HEALTH FINANCING WORKING PAPER NO 8

STRATEGIC PURCHASING FOR UHC: KEY POLICY ISSUES AND QUESTIONS

A SUMMARY FROM EXPERT AND PRACTITIONERS' DISCUSSIONS

Inke Mathauer
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1. INTRODUCTION

Three broad principles guide health financing reforms to accelerate progress towards universal health coverage (UHC). The first is to move towards a predominant reliance on compulsory (i.e. public) funding sources. The second is to reduce fragmentation in pooling to enhance the redistributional capacity of these prepaid funds. The third, and the focus of this document, is to move towards strategic purchasing, which seeks to align funding and incentives with promised health services (1).

A *passive* approach to purchasing is characterized by providers automatically receiving funds (budget allocations) or payment independent of performance, by the absence of performance monitoring or when there are no efforts to influence the quantity or the quality of health services. Shifting to more *active* or *strategic* purchasing involves linking the transfer of funds to providers, at least in part, to *information* on aspects of their performance or the health needs of the population they serve.

Strategic purchasing is hence a purposeful approach to purchasing. However, it is not all or nothing, as there is a continuum from passive to more strategic purchasing. The objectives of strategic purchasing are to enhance equity in the distribution of resources, increase efficiency ("more health for the money"), manage expenditure growth and promote quality in health service delivery. It also serves to enhance transparency and accountability of providers and purchasers to the population. This contributes to the ultimate goals of maximized health outcomes and equity in health gains, financial protection and equity in financing as well as responsiveness (2).

Countries at all levels of income are considering or implementing reforms to increase the extent to which purchasing of services in the health system is strategic. Improving the purchasing function is a constant challenge for health system stewards: new opportunities (e.g. new health technologies or practices, greater availability of data through digitalization) and challenges (e.g. new health priorities, changes in provider behaviour) emerge continuously and require adaptions in how best to purchase services over time.

The purpose of this document is to outline and frame key policy issues and questions that are considered critical for reforms to shift towards strategic purchasing. The paper summarises and structures the issues emerging from the discussions held during a WHO organised one-day meeting of strategic purchasing experts in April 2016. This event explored key issues that countries should tackle in order to develop strategic purchasing policies and reforms as well as country capacity strengthening needs. Moreover, the paper includes the views and insights collected during a one-day strategic purchasing workshop that was co-organized by the World Health Organization and the Institute of Tropical Medicine (Antwerp) in September 2016 in Rabat, Morocco, together with practitioners, largely from the *Financial Access to Health Services* and *Performance Based Financing* Communities of Practice (3) (see lists of participants of the two events in the Annex). Lastly, we seek to enrich this paper with our own country work experiences, country examples and references to elaborate on the raised issues.

2. FRAMING KEY POLICY ISSUES AND QUESTIONS IN STRATEGIC PURCHASING

This section presents and frames five key themes that emerged as being critical for a reform dialogue on strategic purchasing, using country examples for illustrations. The five themes are:

as overarching health systems function:

1) governance;

as core aspects of purchasing:

2) information management systems;
3) benefit package design;
4) mixed provider payment systems;

as cross-cutting aspects:

5) managing alignment, dynamics and sequencing.

The following sub-sections frame the issues and suggest key policy questions thereby pointing to capacity strengthening needs, knowledge gaps or future research questions. While the themes are outlined separately in the following sub-sections, they are closely interlinked, and analysis and reform design and implementation need to be undertaken with a systemic perspective that deals with these themes jointly. These issues are relevant for countries at all levels of income, but the discussion here focuses on low- and middle-income countries (LMICs), as they are faced with more fundamental institutional challenges than are high-income countries with more established purchasing arrangements.

