Strategic Purchasing Pilot

Learning Brief 1: "Strategic" Purchasing: what is it, how are we doing it, and why?

The National Health Plan 2017-2021 (NHP) recognized the need for engagement with non-state providers of health care in order to achieve universal health coverage (UHC). The approach it recommended was to establish a national purchasing body to purchase services from both government and non-government providers. This is a substantial change from the way health services are currently paid for in Myanmar, whereby government funds flow only to government clinics in the form of salaries, medicines, allowances and operating expenses.

It is clear, however, that there is some confusion about what kinds of changes strategic purchasing would entail. CPI, funded by 3MDG and SDC, have partnered with the Karen Ethnic Health Organization Consortium (KEHOC) to investigate how strategic purchasing from EHOs might function.

This is the first in a series of Learning Briefs that CPI will produce to share the lessons learned in this pilot. It attempts to explain what "purchasing" and the "purchaser-provider split" mean, what makes purchasing "strategic," why purchasing from Ethnic Health Organizations (EHOs) is important, and finally how our pilot synthesizes these lessons.

1. What is purchasing? What is a purchaser-provider split? Why do it?

Understanding strategic purchasing is particularly important this year during the creation of the National Health Financing Strategy, in the process of which "Purchasing" will be one of the workshops. This element of health financing stresses that in addition to thinking about the cost of services – that is, *how much* you should pay providers – it is also important to think about the way that providers are paid – that is, *how* you pay them.

Purchasing itself can describe many ways of paying for health services. Purchasing does not only refer to procurement of medicines and technology. Rather, it refers to the approach used to pay for the entire health system: it includes how the system pays for human resources (doctors, nurses, Community health workers), facilities, management and administration.

A **purchaser-provider split** is a specific way to structure health financing that makes the purchasing function clear by separating the organizations that purchase services from those that provide them. This split enables the purchaser to focus on how to make its funds achieve its health objectives (UHC, equity, etc.), rather than having its objectives dictated by provider interests. Meanwhile providers can focus on how best to provide those services. It is a model of health care financing that has been adopted across a wide range of countries, from Thailand, the Philippines and Indonesia to Germany and France.[1]

[1] Even all public health systems like the UK have implemented a purchaser-provider split, doing so within the NHS while keeping all services publically owned.

The alternative to a purchaser-provider split is to have a provider that combines the purchasing and providing roles.[2] This is the system in Myanmar at present (although the services do not reach everyone). There is a centrally organized Ministry of Health and Sports that receives a budget and then spends it on (or purchases from) its own facilities and staff.

In Myanmar, the purchaser-provider split model being discussed would create a semi-autonomous purchasing body (or bodies), which could purchase services from consortia of public, for-profit, NGO and EHO clinics. This would allow a package of health services to be rolled out faster than if the growth depended solely on the government training and hiring new staff as well as building new public facilities across the country. It also recognizes the important role that non-state providers are already playing in the Myanmar health system.

If done well, this approach can discipline all providers (government, EHO, NGO and private) to provide health services that are needed and meet quality standards at reasonable prices. The government would have the responsibility of "purchasing" services (at least for the poor and vulnerable) but MoHS clinics would not necessarily have to face the full burden of providing that care.

2. What makes purchasing "strategic"?

"Strategic" purchasing implies that the purchasing relationship is being done to improve health services, by targeting those most in need, creating the right incentives, and buying from the right providers. "Strategic" purchasing contrasts with "passive" purchasing, which implies that the purchasing is made without conscious consideration of how money would best be spent (for example, budgeting based on last year's costs). A series of alternative definitions are contained in the annex.

"Strategic" purchasing therefore extends well beyond merely offering financial incentives to individual health staff. Performance incentives may be a part of a "strategy" but only if they will improve performance.[3] The payment approach should be aligned to support the national health system's objectives of equity, quality of care, and efficiency (and potentially peace). But furthermore, as part of being strategic it is also important to recognize that the decisions are not only about the structure of the payment mechanism, but the choice of provider, the targeted populations and the content of the package purchased.

