Adjustments in health purchasing as part of the Covid-19 health response:

results of a short survey and lessons for the future

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Introduction

Purpose and rationale

COVID-19 continues to have a tremendous impact on health systems, with countries around the world reconfiguring health service provision in order to meet the changing needs of their population. There is a surge in COVID-19 related care needs, such as testing arrangements, home care and Intensive Care Unit (ICU) bed capacity. At the same time, countries must continue to provide essential health services for non-COVID-19 patients, although many countries have seen a decrease in other health activities. A key challenge is that responding to the pandemic entails increased costs beyond previously planned budgets for the health sector, and most systems cannot simply absorb these, more so in view of other economic factors affecting government budgets. Governments have to reprioritise and provide additional funding to health ministries, and other purchasers of health services, to respond to these additional and urgent health care needs.

Importantly, purchasing arrangements play a key role in facilitating and supporting the adjustments in the provision of personal health services that are required due to the pandemic, for both COVID-19 and non-COVID-19 health services. Country health financing policy makers have taken action to adjust their purchasing arrangements. However, detailed country information on adjustments in purchasing arrangements as part of the COVID-19 response remained scarce for low- and middle-income countries (LMICs). With this in mind, we chose to administer a short online survey geared towards LMIC in order to collect primary data from experts with a background in health financing and health systems

This short note summarises and illustrates how countries have adjusted their purchasing arrangements to respond to COVID-19 and what lessons may be drawn from this for the future. The information provided is based on the responses received to a short online survey undertaken by the Health Financing Team of the World Health Organization in June 2020. The core objective of the survey is to get an overview of country policy responses and practice related to purchasing, also in order to identify potential options for future pandemics. The findings provide a general idea of the developments while pointing to some issues and concerns.

The survey consisted of **seven themes** that cover the core areas of strategic purchasing:

1. How have purchasers coped with the increased needs for funding to assist with the COVID-19 response?
2. How have benefits and cost-sharing mechanisms been adjusted to provide COVID-19 related and non-COVID-19 health services?
3. How were payment methods for health service providers modified?
4. How were contracting arrangements for public and private healthcare providers adjusted?
5. How were governance arrangements for purchasing altered?
6. How were information management systems developed to support the COVID-19 response?
7. What are the lessons for the future?

Data collection and analysis

An online survey was distributed to various policy communities, including the Health Financing Technical Network, the Collectivity (via the newsletter), the Financial Access for Health Community of Practice, the Performance Based Financing Collectivity group, the SPARC practitioners' network and the IHEA Health Financing special interest group. The survey was launched on 25 May and data collection was closed on 21 June 2020.

The questionnaire was offered in English and French and administered online, via LimeSurvey. The aforementioned seven key themes contained a few questions each. The formulation of these questions was informed by earlier work of the WHO Health Financing Team (Kutzin et al. 2020, Mathauer et al. 2020, WHO Europe 2020, Tsilaajav et al. 2020). A mix of question types were applied, including open, yes/no or check box questions. At the end of the survey period these data were downloaded from LimeSurvey into Microsoft Excel for cleaning and qualitative analysis.

Answers were analysed for each key theme. For open questions, we identified recurrent issues and grouped countries along these. Answers for countries with more than one respondent were considered together. In the few cases of incoherence, we gave more weight to responses from government and WHO respondents. Findings were validated in two steps: 1) during a virtual discussion, respondents reviewed the findings and provided feedback; 2) WHO health system/health financing colleagues from regional and country offices examined the findings. Moreover, we also paired the findings with data that we had collected previously for a blog on key purchasing actions during a pandemic (Mathauer et al. 2020). However, it is important to note that the situation is fluid and evolving, and the exact situation in a country may have already changed since the survey was run.