2.1. GOVERNANCE ASPECTS IN STRATEGIC PURCHASING

UNDERSTANDING THE CHALLENGES IN GOVERNANCE OF THE PURCHASING FUNCTION

Governance is an overarching health systems function and is about "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability" (4). It is also referred to as exercising authority, setting roles and responsibilities and shaping interactions of the different health actors, and in this context specifically of purchasers, providers, provider associations, society and beneficiaries (5, 6). This requires leadership and institutional and technical capacity of those actors in charge of governance, as well as being grounded in citizen/population representation. The effective exercise of the health system function of governance is a critical enabler for *strategic* purchasing. As the purchasing agencies are thus governed by the governance actors, they have primarily an "executive function", i.e. they implement purchasing policies.

However, as suggested by discussions with experts and country officials, in many countries the governance arrangements in health systems, and in particular with respect to purchasing, function poorly, are under-developed or even absent. A frequent challenge, especially in systems with multiple purchasers, is fragmentation and lack of coordination in the policymaking and oversight functions in that different actors (for example various ministries

and purchasing agencies) are involved in determining the operations around purchasing tasks. For example in Lao PDR, the MOH, as the national health authority, is responsible for the health sector policies. It has also been responsible for managing the Health Equity Fund for the Poor and overseeing Community-Based Health Insurance for people working in the informal sector. On the other hand, the Ministry of Labour and Social Welfare has been responsible for policy making regarding two separate social security schemes for formal sector employees (7). This fragmentation had made it difficult to align purchasing aspects across the different schemes, such as payment methods and rates as well as benefits.

A second challenge relates to insufficient capacity for governance. Country experience suggests that there is need to align capacity of the Ministry of Health and its related governance arrangements with that of the operational capacities of various players and stakeholders involved in purchasing, in particular that of the Ministry of Finance (8). When the governance actors are weak, a health insurance fund may absorb the policy function, but this can be problematic, for example, where affiliation to the insurance fund is less than universal, policy is driven more by what is good for the insured rather than what is good for the whole population.

More evidence on conducive governance arrangements and governance capacity needs related to purchasing agencies and the whole purchasing market will help to identify ways to strengthen strategic purchasing for UHC. Some of the relevant policy questions are:

- What are appropriate decision-making structures for the whole system that allow for coherent policy decisions, regulations, etc. on strategic purchasing for UHC?
- Which executive functions relating to strategic purchasing should be delegated to which existing actors?
- Specifically when there is a health insurance agency in place: what criteria should guide decisions on the attachment of the agency to one ministry rather than another (e.g. Ministry of Health versus Ministry of Labour)?
- What are effective purchasing arrangements in a decentralized health system?

GOVERNABILITY REQUIREMENTS FOR STRATEGIC PURCHASING

Purchasers and providers need to be “governable” in order to enable strategic purchasing. Governability means the extent to which purchasers and providers can be steered to serve system-wide goals defined by health policymakers, and in particular, progress towards UHC. While this may vary from one country to another, the following three aspects can be seen as important factors.

First, the purchasing agencies need to have a clear mandate for being a strategic purchaser based on legal provisions that specify its powers, i.e. decision-making space as well as a sufficient level of autonomy. Lack of a clear mandate and an unclear division of authority between the Ministry of Health and the purchasing agency over key decisions can be one of the underlying causes of incoherent decisions on the benefit package, provider payment methods or contracting policies, or even conflict. A study on Vietnam, for example, found such incoherence in regulations between the Ministry of Health and the social security agency, as a consequence of which it remained unclear for hospitals to know whether their overspending would be covered or not (9).

Second, to respond to strategic purchasing signals, providers need an adequate level of autonomy while concurrently being held accountable to the purchasing agency. Balancing autonomy and accountability is an explicit part of well-designed performance-based financing (PBF) reforms, as for example in Rwanda's initial design (10). Conversely in many countries, there is no or inadequate provider autonomy to respond to incentives for greater efficiency and quality. At the other end of the spectrum, hospital autonomy coupled with inappropriately defined accountability has led to a heavy focus on profit maximization by hospitals, with insufficient orientation towards financial protection of patients. This was an issue found in Vietnam, for example (9). Importantly, autonomy and discretion space of both purchasing agencies and providers need to be coupled with adequate capacities in the areas of health service delivery and quality, health financing and other functional competencies such as (financial) management, negotiation and contracting.

