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Commission on
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Strategic Purchasing in Ethiopia: Findings from evidence review

20th of June at the Hyatt Regency Hotel, Addis Ababa

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Objectives of the meeting

The motivation for today's workshop is to inform Ethiopia's Strategic Purchasing Journey:

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- Ethiopia has made huge progress in improving population health over the last 20 years and the progressive development of effective health financing arrangements has been a key component of this journey.
- Life expectancy at birth in Ethiopia has increased from 51 years in 2000 to 65 by 2020. As life expectancy continues to increase and the population expands, the healthcare demands of the population will also continue to grow and become more complex.
- To meet these demands, we need to ensure adequate financing and efficient delivery in our facilities, particularly at the primary healthcare level, which serves as the gateway to our health system.
- Strategic purchasing arrangements can encourage more efficient practice within our facilities and strengthen financing channels to ensure that funding is directed to where it is needed most.
- Today's workshop looks to bring together lessons from the global experience of Strategic Purchasing to examine how they can be applied to the Ethiopian context.

Where Ethiopia is now – an outline of progress since 1998 HCF reforms, current challenges, and current initiatives

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- Much progress has been achieved since the introduction of the 1998 Health Care Financing Strategy; the introduction of revenue retention at facility level, governance and autonomy of facility, private wing, outsourcing, exempted services and fee waiver system, and development of a national health insurance strategy which has seen CBHI expanded to cover over 90% of woredas by 2022.
- However, key challenges continue to exist. For example:
  - A low proportion of eligible services are reimbursed under the exempted services scheme – in the 2021-22 financial year, this proportion was estimated at 23% of the eligible total.
  - Progress needs to be made on mobilising funds to achieve UHC. In 2019/20 total health expenditure per capita was estimated at $36, well below the $86 spending per capita recommended by the WHO for the attainment of UHC. Constrained funds make efficiency of spending paramount.
  - Ethiopia faces a growing burden of non-communicable disease and injury (42 of DALYs), but service readiness to tackle NCD conditions is low (18%-51%) and spending on NCDs and injury is 25% of THE and preventive care spending at the primary level is also low.
  - Low CBHI retention/ renewal rate due to poor public facility readiness to deliver quality services and limited engagement of private sector service (47% of household expenditure).

Where Ethiopia is now – an outline of progress since 1998 HCF reforms, current challenges, and current initiatives

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A number of key initiatives are underway to try and address these challenges:

- Process of reviewing and rationalizing the ***exempt services package*** along side reviewing the CBHI benefits package.
- Scaling up of ***capitation*** as a means of ensuring timely and predictable delivery of funds to health facilities and giving facilities more discretion to make investments in capacity.
- ***Private sector contracting*** arrangement.
- ***Pilots of PBF*** have been implemented in Jimma, Borana and Amhara and MoH is in the process of implementing a wider pilot in Addis Ababa, SNNPR, and Somali.
- Inclusion of key ***health financing indicators*** in DHIS and generating informative evidences
- Policy/strategy and organizational reforms.

Today's workshop represents an opportunity to bring together learnings from both international experience and our current initiatives and collect them together to develop a coherent strategic purchasing framework for Ethiopia.

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- In each of the sessions, we should be thinking about how we can translate insights into health practice in Ethiopia.
- We will conclude with a discussion of next steps on the ***journey*** towards Strategic Purchasing in Ethiopia – having so many key stakeholders in one room provides us with an excellent opportunity to coordinate our efforts and build momentum over the coming months.
- Above all, there is need to channel this platforms in formal ways through re-vitalization of HCF TWG to lead the newly revised HCF strategy.
  - Academics and consultants- Evidence generation for visibility of impact and policy reforms.
  - Donors/Development partners- Fund for high impact and green area priorities.
  - Implementing partners- Alignment of priorities and gain efficiency.
  - Public entities- Leverage resources and ensure sustainability of results.

Questions posed to LSHTM/ R4D

Questions

- What purchasing functions should take place at different levels to reduce fragmentation?
- What would a unified benefits framework look like in Ethiopia and what are different expansion paths towards higher coverage?
- What do blended provider payment systems look like in practice? How do countries move from a muddled to a blended payment system and how can this improve incentives and patient experience (equity and quality of care)?
- What are the system requirements for strategic purchasing with multiple schemes?

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Institutional Arrangements, Accountability and Harmonization for Strategic Purchasing

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Reviewed health financing schemes in 14 countries

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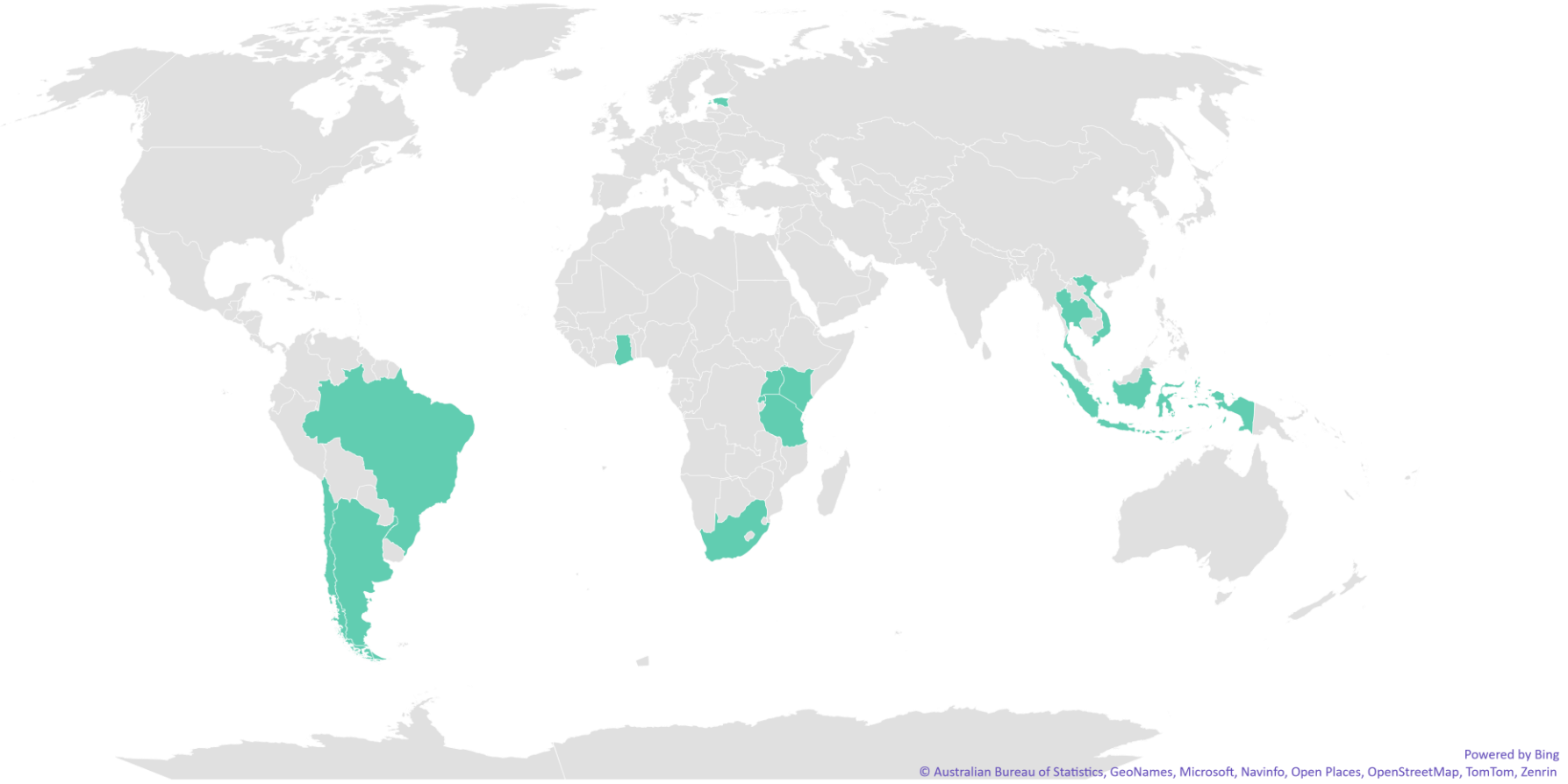