As regards limitations, we note that this approach does not allow for a systematic coverage of all countries and the results may not be representative. Also, as indicated in the next section, due to the comparatively lower response rate, only one PAHO country of that region is covered in this survey, despite the fact that the Region of the Americas is strongly impacted by the pandemic. Nonetheless, the survey provides important information on how countries have adjusted their actions in the policy domain of purchasing health services.

Results

Countries covered and respondents' profile

In total, 56 individuals completed all, or a significant part, of the survey and were included in the analysis. For 13 countries, we received multiple survey responses (from 2-4), which allowed for the cross-checking of answers. As such, the survey provides information on 31 countries across all regions, as outlined in Table 1.

Table 1. Countries covered in the short survey by WHO region

WHO region	AFRO	EMRO	EURO	PAHO	SEARO	WPRO
	Burkina Faso (2) Burundi (3) Cameroon (4) Central African Republic Côte d'Ivoire Democratic Republic of Congo (4) Eritrea Ghana (2) Guinea Kenya (4) Niger (2) Nigeria (4) Uganda Zambia Zimbabwe	Afghanistan Algeria Bahrain Egypt (4) Lebanon Morocco	Armenia (2) North Macedonia	Argentina	India (3) Indonesia (2) Myanmar Nepal Sri Lanka	Cambodia Philippines (2)
31 (56)	15 (32)	6 (9)	2 (3)	1 (1)	5 (8)	2 (3)

Note: The figures in brackets indicate the number of respondents per country or, in the bottom line, per region.

As regards the respondents' profile, the majority were from national government institutions, including ministries of health (13), health insurance agencies (4), and other government offices (4). The second largest group of responses were provided by WHO regional or country staff (11) and international organisations (4). The remaining responses were submitted by health financing specialists at non-governmental organisations (10), academic/research institutes (7) and independent consultants (3).

Purchasing actors

In the majority of the countries included here, there are multiple purchasing actors, the most frequently mentioned ones being the ministry of health, sub-national health administrations, and public health insurance schemes. Respondents also listed private health insurance in half of the countries, and non-governmental organisations in a third of countries as important purchasing actors. Community-based health insurance schemes were mentioned much less frequently (6 countries). Unless specified otherwise, the following sections refer to public purchasers.

Strategies of purchasers to cope with increased funding needs

In the face of epidemics, one primary concern is to provide additional resources to avoid disruption of health service provision due to lack of funding. In fact, in all countries additional funding was

made available for the COVID-19 response, in many cases coming from donors, but also from private sources. Most commonly in nearly all countries in this survey sample, these were channelled through government budget increases to the Ministry of Health at the national-level, or through extra-budgetary separate funds, and/or to the sub-national level (in about a fourth of countries), as well as to health insurance funds, though less frequently. In various countries, additional funding has also been allocated through non-governmental purchasing organizations.

The most common strategy purchasers used to cope with increased funding needs was the reallocation of existing funds in about half of the countries. However, purchasers also had to get into deficit financing or increase flexibility in the use of funds, as indicated in about a third of countries. Interestingly, delays in making payments to providers was reported in only a few countries.