Third, for a purchaser to be able to operate strategically, it needs to have purchasing power in order to stimulate positive change across an entire health system. The size of the pooled funding matters for the purchaser to have scope to influence the service delivery mode and provider performance. Fragmentation into multiple schemes limits this purchasing power: lack of coherence across multiple purchasers, for example as to payment methods and rates and the composition of the benefit package, will limit the potential efficiency gains of strategic purchasing efforts. Moreover, even where pooled funding is large, strategic purchasing may be difficult if most of the funds are already obligated (e.g. for salaries) or if public financial management rules do not allow for a move away from rigid input-orientation. Country experience also reveals that the leverage a strategic purchaser has does not only come from the size of funding that it manages, but whether it is set up to operate at the level of the entire system and all patients/population.

This is reflected in the example of Kyrgyzstan: two years after the establishment of the Mandatory Health Insurance Fund, its share of total government health spending was only 8%, with most public money for health facilities still flowing through historical budget allocations. However, using the MHIF as the driver for a universal health system was designed into its role from the beginning. It managed all patient activity data for the system, creating a unified database that included insured and uninsured persons. The overall small top-up payments it made to providers were critical at the margin, in particular for funding variable cost inputs such as drugs and medical supplies.

Through this approach to implementation of strategic purchasing arrangements including a purchaser-provider split and population- and output-based payment methods, the foundation for a universal financing system was built. When, two years later, the government began to transfer the former line budget allocations into the MHIF, it was able to absorb this because it was already managing all of the data, and to use these data to work with each hospital on restructuring plans to adapt to the full transition to case-based payment (11, 12, 13).

Overall, more evidence on the "governability" of purchasers and the purchasing market is needed. Some key policy questions include:

- What is the most appropriate level of autonomy for a purchaser to guarantee efficiency, quality and equity?

- What are effective governance mechanisms to align purchasing agencies to system objectives?
- What are the needed legal mandate, core functional characteristics and capacities of an effective strategic purchaser?

ENSURING ACCOUNTABILITY IN COMPLEX PURCHASING MARKETS

The structure of a purchasing market and the stakeholders involved vary from one country to another. One of the core parts of governance responsibilities is to set up coherent accountability arrangements and monitor them over them, especially when there are several governance actors in multiple purchaser markets. This serves to align and steer purchasing actors in a consistent direction to achieve system objectives.

The level and type of fragmentation of the purchasing market as well as the complexity of multiple layers determine roles, responsibilities and decisions to be taken by key government actors including the Ministry of Health, as well as others, both at central and local levels. Patient associations and civil society or grassroots organisations are often important stakeholders. In some countries, they have played a critical role in the verification process under a PBF programme, for example (14). Other actors with an important role for strategic purchasing could involve expert organisations, such as quality management and accreditation institutions, financial oversight organisations, and insurance regulators etc. These add to a system's complexity, but ideally, they operate as coordinated "task networks", a term borrowed from the work of RESYST (an international research consortium) on tax collection task networks (15).

To set up and strengthen coherent accountability arrangements, there is thus need to understand the purchasing market structures, driving forces and the interests of involved stakeholders, in particular that of health workers both in the public and private sector. Some of the key policy questions are:

- How to hold different purchasing agencies, such as multiple local governments or a separate purchasing agency, accountable in a way that is aligned with UHC policy objectives and steer them to do what they are responsible for?
- What kind of purchasing decisions could or should be participatory, and how could this be done, and which ones are more "technical"?

INITIATING CHANGES TOWARDS STRATEGIC PURCHASING

Various countries have managed to launch reforms towards strategic purchasing. Other countries have recognized the importance of the subject, but actually struggle in shifting towards a more strategic way of purchasing. Making use of convenient windows of opportunity is hence important, while considering political economy factors. For example, the creation of a separate 'scheme' and purchasing agency, as numerous countries did, may constitute such windows for strategic purchasing.