Criteria for inclusion:

- Low or low-middle income, relatable to Ethiopia
- Mixed health financing systems
- Devolved government with significant autonomy for purchasing at sub-national level
- Progress made on health insurance coverage
- Significant literature (grey and published) as this was a desk-based review

Purpose of the brief

Present evidence and country experience related to:

- Creating **effective institutional arrangements** for strategic purchasing
- Establishing **accountability mechanisms** for purchasing
- Harmonization purchasing functions to **minimize fragmentation**

Institutional arrangements

(1) Who does what?

- The purchasing agency typically carries out most functions in a well-coordinated system, but **some purchasing functions are distributed fully or partially** to other institutions.
  - Benefit package design
  - Purchasing
  - Setting quality standards
- Purchaser usually has **checks and balances** and approval from the MOH or higher levels of government.
- **Institutional responsibilities may evolve over time** as purchasing systems mature

(2) Who does what at each administrative level in decentralized settings?

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- Even in highly decentralized settings, **many countries centralize most purchasing functions**
- **More centralized financing** together with **decentralized service delivery** enables more effective purchasing.
- **A clear framework** that specifies which functions are carried out at which administrative level, is helpful **for communication and accountability**.

Argentina: Programma Sumar

- Argentina has twenty-three federated states (provinces)
- Transfers from central government to provinces for devolved health functions.
- Minimum benefit package and service delivery standards defined centrally by MOH
- Contracts between provinces and participating health facilities define services, payment, and performance metrics to be monitored
- Federal level PBF payments to provinces using capitation payment adjusted by health and performance indicators, and providers are paid using fee-for-service
- Public health facilities have a high degree of autonomy
- Providers are required to submit regular reports to provincial authorities on total enrollment and patient health outcomes

Accountability

What mechanisms can be used to enhance accountability of purchasers to UHC?

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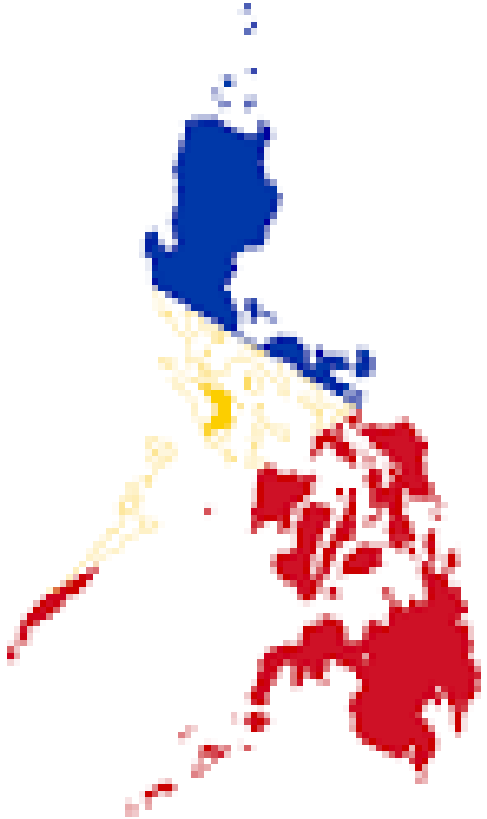
- Purchasers should be held **accountable for achieving health policy objectives of equitable access and financial protection**, not only financial management
- Sub-national governments can be held accountable for health objectives through **collaborative processes and incentives**
- Health providers can be held accountable through **formal or informal contracts**
- A holistic accountability framework can ensure that both health and financial management objectives are prioritized by purchasers and providers

Philippines: Philippine Health Insurance Corporation (Philhealth)



- PhilHealth is overseen by the Philippine government and funded through taxes, premiums, and other contributions.
- One of the main objectives of PhilHealth is to ensure that all Filipinos have access to quality health care.
- It is a government corporation attached to the Department of Health (DOH) – Secretary of Health chairs the Board
- PhilHealth collects premiums, accredits providers, sets the benefits packages (mostly hospital care) and provider payment mechanisms, processes claims, and reimburses providers for their services
- DOH subsidizes PhilHealth premiums for the poor, licenses health facilities and sets service delivery standards
- Philippines has 17 regions divided into provinces, cities and municipalities.
- Sub-national units are responsible for service delivery in provincial and municipal health facilities funded through central government transfers.

Harmonization to minimize fragmentation

Fragmentation should be reduced as much as is politically feasible

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- Fragmentation in purchasing arises when there are multiple pools of funding each with their own purchasing rules and functions.
- Fragmentation can be reduced by harmonizing purchasing functions.
- Fragmentation can be reduced for providers by consolidating funding flows.