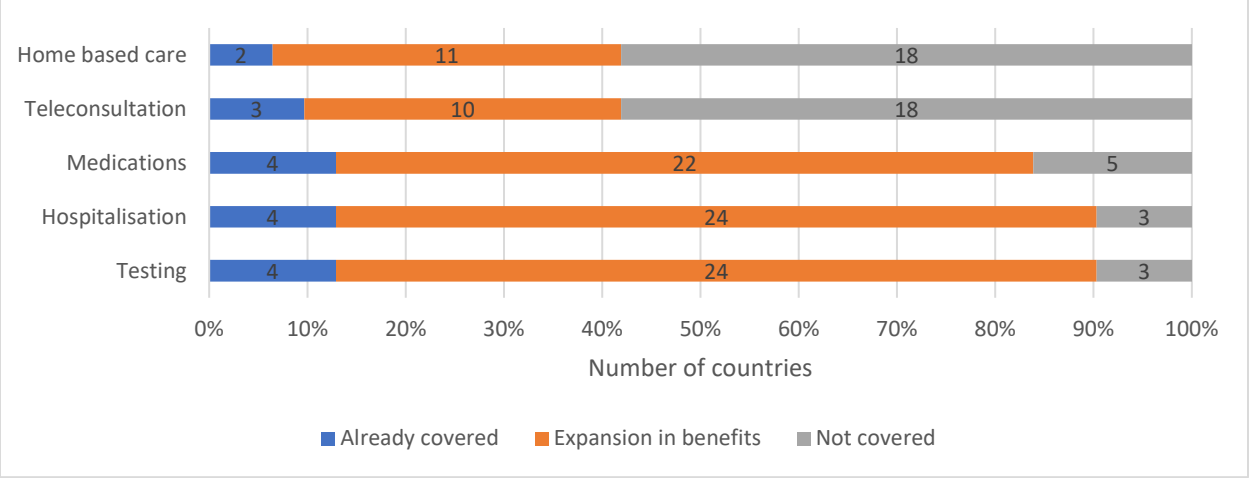
Expansion of the services included in the benefit package

Specifying or adding COVID-19 health services to the benefit package is critical to allow resources to be used on COVID-19 cases. More so, this enhances care seeking thus supporting the COVID-19 response in terms of testing and treatment, when individuals face low or no financial barriers at the point of use. This is closely linked to the level of cost-sharing, as discussed in the next section.

For the majority of the countries in this survey, respondents indicated an expansion of COVID-19 related health services in publicly funded benefits, namely for testing, hospitalisation and medication, as shown in Figure 2. For example, in Kenya, the National Hospital Insurance Fund (NHIF), a public health insurer, initially did not cover these services, but eventually included these benefits in public health facilities. A couple of countries indicated that no expansion was required as these services were already covered. Utilising a notably different approach, Nigeria covers all COVID-19 related health services, including food and accommodation, through the Nigerian Centre for Disease Control (NCDC).

New service delivery modes, such as teleconsultation and home-based care were also part of the benefit expansion in about a third of countries covered in this survey. Previously, teleconsultation and home-based care were part of the benefit package in just three and two countries respectively. Moreover, some respondents indicated that non-medical care costs such as transport, hospital room charges, or food during hospitalisation, are also covered by the Ministry of Health.

Figure 2. Benefit package coverage for COVID-19 related health services



Modifications in cost-sharing rules

Another important element of benefits specification is to clarify and denote the "conditions of access" to these services, i.e. patient cost-sharing and referral rules to guide care seeking behaviour. It is also important that beneficiaries are aware of their entitlements and related access conditions.

For the majority of the countries included here, respondents indicated that the government has mandated that coverage of all COVID-19 related services - including testing, medicines and hospital treatment - be provided free of charge in public facilities. In Kenya, COVID-19 health services initially required co-payments, but the government has since mobilised additional funding to expand the benefit package and provide care free of charge for everyone. In North Macedonia, the existing law on communicable diseases states that all people, whether enrolled in the health insurance scheme or not, are covered for infectious diseases, with a decree making this more explicit during COVID-19. In Nepal, initially all testing services were provided publicly, but the government has subsequently allowed testing in private facilities for people paying out-of-pocket.

Modifications in payment methods

One of the key policy instruments of strategic purchasing is provider payment, i.e. how resources are allocated to healthcare providers. How and how much health care providers are paid by purchasers and what kind of conditionalities come along with it (e.g. reporting requirements) are critical in that payment methods generate incentives that influence healthcare provider behaviour thus ultimately affecting progress towards universal health coverage.

Numerous countries introduced changes in payment methods in order to support the response to COVID-19. In many countries, purchasers allowed providers to make more flexible use of funds. For example, in Zimbabwe, funds from results-based budgeting were rechannelled towards COVID-19 health services as advance payments. Temporarily lifting budget caps as providers received additional budget allocations was also a critical adaptation in about half of the countries. In about

two-thirds of the countries, purchasers introduced financial incentives to motivate health staff working under difficult circumstances.

