministry of finance to harmonize the PFM system with health financing policy to achieve UHC goals is the main objective of this paper.

3. Figueras, J., Robinson, R., & Jakubowski, E. Purchasing to Improve Health Systems Performance. The World Health Organization. 2005.

This resource provide a cross-national health policy analysis, outlining how health care systems in Europe can become more equitable, efficient, and effective.

4. Langenbrunner, J.C, Cashin, C., & O'Dougherty, S. Designing and Implementing Health Care Provider Payment Systems: how-to manuals. The World Bank. 2009.

This manual is intended to guide low- and middle-income countries through the transition from passive to strategic health purchasing. The manual covers critical steps involved in the design, implementation, and management of new provider payment systems.

5. Mathauer, I., Dale, E., & Meessen, B. Strategic purchasing for Universal Health Coverage: key policy issues and questions. A summary from experts and practitioners. World Health Organization, Health Financing Working Paper 8. 2017.

This document outlines key policy issues involved when working towards strategic purchasing. It includes key discussion points from two WHO workshops which focused on strategies to enhance strategic purchasing.

6. Srivastava, D., Mueller, M., & Hewlett, E. Better Ways to Pay for Health Care. OECD Health Policy Studies. 2016. http://dx.doi.org/10.1787/9789264258211-en.

This paper discusses innovative provider payment mechanism divided into three broad categories; payments added on top of established payment structures, bundled payments for episodes of care or chronic conditions, and population-based payments. These three methods differ in complexity and provider autonomy.

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