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Approaches to harmonize purchasing functions

Approach	Description	Benefits	Obstacles
1. Benefits specification: Harmonize benefits package across schemes	• Design a minimum package of services and medicines that is the basis for all benefit packages. Some schemes may have more benefits but the whole population are able to access a specific set of services • Define a clear transparent and inclusive process to expand the package over time	• Similar rules of access for all citizens • Equitable access to a set of services for all citizens	• Defining rules of access/user fees for services and medicines not included in the minimum benefits package • Resistance to change by some population groups if their benefits are reduced or if user fees are introduced
2. Contracting arrangements: Specify benefits, rules of access and obligations of providers to deliver the benefit package	• Set expectations for delivery of the package including service guidelines, norms and quality standards for all providers • Terms and conditions for providers can be similar across schemes to avoid cream-skimming	• Link benefits/entitlements to terms and conditions for the provider • Set expectations and accountability mechanisms for providers	• Adherence to contracting terms by all providers • Creating a level-playing field for participation of all providers regardless of ownership • Resistance to change by some population groups if they are not allowed access to preferred providers
3. Provider payment: Harmonize provider payment mechanisms and rates	• Providers receive the same amount of payment for the same service provided regardless of the purchaser • Blended provider payment taking into consideration effects of the payment mechanism on different service levels of the system • Common population-based resource allocation formula e.g., capitation	• Deters cost and service shifting between purchasers and across different levels of the health care system • Resource allocation formula based on outputs rather than inputs	• Resistance to change in provider payment mechanisms by providers
4. Performance monitoring: Similar platforms for monitoring and claims adjudication	• Integrate performance monitoring platforms e.g., medical audits, clinical audits, claims forms etc. across schemes	• Create a common source of data for purchasing decisions to inform changes to benefits, contracting terms or provider payment	• Significant effort and resources required to integrate existing platforms • New information systems are expensive to develop or procure

Tanzania: Health Basket Fund and Direct Health Facility Financing to Providers

- Tanzania is administratively divided into thirty-one regions
- Consolidated funds from central government and on-budget donor resources into the health basket fund
- Direct health facility financing directly to health facilities for essential package with focus on maternal and child health
- Minimum benefit package and service delivery standards defined by MOH
- Payments to health facilities based on capitation payment adjusted for remoteness (distance to district headquarters)
- Public health facilities receive funds directly into facilities with autonomy for budgeting and planning based on all revenue flows
- Providers planning, budgeting and reporting through the automated PlanRep system

What does this mean for Ethiopia?

Key messages for Ethiopia

- Clarify and regulate the roles of FMOH, RHBs, WoHOs, and EHIS – **vertical and horizontal coordination**
- Create a **strategic purchasing institutional arrangements roadmap**
- Explore the use of contracts between providers and purchasing agencies to **create a culture of accountability**
- **Analyze the flow of funds/channels to frontline providers** and identify opportunities for harmonization and consolidation

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Acknowledgements

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Managing fragmentation in benefits by moving towards an integrated benefits framework

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Objective

Show how an integrated approach to understanding multiple coverage schemes can help to address fragmentation in coverage and offer pathways to expansion

Most countries achieve UHC through a "mosaic" of coverage schemes

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- In early stages there are gaps in coverage, differences in copayment rates and benefits
- These are gradually reduced through expansion and harmonization

Thailand is a good example of a mosaic

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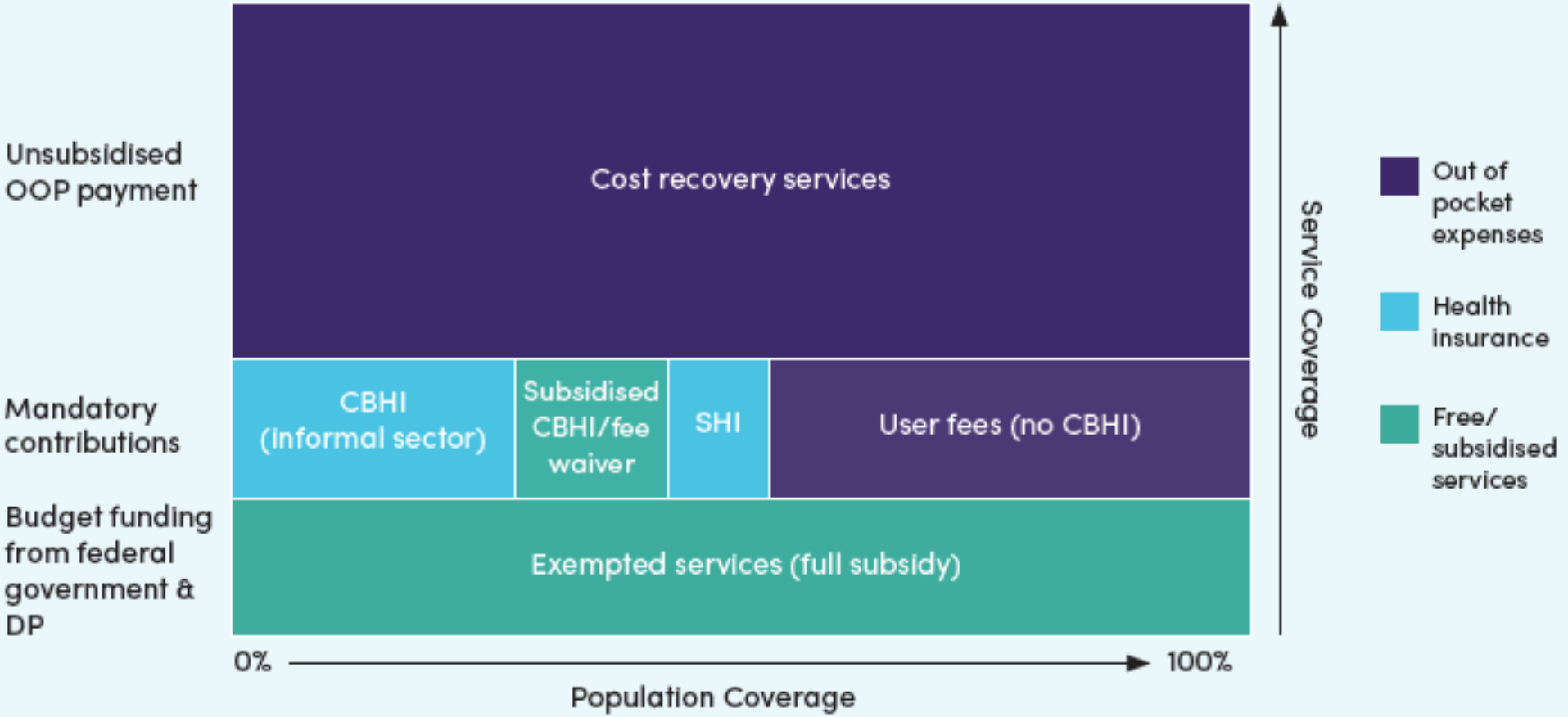
	Social Health Insurance	Civil Servants Medical Benefit Scheme	Universal coverage scheme
When established	1990	1980	2002
Source of funding	Employee Employer Government	General taxation	General taxation
Who is covered	Private sector employees, no dependents	Civil servants, retired civil servants, and their families	People not covered by SHI or CSMBS
Population coverage	15%	9%	75%
Benefit package	Comprehensive, small exclusion list	Comprehensive, no specific exclusions, includes private beds in public hospitals	Comprehensive, small exclusion list
Providers	Competing public and private hospitals > 100 beds (60% private)	Public providers only except for specific diseases	Mostly public network, typical DHS

What is an integrated benefits framework?