In terms of adjustments in payment methods or rates, it was reported that new payments were set for COVID-19 health services in about half of the countries, or payments were modified for existing health services. For example, in Indonesia under the National Health Insurance scheme, per diem rates for COVID-19 hospital patients were introduced for different settings, e.g. depending on whether a ventilator is available or not. Moreover, providing payments or incentives to increase ICU bed capacity was indicated in about a third of the countries. In Kenya, for instance, funds were provided to counties to ensure that the bed and ICU capacity was improved. Finally, in some countries, purchasers (primarily the Ministry of Health) have engaged in a direct reimbursement mode to pay (designated) providers for COVID-19 related care. Less frequent was the provision of specific payments to keep ICU beds available for COVID-19 patients. Very few countries reported to make per diem payments for ICU beds, introducing caps for payments to private sector providers, or improving/incentivising e-claim submissions.

Changes in contracting and accreditation arrangements

Contracting is another important purchasing instrument. A contract involves a prospective agreement between the purchaser and an individual provider regarding the terms and conditions of payments and the type and volume of services over a defined period. In some cases, it may set objectives and indicators to measure contract fulfilment (e.g. on quality). Accreditation is a process of review that allows healthcare providers to demonstrate their ability to meet defined (quality related) standards. It can serve to inform a purchaser's provider selection process (Duran 2005).

Nearly half of the countries were reported to apply new contract or accreditation procedures to facilities providing COVID-19 care. Similarly, a couple of countries introduced changes to existing accreditation procedures, typically to simplify the approval process. For example in the Philippines, accreditation of health facilities was automatically extended, and contracting procedures were expedited in Afghanistan and Burkina Faso.

Several countries also indicated that specific facilities were selected based on their capacity and thus designated as service providers for COVID-related health services, but without another accreditation process. This was the case for example in Armenia, Cameroon and Eritrea. Respondents in the Democratic Republic of Congo report that hospitals selected for COVID-19 treatment have a contract with the government to guarantee service provision by hospitals and the reimbursement of costs by the government.

Adjustments in purchasing and contracting modalities for private sector providers

The majority of respondents did not report a specific contracting modality for the private sector and indicated that COVID-19 related health services are largely publicly provided. Nonetheless, private sector involvement in COVID-19 related service provision was reported to be increasing as a response to raising demand. In some countries, government authorities started considering how to

formally include private sector providers in the response in order to avoid or reduce out-of-pocket payments.

In North Macedonia, private laboratories have been included in the network to provide testing on COVID-19 as well as private hospitals with intensive care units. However, they were reportedly on hold and would only be used for surge capacity. In Armenia, the private sector was not contracted for COVID-19 related service provision. However, several private hospitals have implemented isolation rooms to diagnose suspected cases before admitting them to the hospital, with positive cases sent to specialized hospitals for treatment. Patients who do not meet the requirements to be tested for free by the government may seek services at a private diagnostic centre, or hospital laboratory, and pay out-of-pocket.

In countries where the private sector is involved in COVID-19 related health service provision, some governments have introduced regulatory provisions, such as price caps. In the absence of these, one respondent mentioned corrupt practices in the procurement of goods with expedited procedures at the provincial level (e.g. the purchase of equipment was made at ten times the market price) – an issue, however, that is not just confined to the private sector.

Alterations in governance arrangements for purchasing

Organizing and coordinating the health sector response to COVID-19 requires modifications in the existing governance arrangements of the health sector and these modifications have also altered the governance arrangements for purchasing. A key objective is to ensure coordination and harmonization between the ministry of health and the different purchasers (e.g., social or national health insurance, voluntary health insurance).