The move towards more strategic purchasing may also imply a separation of or shift in functions. When a new purchasing agency is set up or when other ministries have purchasing functions, the role of the MOH will change. But if not well managed, such changes could also create power struggles that need to be dealt with. It is also argued that leadership needs to be institutionalized within the legal and regulatory set-up in

order to be sustained over time. But evidence of this working is often anecdotal.

Related key policy questions include:

- How to institutionalize leadership for strategic purchasing and what else leverages strategic purchasing?
- How to mitigate power struggles in the process of moving towards more strategic purchasing and how to make use of information sharing, capacity building and coalition building for that matter? And related to this, how to ensure that the purchasing agency is a servant of policy, rather than absorbing the policy function from the MOH.

2.2. INFORMATION MANAGEMENT SYSTEMS FOR STRATEGIC PURCHASING

ADDRESSING CAPACITY GAPS AND FRAGMENTED INFORMATION MANAGEMENT SYSTEMS

Strategic purchasing means that funds going to providers are, at least in part, based on *information* on performance aspects or on population health needs. Hence, an important backbone for strategic purchasing and its governance is a data and information management system for payment. Likewise, payment systems in particular are an important trigger to generate and provide information for planning and assessment of population needs, as well as to enable better understanding of what health services are being provided, where, and with what outcomes.

However, data and information management systems frequently face a number of challenges. One key challenge relates to weaknesses in data generation and use. While there is consensus that a cohesive data and information management approach is required with appropriate detailed data in order to shift to strategic purchasing, it is less clear what kind of data are needed and useful (and which ones not) and how data can be used to help strengthen strategic purchasing. Moreover, routine use of some information systems is challenging for some countries with limited institutional capacity. For example, implementing the coding system of the International Classification of Diseases (ICD) turned out to be complex for several LMICs, and there is recognition that there is need to simplify it (16).

Various resource persons at country level also pointed to the lack of analytical capacity as a major reason for underutilization of data, with insufficient analysis of health needs. Anecdotal evidence also suggests that there is sometimes lack of a culture to generate, use and analyse data, and too often there are no incentives to do so. However, there is great potential to establish a mutually beneficial relationship between data/information systems and purchasing, because provider payment systems demand better data that in turn can stimulate improvement in information systems. For example, in high-income countries such as Estonia, Pay-for-Performance initiatives have sharpened the focus on data, where payments to providers directly depend on its accuracy and timeliness. A similar trend is observed in a growing number of low-income countries, such as Burundi: they are seizing the opportunity of PBF to upgrade their health data system, with increasing granularity, transparency and versatility.

Another significant challenge in many countries relates to fragmented information

management systems, coupled with little interoperability. For example data collection and information systems may be organized along vertical programme lines. An information management system may even be more fragmented in a decentralised setup. The example of Kenya is not untypical. Anecdotal evidence suggests that the decentralization took place so quickly, with different information systems coming into place, such that there was no information available anymore at central level on services purchased or quality.

Some of the critical policy questions are listed below, which could also serve as action research topics:

- How to effectively unify data collection and management sub-systems into one in order to overcome fragmentation?
- How to establish a virtuous cycle of designing and implementing payment systems, generation of new data and then again using this data to refine payment systems over time?

STRENGTHENING INFORMATION MANAGEMENT GOVERNANCE

Similar to the need for governance of the purchasing function more broadly, there is a need for information management governance specifically to set up aligned information management systems that will provide a basis for planning and monitoring and evaluation, while guaranteeing data protection for patients. Another important goal of information management governance is to set incentives that enhance reporting and accountability. Information management systems need to be dynamic and adaptive, while at the same time a clear vision of the systems' functions and objectives is important. And as more information technology innovations become available, there is a need for a central actor to steer the system and make sure there is a coherent information management architecture. A strong e-health strategy is an important step for building such architecture. Important policy questions include:

- How to set up a productive interaction with local private information technology companies that can ensure a system orientation?
- How to seize the opportunities provided by the emerging "big data" agenda to assess population needs, analyse users and providers' behaviors and design smart payment systems at population-wide and system level?
- How to ensure patient privacy, data protection and integrity and how to safeguard against manipulation?