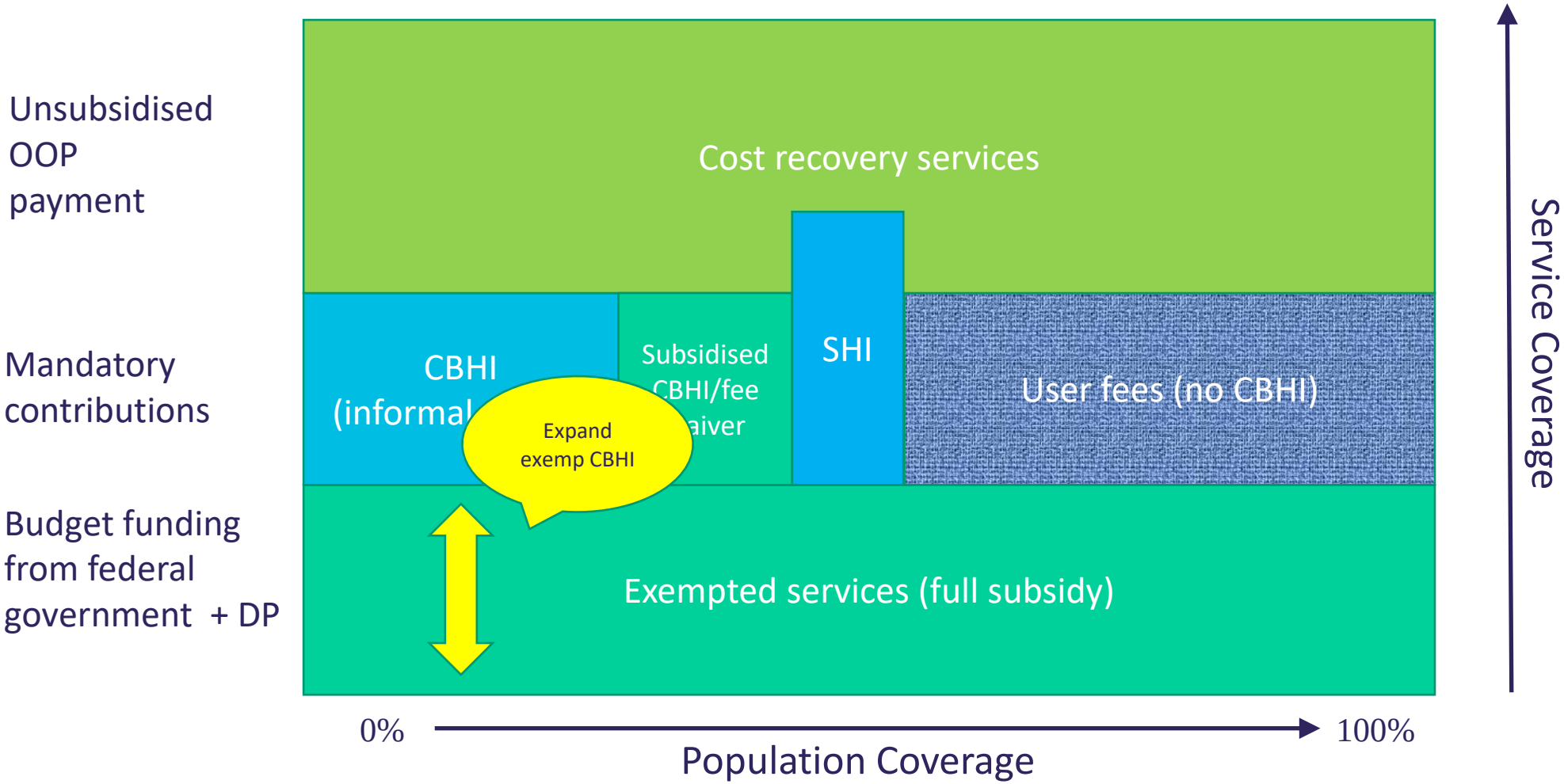
- Encompasses entire population + all services that are at least partially subsidized for some of the population in a given year
- Acknowledges that comprehensive coverage for the entire population is a goal – but the route to that state may progress unevenly, in line with policy choices
- Allows a focus on the system rather than the scheme
- Enables strategic thinking about the pathway to UHC

Fragmented benefits in Ethiopia

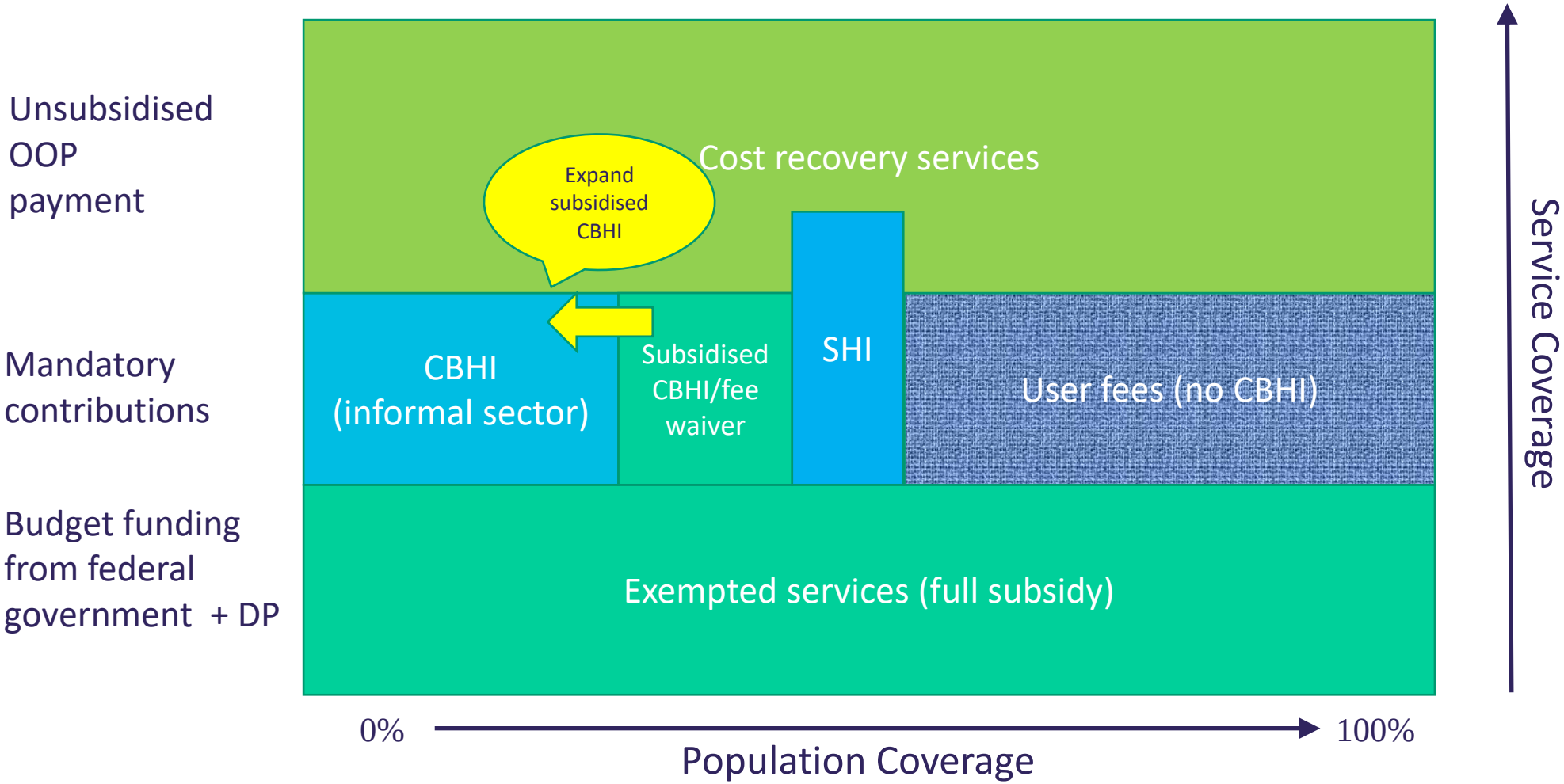
Figure 1: Benefits framework in Ethiopia