To coordinate the COVID-19 health response, the most common governance approach consisted of both strengthening existing arrangements and establishing new coordination mechanisms, as indicated in nearly 50% of countries. Respondents of some countries referred only to establishing new coordination mechanisms, whereas for a few countries, it was noted that they only strengthened existing arrangements.

While the ministry of health would typically lead a technical health committee, in the majority of the countries covered in this survey, new coordination mechanisms in charge of COVID-19 crisis management were also set up at higher levels of government, with a mandate going beyond the health domain. These new coordination mechanisms may be under a head of government, as in Morocco, Cameroon or Armenia (deputy), or even under the direct supervision of the Head of State, like in Sri Lanka, Nigeria, the Democratic Republic of Congo or in Zimbabwe (vice-president).

In several countries, multiple coordination platforms are established, both within and beyond the health sector, in order to coordinate the various dimensions of the response. For example, in Nigeria a presidential task force directs relevant Ministries to respond to economic and social issues, while a separate Health Sector response committee with an expert advisory group is in charge of coordination within the health sector. In devolved settings, similar coordination arrangements are found at sub-national levels. Overall, the leadership of higher levels of government was considered beneficial to ensure coordination across these multiple platforms.

Separate purchasing agencies, such as a national health insurance agency, were not reported as key players in these new coordination mechanisms. Therefore, the role that different purchasing agencies played in the coordination of the COVID-19 response remains unclear. In one country, it was indicated that the response was driven by the Ministry of Health and government health providers, with the new health insurance agency not having a specific role, thereby weakening the nascent purchaser-provider split. Another respondent pointed out that while the purchasing roles of the Ministry of Health and the subnational governments were consolidated during the crisis, the national health insurance agency was missing in action. In some contexts, this was considered a source of concern as purchasing agencies play a key role in the implementation of the response.

Developments in information management support

Information management is a key enabler of strategic decision-making with regards to purchasing arrangements, particularly in a time of crisis like COVID-19 (cf. Shiffman 2020). The crisis underlined the need for the timely generation of information derived from granular patient records to inform the response, and more generally for health security, in order to detect, trace and treat patients.

Respondents mentioned modifications to information management systems in more than half of the countries. One way was to integrate reporting obligations into the existing system. The nature of the applied modifications varied across contexts, depending on the existing system in place and the capacity to modify the system in such a short timeframe. In some contexts, "integration" of reporting obligations into the existing information management system occurred through a tweaking of the existing routine health information reporting system, such as in Zambia, or through the additions of COVID-19 specific modules within the system in place, e.g. within DHIS 2 in Myanmar. **In other instances, new, separate information management systems were introduced to complement the existing systems**, as reported in Nepal. In Myanmar, the introduction of a COVID-19 module into DHIS2 was not the only action taken: the country also introduced a new laboratory information management system in order to collect COVID-19 test results in a timely, and sufficiently granular way.

In some other countries, the existing health information management systems were already well-established and sufficiently reliable to produce detailed COVID-19 patient records and meet information requirements for both patient cases and contact tracing. For example in Armenia, the national health information management system was adjusted to allow primary care physicians to receive results of COVID-19 testing, as well as to mark the quarantine status of patients with mild symptoms and their close contacts who should self-isolate. In North Macedonia, where the health information management system was already quite developed and mostly digitalised, the COVID-19 crisis was used as an opportunity to introduce e-prescription. Such new functionalities are seen to help speed up information exchange.

Lessons shared by respondents

The survey also included a question on what participants would view as the key lessons drawn from the COVID-19 response, as well as their suggestions for future pandemic planning. This section provides a short summary of these responses.

A dominant theme shared by respondents was the importance of having flexibility in the use of funds as well as upfront and rapid budget allocations to providers. Some respondents suggested to change public financial management rules for providers and purchasers and to also strengthen the role of sub-national health authorities. Related thereto was the request to think about long-term funding needs as well as to establish emergency funds (possibly financed through new revenue sources) and/or to set up flexible budget procedures to accommodate unplanned expenditure during an emergency. It was also noted that the upfront payments as well as framework agreements with hospitals to treat COVID-19 patients had proved to be effective.