2.3. BENEFIT DESIGN AND ALIGNMENT WITH PROVIDER PAYMENT

FINDING THE RIGHT LEVEL OF SPECIFICITY IN BENEFIT DESIGN

From the perspective of health financing policy, the benefit package refers to those services that are to be paid, in part or in full, by the purchaser from pooled funds. A guiding principle for benefit package design could be: "Whatever is promised, should be delivered". As such, the benefit package (BP) can be understood as a guarantee to deliver in full the services to which beneficiaries have been entitled and "promised". Ideally, this is based on a transparent process that determined which specific health services, medicines and medical products and technologies are included and which ones are excluded, while

ensuring continuity of care. There are various criteria and design features to consider in the design of a benefit package, such as a positive list (defining what is covered) versus a negative list (defining the services that are not covered). There is also need to have a sufficiently explicit formulation of the benefits versus being implicit (17). Explicit does not necessarily mean detailed, but which benefits are covered needs to be clear so that the population can easily understand what is covered and what is not.

It is important for purchasers to know what to purchase and for providers what to provide, and it is equally important for the population to understand their rights and responsibilities with regard to health service use. However, even when defined, the way providers interpret it may vary, or users may dispute that the actual health services they received match the benefit package as defined (18). Related policy questions include:

- What is a good degree of BP specificity for different types of services, e.g. primary care vs specialized/referral interventions?
- In which contexts and for which beneficiary groups are more explicit BP appropriate? If explicit, what criteria should guide the degree of detail in the specification of the benefits? Under which conditions are more implicit BP more suitable? And what kind of provider payment methods are needed in these cases?
- How to institutionalize a process and mechanisms for BP design/revision? And what is the role of Health Technology Assessment (HTA) and budget impact analysis with regard to any proposed BP additions?
- How can citizens and patients be involved in this process?

FOCUSING MORE ON PRICING AND LESS ON THE COSTING OF BENEFIT PACKAGES

Costing information is important but is often misunderstood. While many countries have undertaken an exercise to cost their BP on the basis of which to request for more resources, experience suggests that costing did not have a big impact on mobilising more resources for their BP. Another important reason for countries to undertake costing studies is to get some price reference to inform the process of setting provider payment methods and rates. Vice versa, one of the objectives of many payment reforms is to create incentives for providers to alter their cost structure. The issue is hence to find appropriate payment methods and rates that set effective incentives for providers to achieve the desired objectives. For example, in PBF schemes, high-impact health services are paid at a higher rate to incentivize providers to increase their provision to ultimately increase population coverage.

Different cost concepts and approaches are required depending on the purpose. Critical aspects to focus on are relative cost weights (rather than absolute costs) and signals and incentives at the margin (rather than focusing on the average). This is closely connected to mixed payment methods and rates.

Furthermore, in many low- and middle-income countries, providers' financial management systems are often highly fragmented and weak (19), which renders costing exercises challenging. There is hence a need to improve approaches to costing and shift the focus to pricing for the development and revision of provider payment mechanisms and benefit package reforms (20). At the same time, more guidance is needed on how to respond to costing requests coming from governments

and development partners, such as the following questions:

- How to set up tariffs? How can the 'costing question' be used as a productive entry point for policy dialogue rather than for a 'gap analysis' that primarily focuses on revenue raising only?
- How can costing approaches effectively contribute to overall policy engagement with government, partners and specifically providers (including the private sector)?