3. Why is purchasing from Ethnic Health Organizations strategic?

In the mountainous and coastal areas around the borders of Myanmar communities have suffered the full effects of Myanmar's civil war, compounded by a lack of development fueled by uncertainty and violence. This legacy has created a paradoxical distribution of government health services, with many communities with the greatest need of health care among the least likely to have access to it.

[2] This can also be described as a type of purchasing, though it is less transparent what is being purchased in such a model.
[3] For example, purchasing each service from a provider (or paying a bonus for each service, known as fee for service) will create an incentive to provide more services, particularly for the services that yield the largest profit/bonus. If people already receive enough care in those areas, this will not be appropriate. If, on the other hand, this is targeted to those areas that are currently under-provided, this would be strategic.

The most recent comprehensive survey of Southeast Myanmar, "The Long Road to Recovery," estimated that among over 5,000 households in mixed control and non-government-controlled areas, only 8.3% of people had been to a government clinic in the previous year (while 70% accessed EHO services).[4] The reasons for this were:

- Distance: Most respondents walked to seek care (75.2%) averaging 85 minutes to reach a clinic. The absence of government facilities in border areas would require a large infrastructure project to cover such a large and difficult terrain.[5]
- Language, trust and culture barriers: as only 41.4% of respondents speak Burmese, being understood and understanding the advice provided by health workers can be a challenge for patients at government facilities.[6] This is compounded by government practice of rotating health workers, preventing them from developing such skills. Added to language barriers, perceptions of differences in culture and potential prejudice are significant barriers to care seeking in government facilities.[7]
- Cost: uncertainty about the out of pocket costs of care in government facilities contrast with the care provided by EHOs that is known to be offered free of charge.[8]

Given the limited extent of government clinics in conflict affected areas, and the mistrust of those clinics that do exist, EHOs have filled in the gaps wherever possible. They provide health services in local languages, by local people, free of charge. Though initially predominantly mobile, more widespread ceasefire agreements in the last decade have improved security for EHOs enabling the establishment of more permanent clinics.

EHOs face uncertainties about future funding and tight resource constraints as a result of reduced funding from the Thai side of the border caused by donors pivoting to supporting the national government after the democratic transition. Nonetheless, they continue to offer invaluable services to ethnic people in Myanmar. Crucial to this ability to serve ethnic people has been the independence of these health providers from a state structure that has been viewed with mistrust. As this mistrust persists, supporting EHOs may not only be the *most efficient* approach but the *only* way to reach large populations in Myanmar's ethnic areas.

In order to work with EHOs, however, there are clear limits to the amount of control that the national government can exercise. An EHO could not submit to be given a line item budget and be instructed how to provide health services: this would be forfeiting their independence. Purchasing services from EHOs, however, offers a new way for the government and ethnic organizations to work together to provide health services for hard to reach populations. Autonomy is maintained while convergence is made possible. It therefore raises a second important possibility: purchasing can begin to build the trust that will be essential for the success of the peace process.