Respondents also considered full coverage of COVID-19 health services through public funding as critical to avoid financial hardship and ensure the response was effective. This required making provider payment methods and benefits explicit. Some respondents also reflected on the need to expand the benefit package of health insurance schemes to cover infectious diseases.

To be prepared for a pandemic, it was emphasised that strategic purchasing modalities should be in place during "normal" times and be quickly adaptable according to the context of a crisis. This would require strong information management systems and data availability, as well as effective governance arrangements to also ensure transparency. It was noted that the crisis could be seen as an opportunity to rapidly improve the health insurance claims management system and make more effective use of the data that a purchaser collects from providers. Moreover, the lessons in provisional accreditation could also help to transition to contracting for output rather than accrediting for input. Furthermore, providing room for innovations was also mentioned, in particular with respect to private sector engagement. Finally, respondents considered increased collaboration and the ability to rapidly contract with private sector actors (e.g. health providers or non-hospital isolation facilities) as critical.

Discussion

Practically all countries covered in this survey have adjusted their purchasing arrangements as part of the response to the COVID-19 pandemic. As a start, nearly all countries have made more funds available, which is also reported by Rahim et al. (2020), and most countries expanded covered health services to ensure that COVID-19 related health services are included. Many countries, but not all, coupled the expansion of services in the benefit package with making them available free of charge. This is in line with WHO recommendations to assess and mitigate potential financial barriers to accessing COVID-19 health care (WHO Europe 2020; Kutzin et al. 2020). A critical question relates to the role of health insurance, where it exists for the majority of the population, and whether pandemic related health services should be included in the benefit package. At the same time, everybody - independent of health insurance status - should have access to needed health services, thus eliminating the contribution-entitlement link. Harmonization of benefits and conditions of access such as cost-sharing rules across different coverage schemes is also of central importance.

The survey also showed that most purchasers adjusted their resource allocation and payment arrangements to providers, such as increasing the flexibility in the use of funds at provider level and/or lifting budget caps (cf. Barroy et al. 2020a, Barroy et al. 2020b). One key driver for flexibility

was also the need to minimize the loss of revenues due to the postponement of non-emergency care. The range of payment modifications reported are similar to those applied in many high-income countries where the COVID-19 pandemic had emerged some weeks earlier. The interesting question is whether this has accelerated a shift toward more strategic purchasing.

Nonetheless, in LMICs, little information is available on the actual details of the adjustments made by purchasers in the payment methods and rates for existing health services or new COVID-19 related health services. There is a clear gap in knowledge sharing at this point for LMIC countries, although for some LMICs, details related to their purchasing response are emerging (WHO Europe 2020, Tsilajaav et al. 2020, OECD 2020b). For European HIC and LMIC countries, information can be found in the European Observatory COVID-19 Health System Response Monitor (see also Quentin 2020).

In a few countries the crisis offered an opportunity to improve information management and to introduce innovations to facilitate purchasing. Whether these innovations – like e-prescription – will be retained as part of routine health system operations beyond the crisis, and whether they will integrate well into the existing data architecture remains to be seen. However, in most contexts, existing health information data management systems have proved inadequate to produce sufficiently granular COVID-19 related patient data. In some countries, the default reaction has been to establish separate information channels to capture key individual data on COVID-19 related cases. However, it is clear that it is difficult to make institutional adjustments to better inform purchasing decisions in the middle of the pandemic, but hopefully they may be part of the Build Back Better ambition (cf. OECD 2020a).