ALIGNMENT OF BENEFIT PACKAGE DESIGN AND PROVIDER PAYMENT METHODS

BP design is related to the three health financing functions: how much money can be expected (revenue raising), how much of this money will be pooled for purposes of supporting the BP (pooling), and what mechanisms will be used to pay for the services in the BP (purchasing). As such, it is important to approach benefit package design as one interdependent part of health financing policy that needs to be aligned with other parts of the system, particularly purchasing. This is because the provider payment system is closely related, as it sets incentives that can enable or disable effective realization of the BP policy. In principle, purchasing arrangements should provide the guarantee to *pay* for the services in the BP, yet in practice, BP design or revision and provider payment methods (PPM) reforms are not always well connected in health financing policy discussions.

Some of the following questions will contribute to developing a better conceptual understanding of this interface:

- How to define what part of the BP is to be covered though budget allocations and which one to be paid for by a separate purchaser?
- Are more strategic purchasing mechanisms applicable to every service provided? Which services are more 'contractable'?
- How to limit or mitigate the potential for gaming, with rules about what is covered by providers depending on how the BP is specified and how providers are paid?
- What are the challenges, for example, when both public, not-for-profit and for-profit private providers offer the benefit package, e.g. with respect to differentiated payment rates and regulation of balance billing? What are the implications for provider payment mechanisms and rates?

2.4. MIXED PROVIDER PAYMENT SYSTEMS

SEEING THE 'MIXED' IN MIXED PROVIDER PAYMENT SYSTEMS

In many countries line-item budgets to government providers co-exist with other payment methods. These may include fee-for-service or case payments for contracted health services from a separate purchasing agency, such as a health insurance scheme, which often pays for marginal costs. This predominance of mixed payment arrangements in most countries, however, has not been adequately recognized nor analyzed. Instead of addressing individual provider payment challenges, there is need to shift to a system perspective that looks at all provider payment methods jointly. With this perspective, the question is no longer, for instance, how to optimize a specific PBF program, but how to align it with the overall provider payment system.

Critical policy questions on mixed and bundled provider payment systems for policy makers include:

- How to understand the real incentive environment facing providers and the problems arising from this, as the basis for designing a coherent reform response?
- What mix of provider payment methods is useful in which context and for which objectives at a given point in time?

Contexts are defined, for example, by the level of decentralization, the degree of provider autonomy, or the type and level of care (e.g. family practice; emergency care).

- How to alter the mix of provider payment mechanisms so as to reduce secondary/ tertiary care provision and increase use of services at the primary health care level?
- What are suitable bundled payment mechanisms for chronic conditions, including e.g. for provider networks to support care integration?

SYSTEM INTEGRATION OF PERFORMANCE-BASED FINANCING MECHANISMS

In the past, new payment arrangements, such as those used within performance-based financing programs (PBF), have sometimes been viewed and implemented as stand-alone 'financing mechanisms' rather than part of a mixed provider payment system (21). A common practice has been to run the "PBF scheme" as a pilot project that is not integrated into the core system (36), although some countries have made efforts to integrate it from the beginning. For example, in Armenia the PBF program for primary health care providers was set up as part of the expansion of the primary health care reforms, using and relying on the already existing strong purchasing agency in place (the "State Health Agency"). As such, it was introduced in a logical sequencing of broader health care reforms initiated in mid-1990s (22), whereby the State Health Agency was given the leadership role in the process and no parallel structures were established (23). Nonetheless, for many countries PBF programs provided a first exposure to strategic purchasing. In these countries, it was the first time that purchasers actively used information to make decisions about payments, and providers were given certain financial and managerial autonomy to decide how best to deliver their services. This was notably the case in the early days of PBF in Burundi and Rwanda.

With the aim to strengthen the alignment of mixed provider payment systems, more evidence is needed on the following questions:

- How can PBF be best integrated into the country health system to spearhead reforms in strategic purchasing?
- How to optimize the interface between PBF mechanisms and other existing payment methods in the system?
- Does PBF require separate verification mechanisms as is often the case in low- and middle-income countries? How can existing verification mechanisms be modified in order to facilitate integration of PBF in the overall health financing system?
- How can a country address misalignment between output-based payments and its public financial management system? What are the health system and public financial management prerequisites for a country to introduce PBF?