Expansion 1


Unsubsidised OOP payment
Mandatory contributions
Budget funding from federal government + DP
Cost recovery services
CBHI (informal
Subsidised CBHI/fee aiver
SHI
User fees (no CBHI)
Expand exemp CBHI
Exempted services (full subsidy)
Service Coverage
0%
100%
Population Coverage

Expansion 2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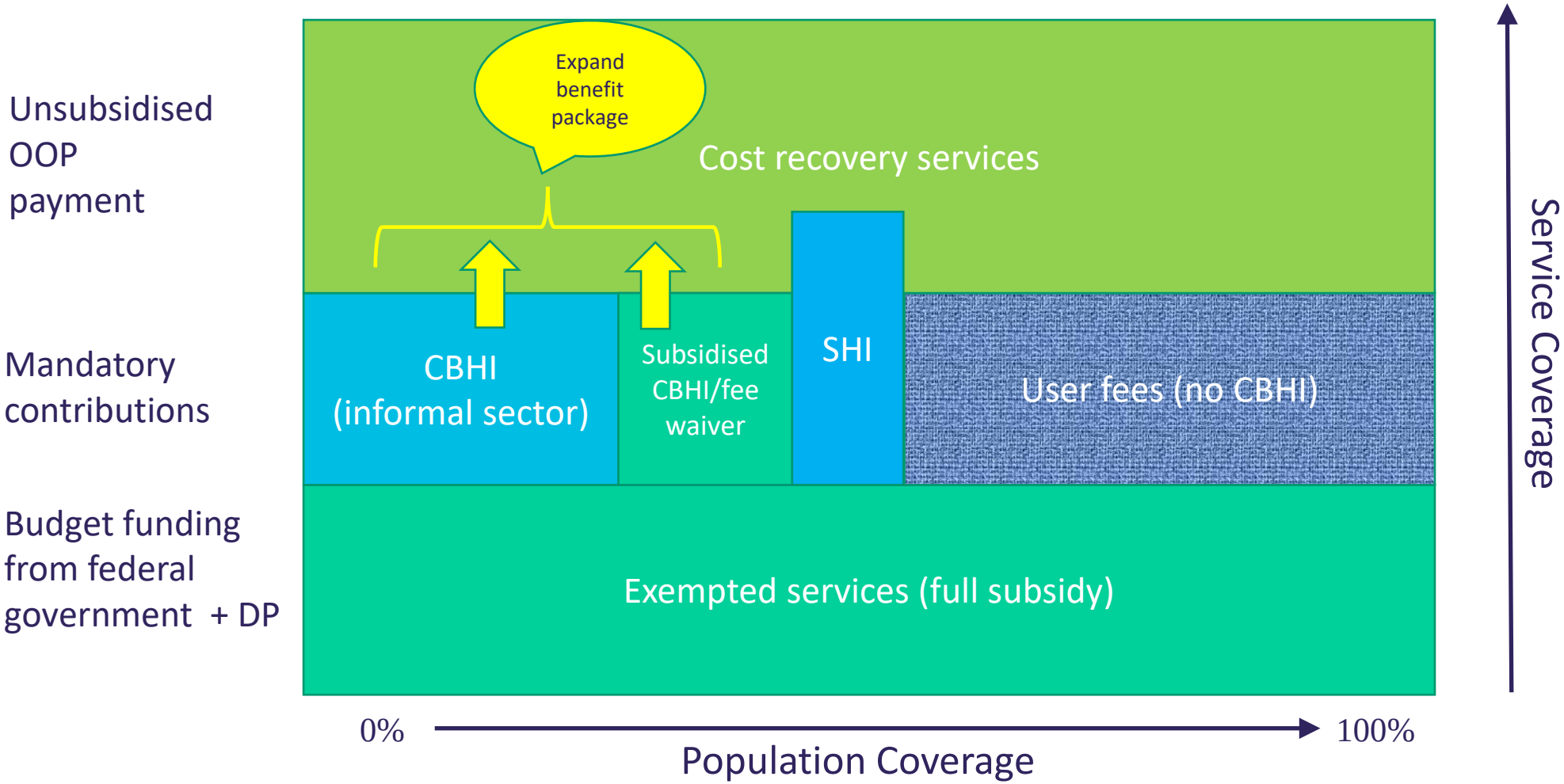
Expansion 3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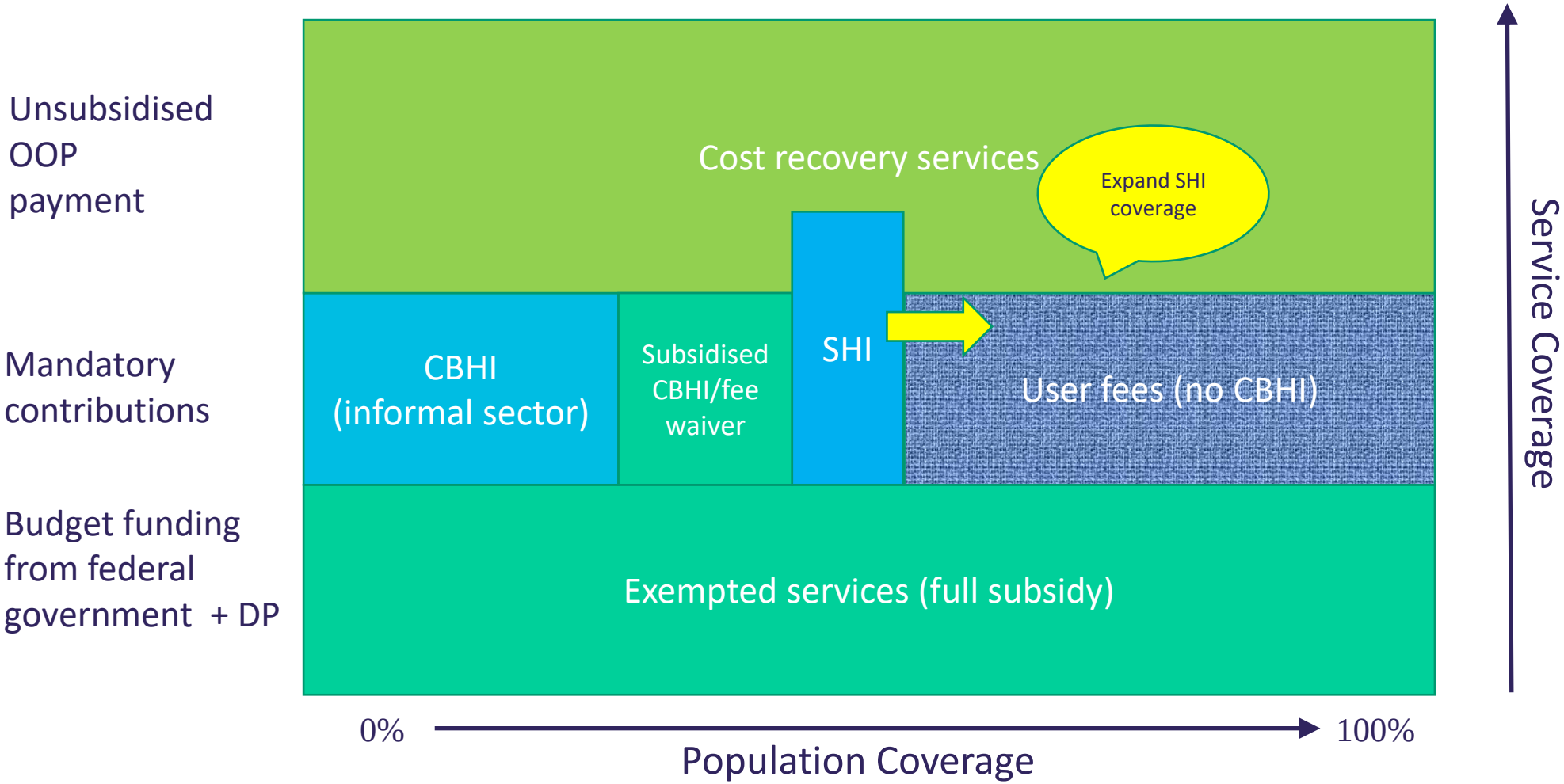
Expansion 4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Expand SHI coverage
CBHI (informal sector)
Subsidised CBHI/fee waiver
SHI
User fees (no CBHI)
Exempted services (full subsidy)
Service Coverage
0%
100%
Population Coverage

