

Reimagining governance for strategic purchasing: evidence from 10 countries in eastern Europe and central Asia

WHO Barcelona Office for Health Systems Financing

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Abstract

Effective governance arrangements are a critical enabler of strategic purchasing by facilitating strong coordination of all key actors, setting clear rules for decision-making, having proper regulations in place and seeking to ensure strategies are implemented. This study reviews experiences over the past 20–30 years across a group of countries in the eastern European and central Asian subregion that have undertaken health financing reforms involving the establishment of a single national purchasing agency and the introduction of strategic purchasing. The study, through both a literature review and interviews with relevant experts, looks for empirical evidence on the relevance and effectiveness of recommended good governance principles and practices in these countries in this regard. Study findings support and expand previous literature by indicating that effective governance for health purchasers requires consistency and stability; coherent decision-making structures that align accountability and authority; a clear legal framework and enforced rules; supervision structures and monitoring; and transparency and information disclosure. The participation of stakeholders in governance did not always support purchasing effectiveness in the study countries but assuring a balanced representation, essential skills, and the avoidance of conflicts of interest on the governance body is important. Stakeholder consultation and seeking consensus was seen as vital as an input to decision-making, but only when there are institutions and processes for balancing this input and focusing it on the common good.

Keywords

GOVERNANCE
HEALTH FINANCING
STRATEGIC PURCHASING
PURCHASING AGENCY
MIDDLE-INCOME COUNTRIES

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Abbreviations

CabMin	Cabinet of Ministers
CEO	chief executive officer (or director in many purchasing agencies)
EHIF	Estonian Health Insurance Fund
EU	European Union
FFS	fee-for-service
GDP	gross domestic product
HIC	high-income country
LMIC	lower-middle-income country
MHIF	Mandatory Health Insurance Fund (in Kyrgyzstan)
MIC	middle-income country
MoH	Ministry of Health
MoF	Ministry of Finance
MoSA	Ministry of Social Affairs
NHSU	National Health Service Ukraine
PFM	public financial management
PHC	primary health care
PM	Prime Minister
PMG	Program of Medical Guarantees (in Ukraine)
P4P	pay for performance
SAMHI	State Agency for Mandatory Health Insurance (in Azerbaijan)
SB	Supervisory Board
SCHIA	State Compulsory Health Insurance Agency (in Latvia)
SWAp	sector-wide approach
UMIC	upper-middle-income country

Additionally, for ease of presentation the International Organization for Standardization's three-letter country codes are frequently used in tables, and are as follows:

ARM	Armenia
AZE	Azerbaijan
EST	Estonia
GEO	Georgia
KGZ	Kyrgyzstan
LTU	Lithuania
LVA	Latvia
MDA	Republic of Moldova
UKR	Ukraine
UZB	Uzbekistan

Executive summary

This study of health purchasing governance in 10 countries in eastern Europe and central Asia (Armenia, Azerbaijan, Estonia, Georgia, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Ukraine and Uzbekistan) aims to draw lessons on the key governance-related drivers of and barriers to progress in *strategic purchasing*¹. It seeks to identify important contextual and facilitative factors to enable governance mechanisms to operate effectively. The approach combines the review of existing literature and official documents with semi-structured interviews with up to three key informants per country in senior health sector roles. The interviews explored governance at three levels: country, health system and *purchasing agency*.

1. Technical terms clarified within the glossary are italicized within the main text upon their first presentation.

Challenges in country-level governance

A lack of national policy consensus and political instability has led to unstable and inconsistent policy and/or to frequent changes in the leadership, management and structure of the Ministry of Health (MoH) and the purchasing agency in some of the countries reviewed. These conditions lead to periods of stasis or reversal in development of strategic purchasing and the purchasing agency.

A delay in the reform of *public financial management* (PFM) and public administration in some of the lower middle-income countries reviewed has left a legacy of detailed prior controls of expenditure inputs and human resources that have weakened the impact of output-oriented provider payment reforms and presented an obstacle to strategic purchasing. These countries were unwilling to give public providers high managerial *autonomy*. In some of these countries, transparency and effectiveness in the purchasing agency's processes are dependent on the integrity and capacity of the individual appointed as the Chief Executive Officer (CEO) and their senior managers, rather than on a rules-based framework that was followed regardless of personalities or relationships.

