Strategic Purchasing Pilot

Learning Brief 3: Determining the Package of Services

The CPI-KEHOC[1] pilot is the first example of strategic purchasing health services with an Ethnic Health Organization (EHO) in Myanmar. As such, it has been a step into new territory for both the purchaser and provider organizations, along many dimensions, including the mechanics of the purchasing process. The pilot is intended to increase understanding for all parties about how purchasing from an EHO could work: not only for CPI and KEHOC, but also for the Myanmar Ministry of Health and Sports (MoHS) and for other EHOs, NGOs, INGOs and donors operating in Myanmar.

In the first brief we focused on definitions for purchasing, the purchaser-provider split and "strategic" purchasing; we described why purchasing from EHOs is particularly important; and we highlighted how this pilot effectively demonstrates "strategic" purchasing. In the second learning brief we explained the process of selecting beneficiaries for whom the Steering Committee will purchase services.

In this third brief we summarize the process of selecting interventions to be included in the package of services purchased, as well as how this package was communicated to the community and staff of KEHOC. It is essential to define such a package for strategic purchasing because the payments are linked to the services being provided, rather than to inputs. Without knowing what services are being paid for, one cannot know how much to pay the provider.

1. Services currently offered by KDHW clinics

Prior to the CPI-KEHOC pilot, KEHOC did not guarantee a standard package of services across its 68 clinics. Rather, the services provided by clinics were highly variable, and reflected availabilities of local resources, such as infrastructure, staffing, equipment and medicines. (The range of services available in government facilities has historically demonstrated similar variation.).

The origins of this variation in services across KEHOC clinics is multi-factorial, though they are largely a function of budget constraints: due to insufficient amounts of total funds and to the intentionally narrow range of services supported by vertical funding mechanisms to target specific diseases in specific localities.

This is not to say, however, that the pilot worked from a blank slate. Three main components were in place to guide the formation of the package:

[1] Community Partners International and the Karen Ethnic Health Organizations Consortium

- Pre-existing staff training means health staff possess certain skills but lack others. As the pilot aims for scalability, the current skill levels of staff have to be one basis for selecting what services are offered.
- The approximate package of services determined in KDHW's Annual Operational Plan (AOP) process in 2017
- The Basic Essential Package of Health Services (BEPHS) the MoHS plans to make available in all 330 Townships in Myanmar, as part of the National Health Plan (2017-2021) (NHP).[2]

It is important to note that services outside of the package under the strategic purchasing contract can continue to be provided. If additional services beyond the package are determined to be important by KEHOC then these additional services should be provided where and when possible, contingent on budget availability and burden of diseases. It remains to be analysed the extent to which such additional services are offered.

2. Factors shaping the package of services

The Steering Committee (purchaser) considered the following criteria when developing the package of services to be purchased within this pilot:

1. Quality: services offered should be of high quality and delivered by fully trained staff (according to their position and KDHW training requirements) employed according to the standard clinic human resource structure
2. Alignment with MoHS's National Health Plan (2017-2021)
3. Health impact: the services offered should have a high impact on the health of the communities served. This included both understanding the impact of interventions and the local burden of diseases (though the geographical specificity of the latter is lacking).
4. Community voices: a key requirement for the package to be considered desirable and effective by beneficiaries is that when someone is ill or injured, care is available. A package that exclusively provides preventive and promotive public health services would not offer that, and in hard to reach areas there may be no alternative (or only untrained alternatives). The package therefore had to include key curative functions.
5. Consistency with KEHOC's ongoing strategies and approaches: this ensures the pilot contributes to system strengthening, and not to the creation of a parallel system.
6. Affordability: the package should be scalable, and sustainable, given funding constraints and uncertainty of support from both development partners and government contributions. The total cost of the package therefore had to align with acceptable costs for impact.