Implications for Ethiopia

- Plotting out with real data how different schemes fit together into this “mosaic” can help identify coverage gaps
- Population coverage and service coverage (benefit package) need to align with fiscal capacity
- As fiscal capacity expands, different routes to increasing coverage can be costed and considered

Q&A and discussion

The case of Estonia

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Designing a blended payment system

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Designing a blended payment system

- A single method is often not sufficient
- Getting the right mix takes time → balance of simplicity and comprehensive
- Being aware of the potential undesired effects → overcome by adding an additional method of payment into the mix
- **Payment system to influence provider institution** (e.g. facilities, district health offices, etc.)
  - Which then cascades to provide incentives to individual health workers
- A strong pattern emerges:
  - **A close-ended base payment: achieving main objectives while also acting as a cost control**
  - **Complementary small variable payments: encourage another system objective, e.g. quality of care**

Designing a blended payment system

- **England**: risk-adjusted capitation blended with P4P and FFS
- **Estonia**: age-adjusted capitation blended with fixed allowances, P4P, and FFS
- **Thailand**: age-adjusted capitation, fee schedule for high-risk conditions, block grant for promotion and disease control activities
- **Burkina Faso**: *Gratuite* policy: compensating for the user fee exemption policy by paying prepaid funds quarterly at the district level
  - Reimbursement is still based on FFS but with a spending limit
- **All advanced model starts from a simple model**
  - Overtime the share of variable payments gets larger, while (share) of base payment gets smaller to make space
- **Avoid unregulated fee-for-service: hard to control and difficult to address**

Integrating blended payment into gov't PFM system

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- Publicly provided annual non-wage recurrent
- Depending on the legal status of health facility and their visibility in the national Integrated Financial Management and Information System (IFMIS)
- Ethiopia: Health facility operates outside of IFMIS
- Receiving a transfer of finance (a grant) from central through the subnational gov't
- Challenges:
  - Diversion of funds
  - Who manage health facility's finances
- Uganda story in mainstreaming RBF
  - Facilities still retain some degree of autonomy (since 2015)
  - Dialing down the RBF functions to match local capacity: Less flexible, less money, less frequent verification

Harmonising blended payment systems

- Purposeful blended payment vs ‘messy’ multiple payment
- Undesired effects:
  - Resource shifting: favour of treating patients with ‘better’ scheme
  - Service shifting: ask patients to buy branded instead of the generic one
  - Cost shifting: charge higher fees to compensate providing ‘free’ services to a certain group
- Thailand: both Social Health Insurance and Universal Coverage Scheme are using capitation to pay for outpatient care.
- Colombia: the contributory and subsidised schemes agreed to follow a unified benefit package
  - In addition, both schemes pay providers through capitation but at a different rate.
- Subject to another brief

Lessons learned for Ethiopia

- Design a blended payment system with a mix of close-ended base payment and some small variable payment
- A seamless funding flow with substantial power to health facilities to manage the funding
- If needed, RBF should be designed with the existing government system in mind; avoid creating a parallel system
- Mapping all the multiple funding flows and start an incremental step to harmonise it (i.e. benefit package, payment method, payment rate, etc.)

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System requirements for strategic purchasing with multiple schemes

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Objectives

Share evidence and country experience related to the system requirements to implement strategic purchasing approaches in systems with multiple financing schemes:

- **Governance structures** to oversee and harmonize purchasing across schemes
- **Technical capacity** to carry out strategic purchasing functions
- **Operating systems** to run purchasing processes

Governance structures to oversee and harmonize purchasing across schemes

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Main lessons

- Effective governance structures are needed to **facilitate coordination** across schemes and key actors
- Governance structures are most effective when they have a **higher level of authority than the agencies implementing purchasing policies**
- Strong governance capacity includes establishing the **right balance of autonomy and accountability** for health care providers