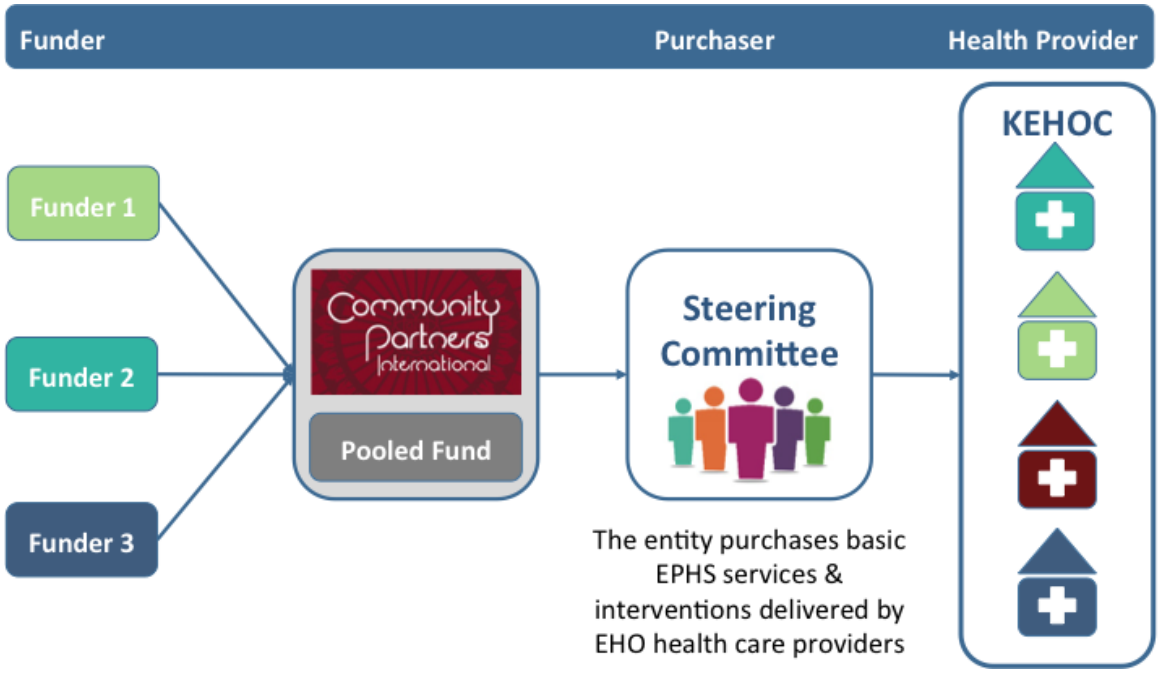
[4] "The Long Road to Recovery" (2015). This was prepared by the Health Information Systems Working Group (HISWG) in Mae Sot, with supporting partners including Community Partners International (CPI), Burma Relief Centre (BRC), Johns Hopkins Bloomberg School of Public Health, Harvard University, and the University of California, Los Angeles.
[5] *Ibid., p.35*
[6] *Ibid., p.23*
[7] *Ibid., p.36*
[8] *Ibid., p.36*

This system enables donor funds to support both health and peace building. By channeling funds to EHOs in this way, strategic purchasing from EHOs could facilitate cooperation between EAOs and national government in future while also improving health outcomes in the present.

4. The CPI-KEHOC Strategic Purchasing Pilot

Bearing in mind both the aim of peace and high quality health services, CPI and KEHOC have developed a strategic purchasing pilot. The pilot expands on the services KEHOC offered at four clinics, preserves EHO autonomy and ensures high quality data to document that services have been provided.

The basic structure of the purchasing arrangement is as follows:



This differs significantly from current models in which donors hire and pay staff directly, provide drugs and supplies, conduct M&E and avoid overlap (or not) with other health service providers. This shifting of responsibility towards the EHO increases both their autonomy and the scalability of the model given inevitable capacity constraints for a fledgling national purchasing body.

CPI and KEHOC have formed a Steering Committee for the pilot which is the official purchaser.[9] In the first stage of this pilot, it is purchasing a basic package of health services (modelled off the government's Basic Essential Package of Health Services - BEPHS - but adjusted for local capabilities) for 10,300 citizens living around four clinics in different townships in Karen State and Bago Region. This package is being purchased on a capitation basis to fund not only the provision of

[9] To ensure the benefits of the "split," CPI has the deciding vote, while learning from KEHOC's on-the-ground experience (provider representation on purchasing boards is common).

health services, but the health system that enables services to be reliably offered and information about those services recorded. That is, the funding that KEHOC receives depends on the number of people that are provided with the BEPHS. The information on how the number of people was counted is explained in the second Learning Brief, while the approach to calculating the capitation rate will follow in the fourth.

CPI is also offering health systems strengthening support to KEHOC to help them. This has included support for planning, prioritizing, budgeting, logistics and M&E to ensure high quality services and to better understand the challenges faced in this process. CPI and KEHOC are aiming to develop this capacity and to understand how vertical programs best fit within a strong EHO health system.