The influence of powerful, politically connected stakeholders on policy and purchasing decisions in some countries was non-transparent, driven by private interests (such as in pharmaceuticals, private provision and private health insurance) and largely beyond the health sector's control. In other countries, powerful public sector health institutions (e.g. major teaching and research institutions and specialty interest groups) may have a disproportionate influence on these decisions compared to primary health care and public health stakeholders, for example.

Challenges in governance at health system level

Gaps and inconsistency in health sector strategy, health financing policy and health budget formulation in some countries, have also undermined the purchasing agency's clarity of their objectives and weakened the extent to which the agency can be held accountable for strategic purchasing. A common problem is a framework focused on tasks and processes, unconnected to outcome goals such as financial protection, access, health service quality and efficiency, equity and population health. Strategies expressed in terms of highly general long-term vision and outcome goals have less impact on *purchasers* than those with concrete short- and medium-term actions.

Some middle-income country purchasing agencies have faced difficulties because other pillars of health sector strategy developed later or were implemented more slowly than health financing reform, putting pressure on the purchaser to fill gaps (e.g. in the development of quality standards) or take on a wider role than purchasing (e.g. in control of public health-care provider expenditure or management of the provider network), leading to a tendency for governments, providers and civil society to demand purchaser accountability for areas of policy and performance that they cannot be reasonably expected to deliver.

A pervasive problem for health financing strategy in all the middle-income countries reviewed, has been a benefits package that is not fully credible given the budget available, with patients paying substantial amounts out of pocket for services notionally covered by the benefits package. This makes it very difficult to hold the purchaser accountable for the financial protection of beneficiaries.

Challenges in governance at the level of the purchasing agency

Most countries set out to implement a purchaser–provider split, and so gave the purchaser a greater or lesser degree of technical and operational independence from the MoH, while maintaining the role of the MoH as the lead policy agency for the sector. However, eight out of 10 countries reviewed have encountered misunderstandings or disagreements about the independence of the purchasing agency. In countries where the purchaser was established by decree or regulation, without a clear legislative basis, such disagreements easily led to a reduction in the purchaser's role to purely administrative payments and accounting under the hands-on direction of the MoH, with no scope to carry out strategic purchasing and with vulnerability to political intervention in operational matters.

In some countries, repeated changes to the organizational scope, legal form or the subordination of the purchasing agency to the MoH have caused instability in the purchaser and periods of loss of focus on the *purchasing strategy*, without making any real difference.

The Supervisory Board (SB) of purchasers lacks functionality in a few countries, in part due to a failure to define clear new SB roles in legislation and a related failure to reform and align pre-reform legislation and regulation defining the roles of the MoH and Ministry of Finance (MoF), leading to a lack of coherence across multiple lines of accountability. In these countries, the main lines of oversight and direction are from the MoH and MoF, with the SB playing a more limited role. The lack of SB functionality in these countries is also due to political and cultural contextual factors – a personal, direct and informal approach to accountability – and a lack of good examples of governance boards in public and private sectors from which to draw experience. As a result, pre-reform patterns of decision-making on resource allocation, oversight and control persisted, even where these were inconsistent with the development of strategic purchasing.

In countries where the purchaser does not have an SB that takes primary responsibility for overseeing the accountability framework, some countries attempt to make use of the accountability frameworks within reformed PFM and public administration systems, such as using relevant performance indicators in the programme-based budgets for the purchaser and using strategically aligned performance agreements for the purchasing agency and CEO and staff. While there is clear potential to build on these systems over time, programme-based budget frameworks did not play a significant role in purchaser oversight and accountability in any of the study countries, due to lack of realistic, reliable and aligned results-oriented indicators and/or lack of systematic monitoring, review and feedback cycles.

Some countries lack rules and processes that protect the purchasing agency CEO from politically motivated, arbitrary dismissal, leading both to a loss of capacity and continuity and making CEOs cautious about decision-making.

Suggested enablers for more effective governance for strategic purchasing

Over the past 20–25 years, health purchasing agencies in the 10 study countries have implemented advice on good practice legal and *governance frameworks* and institutional capacities to a greater or lesser extent. This review has found that better functioning purchasers have put more of

these practices in place. The higher-income countries were able to do this at an early stage of reform, while they were middle-income countries, and have sustained and further developed purchaser governance over time. However, many of the current middle-income countries reviewed have found it difficult to implement some key aspects of good governance frameworks or to develop them to the stage where these become drivers of more effective strategic purchasing over time. This study has identified some of the persistent contextual reasons for these difficulties that lie beyond the purchasing agency and its institutional governance, but has also found some conducive factors and enablers that can mitigate some of these difficulties in governance and foster progress in strategic purchasing.