A range of options for governance structures

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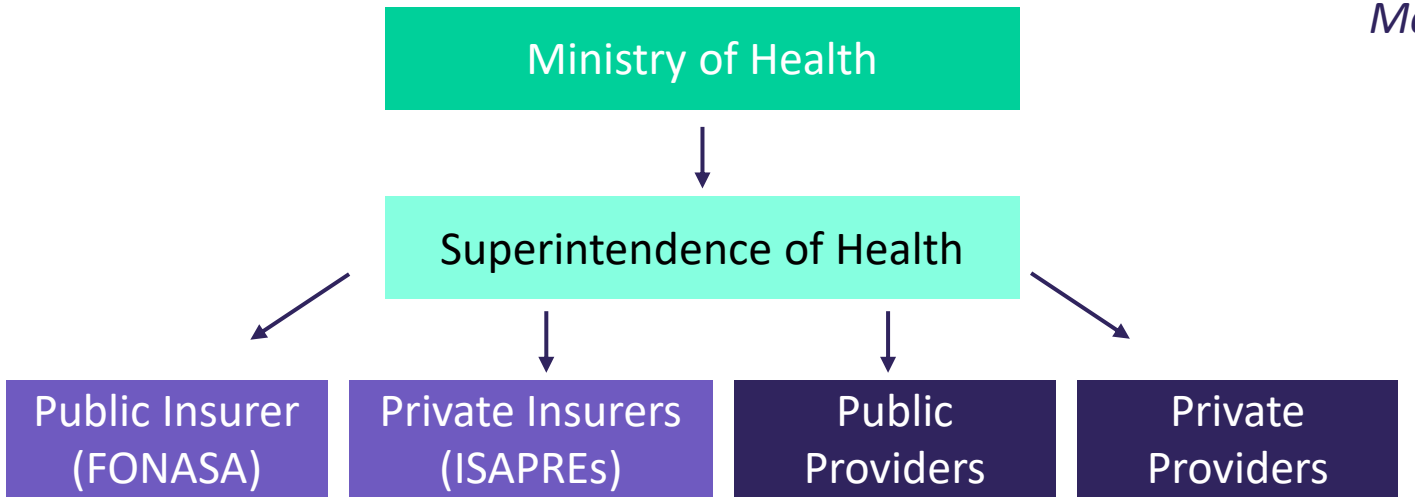
Highly formalized Superintendence of Health in Chile



More informal steering group at the level of the Minister Indonesia with ad hoc working groups

The governance structure should have the capacity and authority to enforce coordination and harmonization efforts, engage in dialogue on equal footing with finance authorities, and influence political decisions

What is provider autonomy and why is it important?

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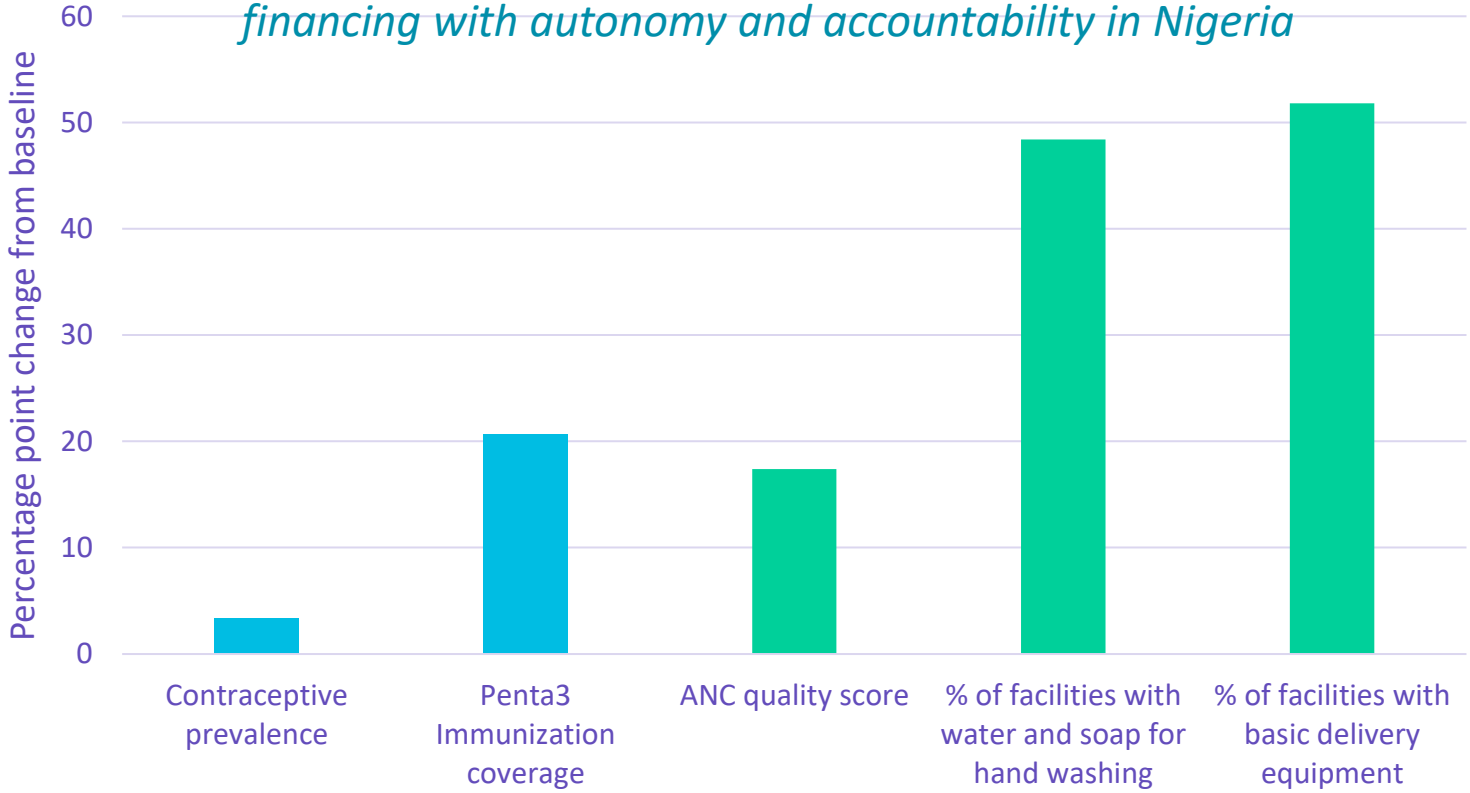
- Provider autonomy refers to the right to make financial, personnel, service delivery, and other decisions.
- The more areas over which providers have decision rights, the more flexibility they will have to respond to purchasing incentives.
- Greater autonomy needs to be balanced with new accountability measures.

Service coverage and quality improvements after direct facility financing with autonomy and accountability in Nigeria



Khanna, M *et al.* Decentralized facility financing vs. performance-based payments in PHC: a large-scale randomized controlled trial in Nigeria. *BMC Med* **19**, 224 (2021).