5. What about this purchasing is "Strategic"?

The purchasing relationship established in this pilot is strategic in the following senses:

- **Choice of provider**: EHOs are the most established and well trained health providers in each of the areas in our pilot, speak local languages and have community trust. Peace is perhaps the largest factor that will influence the life outcomes (and health) of those in border regions. Politically, large-scale production of government health facilities in disputed areas would be highly contentious. In contrast, funding EHO providers to deliver services could be a crucial step towards creating a positive peace.
- **Targeted populations**: People living in hard to reach areas are among the poorest and least healthy in Myanmar. Inclusion of these areas is critical to achieving the equity goals outlined in the NHP. (Equity provides a strong justification both for CPI's choice of target clinics, and for the national purchasing body to be well equipped to purchase services in ethnic regions.) According to the HARP/MIMU study of vulnerability, three of the townships included are described as "Type 1: Extreme outliers in terms of development needs and/or exposure to conflict" while one is "Type 4: Very Low access to basic services and infrastructure."[10]
- **Package of services**: the package on interventions selected for the pilot aligns with the goals outlined in the NHP to first focus on basic primary health and public health for all. The initial services packages prioritizes BEPHS interventions outlined by MoHS with the potential for greatest population health impact, that are feasible within the human resource constraints. More detail on the process of defining the package will be contained in the third Learning Brief.
- **Payment structure**: Using a capitation rate will incentivize more prevention for health care rather than expensive treatment approaches. This is because the EHO receives money for each person, regardless of whether they become ill, so if they can reduce the number of people becoming ill through preventive programs it will allow them to make their money stretch further. This is the most commonly used strategic purchasing approach for primary health care services.[11] By using the simple capitation approach, we leave ourselves free to change incentives and institutional arrangements as we learn. Furthermore, at a national

[10] HARP-F and MIMU (2018). "Vulnerability in Myanmar: A Secondary Data Review of Needs, Coverage and Gaps."

[11] We note that delivery services are not usually paid for using such a system (as these cannot, nor are they desired to be, prevented). However, given the small scale and relatively small cost of individual un-complicated birth services offered, it was not felt to be an issue that warranted complicating the payment system significantly. There are also concerns that capitation rates can incentivize under-provision of services to reduce costs; this risk will be monitored to see if there is any evidence of this happening.

level, a capitation payment system is more politically acceptable (as it values each citizen equally) than one which would pay more for citizens in some areas than others.

Another important aspect within the CPI-KEHOC pilot is that it is purchasing from the provider at the system, or consortia, level: not from individual clinics. This is a key difference from the PSI and Social Security Board models. The approach was chosen for two reasons. Firstly, it preserves and strengthens, rather than atomizes, the EHO health systems. Secondly, this structure is more scalable. It would be infeasible for a national purchasing body to monitor every individual clinic, so it would require consortia of clinics to work together. This pilot therefore informs debate about how to purchase from consortia, and enables EHOs to develop the capacity to be such consortia.

This system-level structure means that the incentives created apply at the level of the organization. The incentives encourage KEHOC to effectively carry out the M&E, logistics, management and HR functions specified in the contract. This requires that KEHOC make decisions about the structuring of their own services to make best use of their funds. At this stage, they have chosen to provide salaries to staff, but the provision of medicines, supplies and outreach activities differ according to population numbers. They also have flexibility with extra funds to prioritize areas that they believe are important for population health, including potential supplementary activities.

This payment system differs from their current financing model because both salaries and drug procurement have previously been done on an *ad hoc* basis, sometimes directly from donors completely missing out KDHW and BGF. It has been based on donor priorities more than community needs. A part of this pilot will also include the consideration of further internal strategic purchasing: the creation of incentives for clinic workers based on performance during this project. At present, however, the information about performance at clinic level is too limited to know which incentives are appropriate.

This pilot should therefore produce valuable information for national policy making about how a national purchasing body with limited capacity to monitor every clinic should make purchasing decisions from consortia of providers. We believe this will be the decision the purchaser will make, and we believe that our pilot structure will enable learning to inform that approach.

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For questions and further details, please contact Tom Traill (at tom.traill@cpintl.org), Dr Zarni Lynn Kyaw (zarni@cpintl.org) and Dr Nay Nyi Nyi Lwin (at naynyinyilwin@cpintl.org).