Respondents indicated a range of modifications in governance arrangements taken to coordinate the response. Generally, coordination has been ensured by different and in principle complementary committees in various sectors (health, social, economic) and different levels (sub-national, line ministry or cabinet level). The involvement of senior government officials could improve coordination across these committees, bringing more coherence to the multisectoral response. However, this is challenging from a technical level due to the inherent trade-offs of the multisectoral response to COVID-19 and issues of coordination may occur at the operational level. It is interesting that countries that had faced an epidemic such as Ebola in the past were able to build on the existing coordination platforms to implement their response. The mandate of these committees was expanded in several cases, and their capacity developed to coordinate the COVID-19 response.

One aspect deserving increased attention is the role played by separate purchasing agencies in the governance arrangements in charge of the health response, such as a national health insurance scheme as and when it covers a large part of the population**.** Separate purchasing agencies were not explicitly mentioned to be members in these new committees. Their role in the response remains unclear and, primarily in countries where they are rather weak actors, they may actually have had insufficient opportunities to participate. However, when they are strong strategic purchasers getting funds to providers coupled with effective incentives, their involvement may be pivotal to the quality of the response, even if their focus is primarily on personal health services in many countries. As such, it is critical to clarify the mandates of the various committees in charge of the health sector response with respect to health service purchasing in a pandemic situation. It is also important to specify and align the responsibilities of different purchasing agencies.

Conclusions

In summary, this survey generated a broad overview of developments in purchasing arrangements related to the COVID-19 response in LMICs. Overall, the examples provided by respondents, as well as the challenges described, reinforce the five critical purchasing actions proposed in an earlier blog:

1. Ensure that public funds are effectively translated into the provision of Common Goods for Health by appropriate purchasing arrangements
2. Expand benefits and inform the public with clear simple, messages
3. Adjust payment methods and rates to new service delivery arrangements and ensure continuity in funding flows to health care providers
4. Use private sector capacities where needed
5. Establish governance arrangements for accelerated decisions-making and set clear reporting standards

Restating one of the key lessons shared by respondents, strategic purchasing modalities need to be in place to enable rapid adaptation to the context of a pandemic crisis.

Nonetheless, there is a strong need for more insights on actual details of modifications in payment methods and rates. This serves to engage in further reflections on how to pay health providers for personal health services as well as for public health functions (such as testing, contract tracing) during health emergencies, but also as part of emergency and pandemic preparedness. For example, providers paid based on volume (such as fee for service or case-based payment) have faced severe income decreases. The question is which combination of payment methods may be useful so as to balance the expenditure risk between purchasers and providers not just for COVID-19 health services under increased demand, but also for non-COVID-19 health services, which have experienced lower utilisation rates. There is also a need for more detailed information on the role of purchasers in governance mechanisms, particularly in relation to health insurance schemes. For a pandemic plan, it may be useful to consider formalising the role of purchasing agencies in governance arrangements, especially when dealing with health financing and purchasing questions. Furthermore, in line with the conclusions of a blog on how to involve and contract private sector providers in the WHO South East Asian Region, it will be important for governments to document and evaluate their responses in relation to private sector providers (Tsilaajav et al. 2020). Evidently, there is need for a "clear pathway to collaboration that maximizes the benefits and reduces the demerits of engaging with this sector", as outlined by Olalere (2020).

As a next step, it is critical that country policy makers explore to what extent these modifications in purchasing arrangements should be retained to make use of advances in purchasing arrangements. Such examples may relate to furthering the role of teleconsultation or the provision of home-based care by community health workers. Ultimately, more evaluations on the effectiveness of the adjustments seen in purchasing arrangements are needed not only with respect to whether purchasing has led to increased efficiency, transparency and equitable resource distribution, but also whether they had an impact on actual coverage. It will also be critical to disseminate any innovations emerging from the pandemic response in the field of purchasing.

Policy makers, practitioners and researchers are invited to share their country practice and experiences. This serves to facilitate mutual learning and a better understanding of what are useful purchasing responses during emergencies or a pandemic, as well as for emergency preparedness in order to draw lessons for the future.

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