The evidence is overwhelming that health provider autonomy leads to service delivery improvements with no evidence of significant misuse of funds at the PHC level

Technical capacity to carry out strategic purchasing functions

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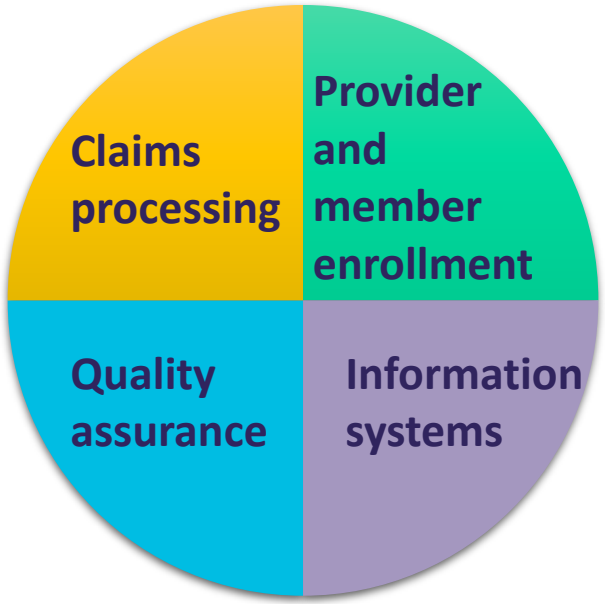
Main lessons

- The key institutions involved in strategic purchasing need to have the technical capacity — **the systems, knowledge, skills, and expertise** — to carry out their roles and responsibilities related to the purchasing functions.
- Investments in technical capacity are needed at **both the institutional and individual level**
- Most countries adopt **both a long-term strategy for building technical capacity and short-term measures** to bring in knowledge and skills immediately.
- Institutional capacity may **initially focus on strengthening the core purchasing functions** and evolve as purchasing approaches become more complex.

Gradually building capacity and complexity in Ghana's National Health Insurance Scheme



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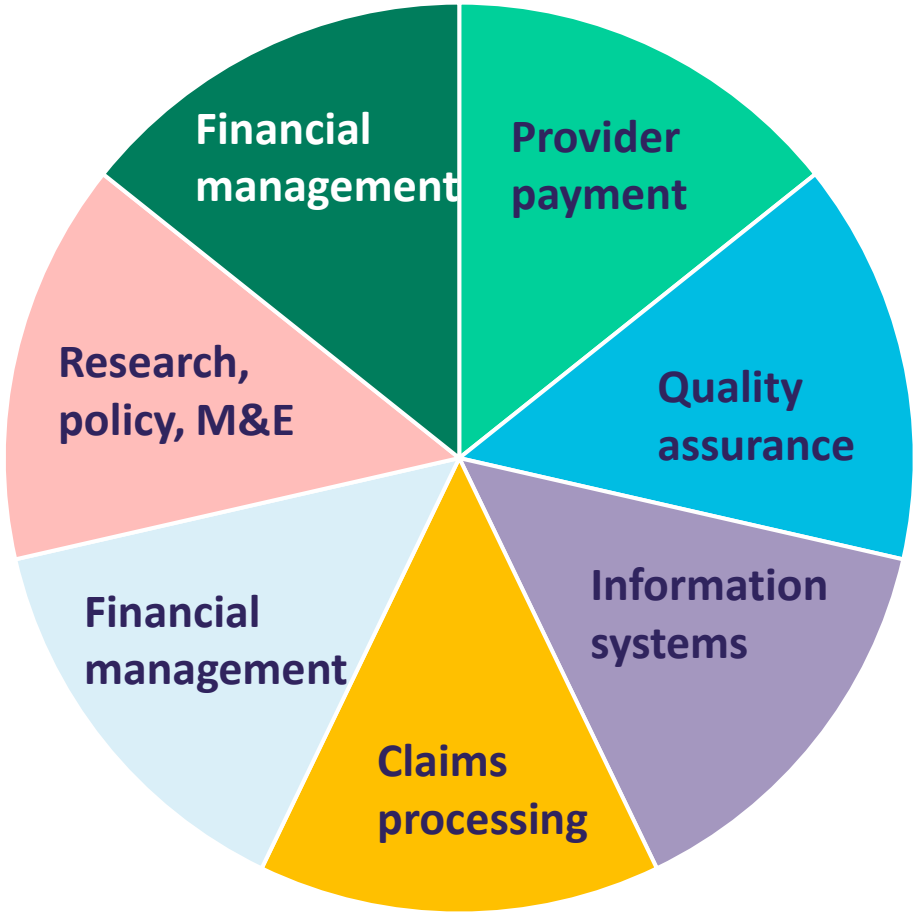


2018

Source: Ghana National Health Insurance Authority Annual Reports, 2014 and 2018

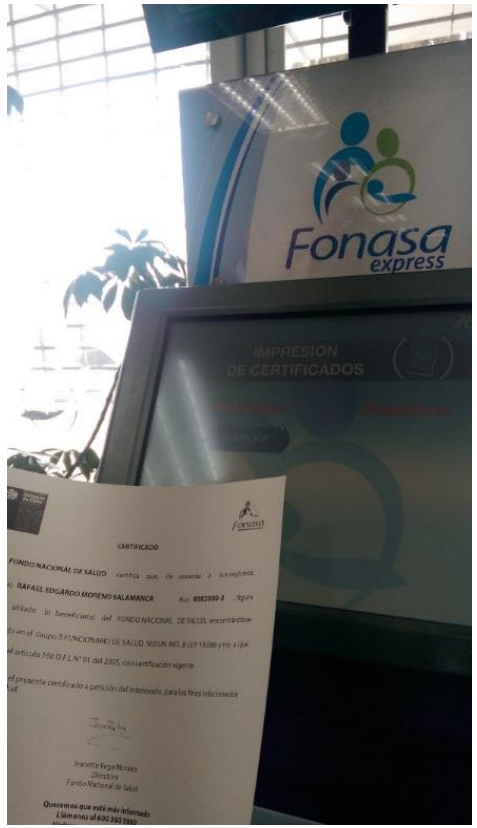
Operating systems

Main lessons

- Operating systems o carry out strategic purchasing functions **should start simple and evolve** as the purchasing functions become more complex
- As information systems are put in place for different purchasing functions, there should be a **view toward interoperability and eventually integrating** across information systems
- **Verification and claims vetting processes should be streamlined** and in line with the actual threat of fraud and abuse to be cost-effective

Minimizing administrative burden should be an objective of operating systems

Paper-based claims for fee-for-service provider payment is an enormous source of administrative burden, delayed payments, and break down of trust in many systems.



Closed-ended provider payment with good contract monitoring and risk-based verification/clinical audit reduce administrative burden and provide cost-effective safeguards against fraud

What does this mean for Ethiopia?

Some ideas to get the discussion started

- Establish an **overarching governance mechanism** that has the authority and capacity to oversee the multiple financing schemes in place and to manage their harmonization.
- Review current regulations and PFM rules related to provider autonomy and **identify opportunities to increase autonomy of frontline providers** over the use of all sources of government revenue
- Develop a short-, medium- and long-term **plan to build institutional and individual capacity** in strategic purchasing across the relevant institutions.
- Identify opportunities to **simplify, streamline and automate operating sy**stems
- **Prioritize and invest in key information systems** to carry out purchasing functions with a view toward interoperability.

Q&A

Group discussions

In your group:

- Identify rapporteur
- Choose a topic
- Refer to guiding questions in corresponding brief
- Discuss immediate steps we can start taking

(60 minutes)

Report back

Rapporteurs please email your notes to nouria.brikci@lshtm.ac.uk before going to lunch

Thank you!

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Contact: kara.hanson@lshtm.ac.uk

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The case of Thailand