Annex: Definitions of Strategic Purchasing

Author/ Organization	Definitions
European Observatory (2007:45)	Strategic purchasing is a "systemic approach. . .[that] aims to increase health systems' performance by effectively allocating financial resources to providers, by deciding the following: which interventions to purchase in response to population needs, national health priorities, and evidence-based cost-effectiveness; how to purchase these interventions, including contractual mechanisms and payment systems; and from whom to purchase, taking into account quality and efficiency of providers."
World Health Organization (2000:97, 104–107)	Purchasing organizations should "continuously search for the best interventions to purchase, the best providers to purchase from, and using the best payment mechanisms and contracting arrangements possible to achieve the highest, equitable health outcomes possible." The following are key elements of strategic purchasing: 1. The use of public health to determine priorities for public financing, enforce stewardship, and use population health data in choosing which interventions to buy. 2. Prioritize units in purchasing in order to promote the creation of more long-term contracts. 3. Avoid micro-purchasing and micro-managing which prevents the pooling of health services and populations and prevents risk-sharing. 4. Through budgeting and contracting, establish an environment in which there are appropriate incentives for providers to prevent health problems of pool members [2], provide services and solve health problems of members, be responsive to people's legitimate expectations, and [4] contain costs. 5. Establish appropriate political capacity and governance to promote flexible provider resource management, promote accountability, and prevent negative consequences of financing reforms.
World Bank (2007:3–4)	The World Bank uses a normative approach towards their strategic purchasing framework. Implementing a proper strategic purchasing policy framework requires addressing the following sets of issues in order to ensure improved health system efficiency and equity. 1. Political Economy a The Political choice about the appropriate role of the state, government failure, market failure, and stakeholders 2. Policy Design a Resource Allocation and the Purchasing Arrangement which determines for whom to buy, what to buy, from whom to buy, how much to pay, and how to pay b Revenue Collection Mechanisms which include the level of prepayment, degree of progressivity, earmarking, choice, and enrollment c Pooling of Revenues and Risk Sharing which considers the size, number, risk equalization, coverage, and risk rating 3. Organizational Structure a The organizational forms (including contractual relationships), structural configuration, and incentive regimes at play 4. Institutional Environment a The legal frameworks, regulatory instruments, administrative procedures, and customs and practices 5. Management Capacity a The management levels, skills, incentives, and tools available
UK Department of Health (2007:3–6)	1. The United Kingdom, which arguably started the whole purchasing conversation with its 1980s purchaser-provider split, incorporated strategic purchasing into their commissioning cycle for health services ("commissioning" is the term for strategic purchasing in England since 1997). The cycle is centered on the patient/public and attempts to meet national

	health targets. While the English NHS has since been reorganized so as to leave the context of this particular document irrelevant, the model it contains is worth noting: 1. Assessing needs 2. Reviewing service provision 3. Deciding priorities 4. Designing services 5. Shaping the structure of supply 6. Managing demand 7. Referrals, individual needs assessment, advice on choices, and treatment/activity 8. Managing performance (quality, performance, outcomes) 9. Seeking public and patient views
Honda et al (RESYST consortium) for WHO-WPRO (2015:4)	"In strategic purchasing, a purchaser is an organization that buys health services, using pooled funds, for certain groups or the entire population. The purchaser can use levers to influence the behavior of providers to improve quality and efficiency in health service provision and facilitate equity in the distribution of healthcare providers. However, purchasing mechanisms operate within each country's policy framework and, in strategic purchasing, government is required to play a stewardship role by providing a clear policy framework and appropriate guidance to ensure that resource allocation and purchasing decisions are linked to public health priorities. As the purchaser buys health services for people, it is important for the purchaser to ensure that there are effective mechanisms in place to determine and reflect people's needs, preferences and values in purchasing, and hold healthcare providers accountable to the people."
Synthesized Definition	An evidence-based process that sculpts health care systems by prioritizing the financing of certain goods and services over others through collaborative planning across various healthcare stakeholders while incorporating the needs and priorities of citizens in the distribution of health care and promoting equity, quality of care, efficiency, and responsiveness in the provision of health services.

Source: Katarzyna Klasaa, Scott L. Greer, Ewout van Ginneken, "*Strategic Purchasing in Practice: Comparing Ten European Countries,*" Health Policy 122 (2018) 457–472