Suggested actions that have enabled governance to drive strategic purchasing forward in some middle-income countries in spite of the challenges include:

- carrying out technical preparation to take advantage of so called golden periods of strong health sector leadership, good relationships as well as *fiscal space* to make realistic steps towards strategic purchasing goals in selected priority areas, for example, improving depth of the benefits package or introducing performance-related incentives and better monitoring for priority services, rather than using these periods to develop over ambitious comprehensive plans;
- developing broader-based health sector stakeholder organizations, which could help to balance narrow interests, reinforced by fostering active civil society input to policy and commentary on health sector performance;
- engaging the MoF in health financing reform design and the design of purchaser governance and accountability framework, based on fostering the MoF's understanding of the potential for strategic purchasing to improve efficiency and sector performance;
- establishing an independent purchaser based on a well elaborated, transparent law governing the purchaser and strategic purchasing, defining clear roles for key agencies, transparent decision-making processes, and an accountability framework including a supervisory structure; ensuring that other conflicting laws and regulations are repealed or amended;

- developing a balanced set of goals and indicators for monitoring purchaser performance using realistic results-oriented indicators (balancing access and efficiency indicators, for example);
- timely investing in digitized business processes and in the development of electronic data collection by the purchasing agency, and using the data for automated elements of verification and audit of provider claims, with transparency, through timely online publication of contracts awarded, expenditure and other reporting, together with giving open access to data;
- combining improved data with the building up of analytical capacity to create a more strategically oriented organization;
- ensuring adequate staffing at subnational level for some key aspects of strategic purchasing that involve engagement with local stakeholders and negotiation with providers; and
- making better and more regular use of domestic expertise in national universities, think tanks and technical consultancy firms to mitigate persistent skilled capacity limitations in the purchaser and to support governance processes (e.g. through using them to produce independent analysis and evaluation of purchasing policies and their implementation).

1. Introduction

In the WHO European Region most countries have established publicly financed institutions to purchase health services. In countries where these services are financed in part from mandatory payroll contributions, these are usually called health insurance funds. In countries where these are financed from government budget allocations, these have various titles, including National Health Service. In this study, we focus on the function all these agencies have in common: purchasing a *benefit package* of health-care services and products from health-care providers. All these agencies are referred to as *purchasing agencies* or *purchasers*.

WHO work in countries in the Region has found that specificities of country institutional context and capacity have had a great bearing on the development of publicly-financed health service purchasing agencies and the feasibility of implementing the models of good practice in governance and *strategic purchasing* that are recommended by international agencies. This document reviews country experiences over the past 20–30 years across a group of countries in the eastern European and central Asian subregion that have undertaken health financing reforms involving the establishment of a single national purchasing agency which – to varying extents across countries – has attempted to establish strategic purchasing. In doing this, they took a policy direction towards institutional purchasing of health services adopted in many countries in the WHO European Region and beyond. Strategic purchasing is important because it pro-actively involves “a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom” (McIntyre et al., 2016). This frees resources that can be used to extend coverage. Strategic purchasing can also send signals to health providers to improve the quality of health services.

This study investigates how governance influences the development of the health purchaser and strategic purchasing. The concept of governance used in this paper is a broad one, which can be defined as follows:

“Governance is an overarching health systems function for ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability. This broad conception thus encompasses wider mechanisms for setting direction and achieving accountability for health purchasing in the fields of public sector management, health policy and strategy, in addition to more specific governance structures and instruments applied to purchasing agencies and health-care providers. Effective governance arrangements are a critical enabler of strategic purchasing, as making purchasing more strategic requires strong coordination of all key actors, clear rules for decision-making and appropriate regulations” (WHO, 2007).

This document is written primarily for those working in the field of health financing and health systems and is structured as follows. After describing the objectives and approach to the study, the report summarizes the findings at three levels at which governance takes place: country, health system and purchasing agency. It then summarizes findings about conducive factors within the purchasing agency that help to support governance mechanisms to adopt a strategic focus. Each chapter also summarizes recommendations on enablers of progress in strategic

purchasing and lists country examples that may be useful sources of learning for others. A concluding chapter draws out some cross-cutting observations relevant to cross-country learning. Annex 1 provides a glossary of terms.