2.5. MANAGING ALIGNMENT AND DYNAMICS

ALIGNMENT OF STRATEGIC PURCHASING WITH OTHER HEALTH FINANCING FUNCTIONS

Strategic purchasing mechanisms are affected by revenue raising and pooling arrangements as well as service delivery arrangements, and equally they have an impact on these in return. Public financial management regulations are a particularly important factor in that respect. Often, these are rigid and make a shift to output-oriented payment methods difficult. Even more, there is often a tendency to think about purchasing reforms in a separate way, disconnected from public financial management rules or service delivery modalities. It is therefore critical to plan and design strategic purchasing reforms in a holistic way and align these with other health financing system aspects. For this alignment to take place, strong governance for purchasing and more broadly for the health financing system is needed.

Key policy questions include:

- How to align the various components of strategic purchasing with other health system reforms?
  In particular:
  How to encourage and ideally establish revenue raising arrangements that generate a stable and predictable level and flow of funding, as a basis for setting payment levels for providers to deliver the promised services?
  How to ensure that incentives set by provider payment methods support desired service delivery objectives?
- How to ensure better alignment of purchasing with other health financing functions, especially with public financial management and pooling?

MANAGING DYNAMICS

Improving the purchasing function is a constant challenge: Needs, demands and priorities, funding levels, treatment options and technologies/medicines change over time, as do provider and user behaviours as a result of adapting to (and coping with or gaming) provider payment methods. Health system stewards and strategic purchasing agencies must have the capacity to adjust to new conditions and to capture and manage these dynamics, which includes monitoring of all interested stakeholders' reactions including those of pharmaceutical and technology manufacturers and suppliers. Particular focus needs to be put on the continuous adaptation of the benefit package and the provider payment system including both payment methods and complementary administrative mechanisms, as a way to respond to provider behaviour caused by provider payment methods themselves (as with the "upcoding" response of hospitals to the introduction of Diagnosis Related Groups (DRGs), for example). Moreover, effective mechanisms must be in place to gather information in order to inform future remuneration rates, while improved and refined data is produced in the course of implementation.

Key policy questions include:

- How to anticipate likely provider responses to new payment methods and what are the options and administrative measures to counteract potentially harmful incentives?
- How to institutionalize system review processes?

3. CONCLUSIONS AND RECOMMENDATIONS

The policy questions outlined in this paper point to capacity strengthening needs and research gaps as identified in discussions with country policy-makers and development partners. Generating new evidence on these issues will help to develop policy guidance and inform reform discussions. It is also hoped that these reflections strengthen a global collaborative agenda that enhances coherent capacity strengthening in strategic purchasing. It is critical that development partners play a supportive role in this agenda.

Moreover, the discussions emphasized the need to focus on governance as an overarching and cross-cutting function. Strong governance is needed to define consistent policy objectives, to facilitate stakeholder consultations, to monitor and evaluate UHC progress, and to align strategic purchasing reforms with other health financing reforms. A second key point that emerged from the discussions was to recognize the importance of strong data and information management systems as a critical backbone for strategic purchasing. System standardization and unification needs to get more attention. For future country reform efforts as well as technical and policy advisory support by development partners, a change in the conversation on purchasing mechanisms will be needed, shifting from an isolated view on individual payment methods to an approach that recognizes that most provider payment systems are mixed. Applying a system perspective in both design and implementation of strategic purchasing reforms will also contribute towards institutionalization in the health system. Effectively managing the underlying dynamics and sequencing of reforms will be critical success factors in this endeavour, with effective use of the information from provider payment databases being a key driver for this. Last but not least, the meeting discussions made the case for more advocacy, knowledge management, experience exchange and networking for strategic purchasing.

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ANNEX

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