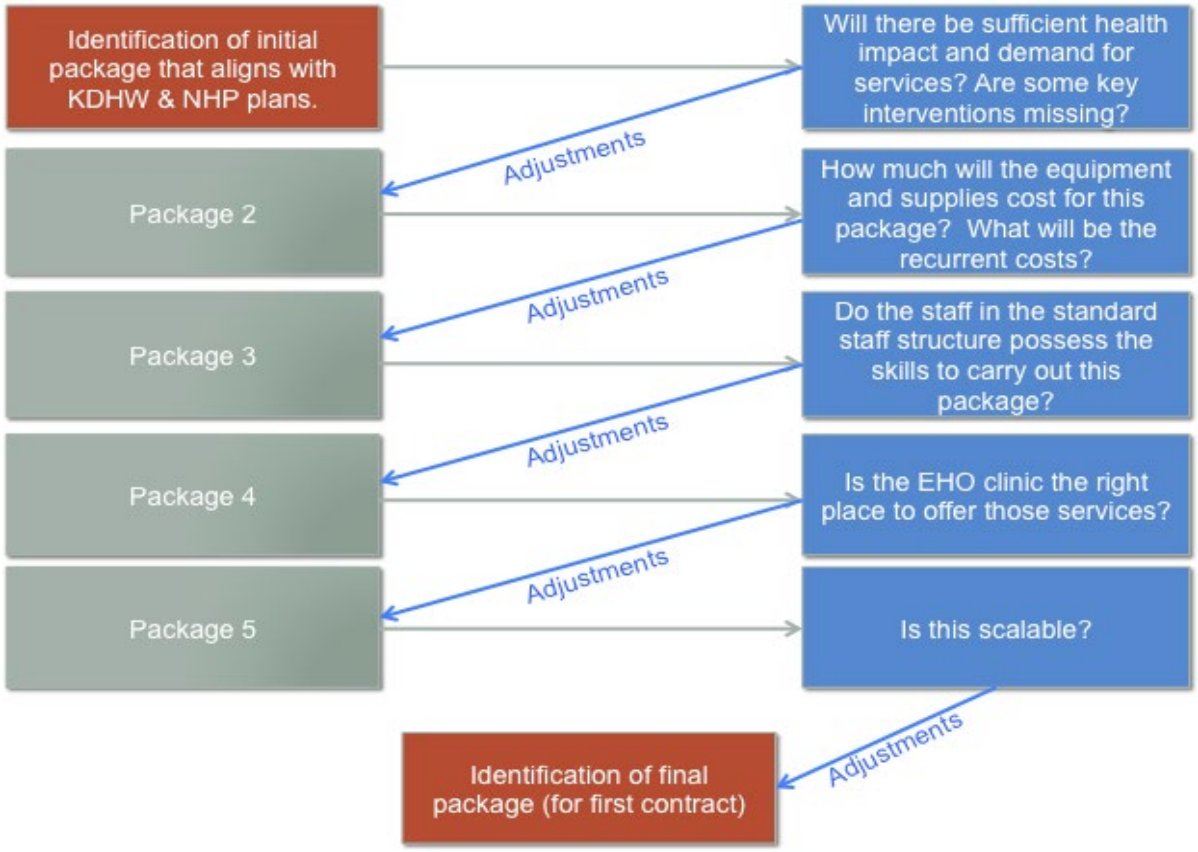
[2] The BEPHS was in draft format when it informed development of the package of services included in the CPI-KEHOC pilot.

3. The process of setting the package

The first decision about setting a package is whether to have a positive or a negative list of services. That is, will it be a list of services included, or a list of those that are beyond the package. Given the limited resources (and training) of EHO staff, the number of services possible is necessarily limited. A positive list was therefore chosen to make the process simpler, more transparent and more in line with the MoHS's BEPHS.

The process of defining the package was iterative: it required multiple stages of consideration and revision. This is because the cost for the purchaser is affected not only by the package of services, but also by the target population constituents and size and the extent of cost sharing. Therefore, while we have produced separate Learning Briefs about the selection of the target population, the identification of the package of services, and the costing process, in reality these three processes are all intricately linked. The figure below therefore shows the iterative process used:

Figure 1: Iterative process of selection of service package for first contract



We further expect that this package will continue to change as the pilot project measures and analyses data and information throughout the project to understand the community's (changing) health needs. The package will be reviewed at each renewal of the contract.

Below is a description of some of the adjustments made at each stage:

- **Will demand for services be sufficient?** From regular information sharing with PSI concerning its pilots, we were informed that the majority of patients seek care for general illnesses complaints (for example, upper respiratory and other viral infections, musculoskeletal complaints); and rarely present for care of common conditions like NCDs that remain under-diagnosed in rural Myanmar. It is therefore important to include and better understand the term "general illnesses."
- **How much will equipment and supplies cost (cost effectiveness)?** Eye care services are in high demand in remote areas, where conditions such as myopia are under diagnosed. However, the cost of the equipment for eye testing are prohibitively expensive. It was therefore decided that eye diagnosis could not be included in the minimum package, but that should KEHOC wish to (fund, and) offer this service it would be encouraged.
- **Do staff possess relevant skills? And is the EHO clinic the right place to offer specific services?** For people living in the villages served in the pilot, treatment in case of complications during delivery are difficult to access. Provision of such services is a crucial component of an equitable health system. KEHOC possesses health workers with the skills to provide such care (EmOC cadre), but these were not present in our clinics at the beginning of the pilot. It was therefore decided that either KEHOC would allocate such staff to clinics, or in those clinics where they could not, referral fees would be provided to send women to the nearest hospital. A comparison between clinics with and without EmOC workers can then be simplistically analysed to understand the relative costs and health outcomes of staffing rural clinics as opposed to referring to care. This pilot will contribute to answering whether the EHO clinics are the appropriate locations to provide such care.
- **Are other providers overlapping?** For malaria and TB, there are vertical programs that work with village health workers directly (although employing them through KEHOC). These projects pay directly for supplies and compensation for workers. Including such services in the package would therefore be double counting, and paying for those services twice. Some services do remain available in the clinic, however, such as testing. The package therefore includes malaria testing, but with lower compensation based on lower expected demand.
- **Scalability**. Scalability is deeply linked to the above questions of affordability, prevalence of adequate skills and demand. It also relates to how data is collected. Introducing advanced technology which requires significant training may be prohibitive of scalability in the medium term (particularly as national high tech solutions may differ from those introduced in the pilot), as well as being disruptive of services and information collection in the short term. With scalability in mind, M&E and management systems were therefore kept deliberately *lean* and *low tech* at this stage.