1.1. Objective and scope

The objective of the review is to draw lessons from participating countries on what are:

- the key governance-related drivers of progress in developing the purchasing agency and strategic purchasing;
- the major governance barriers or reasons for setbacks to development of the agency and strategic purchasing; and
- important contextual and facilitative factors for the operation of governance mechanisms.

The purpose is to help inform countries newly embarking on similar reforms and share learning from countries with a longer history of purchasing agencies.

The review explores the impact of various governance mechanisms and good practices recommended in the *governance frameworks* of WHO and other international agencies, within the specific country and institutional context of the participating countries' health systems.

Ten countries participated in the review, all of which were lower- or middle-income countries (MICs) when reform commenced. These countries were chosen because they share a common institutional history of a tax-financed, publicly provided health system on the *Semashko model*, common characteristics of their political and economic systems in the past, and because they have all implemented a single purchaser model for health financing. WHO's intention is to follow up this study with a similar review of other countries in south-eastern Europe, which have established single purchasers. The participating countries are listed below (Table 1.1) in three broad groupings that we found salient to understanding and comparing country experiences. In three countries, reforms were either only fully implemented in 2020 (Azerbaijan, Ukraine) or in the pilot stage of implementation (Uzbekistan).

Table 1.1. Participating countries

HICs with long-established reforms		MICs with long-established reforms		MICs with recent/ongoing reforms	
HIC	Estonia (EST)	LMIC	Kyrgyzstan (KGZ) Republic of Moldova (MDA)	LMIC	Ukraine (UKR) Uzbekistan (UZB)
	Latvia (LVA)	UMIC	Armenia (ARM) Georgia (GEO)	UMIC	Azerbaijan (AZE)
	Lithuania (LTU)				

Notes: HIC: high-income country; LMIC: Lower-middle-income country; UMIC: upper-middle-income country. Countries are classified according to the 2021 World Bank country income group classification of countries (World Bank, 2022a). Long established reform countries began reform in the 1990s with further reforms in the 2000s, except for Georgia, where the most recent reforms were carried out from 2013. Recent reforms are those in which implementation began within the last five years.

1.2. Approach

The first stage of the current study used existing documents, reviews, and studies of the 10 participating countries to map key health financing system design characteristics, the institutional and governance structures of the purchasing agency and the key governance processes of the health system and the purchasing agency, along with select indicators and general country characteristics. This literature review encompasses both published studies and an unpublished study and identified any previous assessments of the health purchaser or health financing system relevant to current study objectives.

The second stage of the study involved interviews with three to four key informants per country (a senior representative of the Ministry of Health (MoH), a senior representative of the purchaser, and an independent expert from either academia, a think tank, the Ministry of Finance (MoF) or a development agency) in order to explore which aspects of the governance framework were most important as drivers, enablers or as barriers to the development of strategic purchasing. Some key informants were currently in post at the MoH or purchaser; others were former officials, advisers or ministers. Additionally, interviews were conducted with three informants with multicountry experience of health financing and governance in the subregion.

In all countries except Uzbekistan, the questions used in the interviews were tailored to the stage of implementation of the country health purchasing reforms. For Uzbekistan, because of the very early stage of implementation, interviews were not conducted, but information on the drivers of reform and reform design was retrieved from literature reviews and in-country missions. All together 28 interviews were completed, using Zoom or Microsoft Teams video communication services. The interviews lasted approximately 60–90 minutes and were recorded for internal use. For the majority of the interviews, translator services were used.

The analytical framework used to guide the interviews loosely followed that set out in WHO's *Governance for Strategic Purchasing: An Analytical Framework to Guide a Country Assessment* (WHO, 2019) to develop broad questions and prompts for follow-up questions for the interviews. However, it was beyond the scope of this study to produce detailed assessments for each country.