4. The package of services

The result of this iterative process was a set of interventions that are being purchased by the Steering Committee from the providers (KEHOC). For each intervention, the authorized personnel to carry out the services were defined. The package contains interventions in the following categories: Reproductive and Maternal Health (including family planning), Child Health and Development, Nutrition, TB, HIV, Malaria, Minor/General Illnesses, School Health, Non-Communicable Diseases, Health Education/Promotion, Trauma Management, Dental Care, and Eye Care.

Furthermore, for many interventions the *intensity* of the intervention had to be specified. For example, for school health promotion, it had to be decided if this ought to be done once every six months, or every month. Or for nutrition for adolescent girls, the level of supplements to be offered had to be fixed. These details were all specified within the contract signed between the Steering Committee and KEHOC (for more details please contact us).

It was also important to consider what would happen if the services needed by a patient were not contained in the package. KEHOC will continue to provide all the services they offer free of charge. However, for care outside of the guaranteed package, the resources and skills will not necessarily be available for patients to receive that care. Nonetheless clinics can provide guidance as to what care is needed and where it can be sought. One could therefore consider *referrals* to be an additional service in the package. However, at this stage these referrals are not funded, apart from for emergency obstetric care and a small (unrestricted) allowance for each clinic. This referral mechanism therefore remains something to be developed.

The pilot has therefore already suggested some lessons for the potential Semi-autonomous Purchasing Agent (SPA) when specifying its package of services. Most importantly, the package cannot be developed centrally and then simply purchased from all providers: understanding what a given community needs and a given provider in a specific geography can offer is crucial. This process should be iterative, while maintaining the overall aim of ensuring that all citizens are covered for the full Basic Essential Package of Health Services at providers that are accessible (and affordable).

As the pilot continues, further data will be collected and information gathered as to the demand for health services, quality of EHO providers for the services included in the package, and some idea of the best and most affordable ways to offer services for all in hard to reach areas.

5. Communicating the package to different stakeholders

It is important to note that theoretical *access* to health services alone is not sufficient. Both communities and health staff need to know and understand what that *access* means.

Communities
CPI worked with KEHOC to prepare a communications briefing on the new guaranteed package that could be presented in each village. Furthermore, throughout the registration phase (which will be explained in more detail in Learning Brief 5) clinical staff both registered the community members and offered explanations about the availability of services.

As all services at EHO clinics remain free-of-charge, communication did not have to explain a new payment structure, but this also added a difficulty: it isn't clear what difference it makes to a community member whether or not a service is included in the package. Given that community members may not understand their own health condition prior to seeking care, the main change the pilot introduces is an expansion of services offered (and the guarantee that *medicines and supplies,* as well as services, should be free and available).

CPI and KEHOC therefore made the decision to focus more on this, and the expectation of high quality services, rather than on technical policy issues of strategic purchasing and the specific services included. We hope that the messages given will increase demand for services at EHO clinics, and increase the standard demanded of services.

Clinic Staff
In addition to informing communities, it is vital that health clinic staff understand what is included in the package: that is, what is expected of them. The clinical package should be linked to the roles that each health worker plays, what their priorities are, and how they treat patients that come to them. This therefore requires a different communications strategy.

Clinic staff were given specific training to refresh their skills prior to the pilot, and these included explicit explanations of the terms of the contract and the services (including outreach) that were expected of clinics. With these in mind, KEHOC created monthly workplans for clinical staff members. Something akin to this process would be crucial for any organization trying to explicitly prioritize a set package of services.

However, the extent to which clinic staff have changed their behaviour in light of the package is an important follow up issue. How best to communicate "policy" changes to front line clinic staff remains an important consideration upon which this pilot attempts to shine some light.

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