The interviews explored governance instruments and processes at three levels: country, health system and purchasing agency as well as exploring conducive factors. At country level, the study explored public administration and the financial management context, the political context, and stakeholder/civil society engagement. At health system level, the explored governance instruments included health sector and financing strategies, policy and legal/regulatory frameworks and associated roles and processes. Governance instruments explored at the purchasing agency level included subordination, autonomy, oversight, accountability and transparency mechanisms and associated processes. Finally, the conducive factors explored included capacity, data, information technology and leadership. The interviews used open-ended questions to guide discussion and also provided interviewees with an opportunity to propose broader observations and recommendations regarding governance enablers and barriers to progress in strategic purchasing. Table 1.2 summarizes the approach.

In the third stage of the study, data summaries of findings from the first and second stages were validated with country counterparts via local health financing experts in WHO country offices – the latter also being invited to comment on the validity and relevance of study findings.

Finally, the draft multicountry paper was shared with participating country representatives for their feedback.

It is important to bear in mind that the data presented and experiences reflected upon in the interviews relate to the period prior to the COVID-19 pandemic and the war in Ukraine, both of which have had a marked impact on the health systems and health financing in the Region.

Table 1.2. Summary of the study approach

Notes: PFM: public financial management.

Governance levels and salient conducive factors	Focus of investigation: governance instruments and salient contextual factors
Political and public sector management context	<ul style="list-style-type: none"> • Economy and <i>fiscal capacity</i> • The role of politicians, stakeholders and civil society • PFM system • Provider autonomy • Public administration system
Governance at the health system level	<ul style="list-style-type: none"> • Reforms to develop purchasers and strategic purchasing • Alignment between national health strategies and health financing reforms • Policy commitments and alignment with budget • Reform sequencing and implementation • Monitoring and review cycles
Governance of the purchasing agency	<ul style="list-style-type: none"> • Autonomy and lines of accountability • Oversight • Accountability mechanisms
Conducive factors for effective governance for strategic purchasing	<ul style="list-style-type: none"> • Leadership • Organizational capacity • Quality of relationships

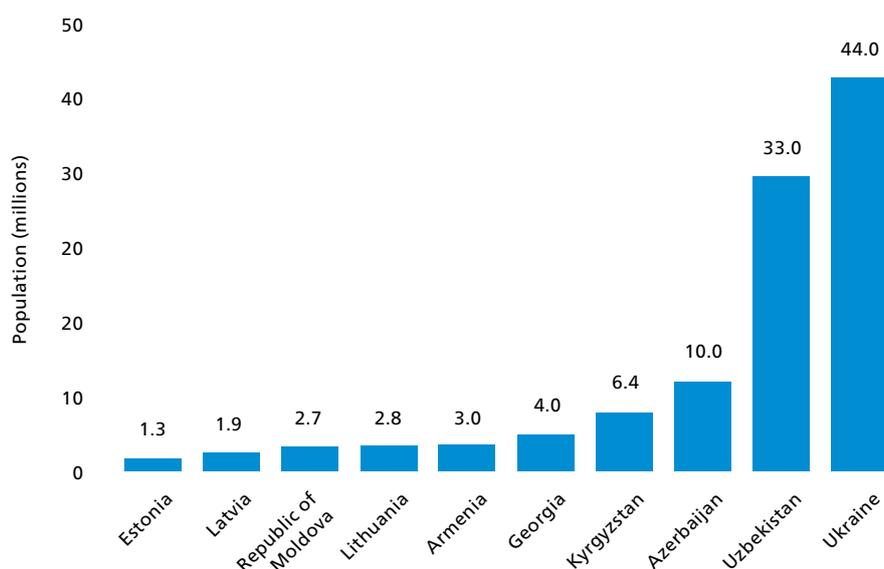
2. Governance determinants at national level: the economic, political and public sector management context

2.1. Economy and *fiscal capacity*

At the end of 1980s or in the early 1990s, a major economic and social transition began in all 10 study countries after the collapse of the Soviet Union. Each of the countries had different starting points in terms of economy and in their capacity to raise tax and other revenues to finance public services and have still not converged socioeconomically over time. Today, the 10 countries vary significantly in terms of both population size (Fig. 2.1) and macroeconomic context (Fig. 2.2a, Fig. 2.2b).

Fig. 2.1. Population of the 10 study countries, 2019 (millions)

Source: Produced using data from WHO (2022a).



In the eight smaller countries with a population size of 10 million or less, subnational governments play a smaller role in the health system in comparison to the two bigger countries, Ukraine and Uzbekistan, which have a population size of more than 30 million. In these two latter countries, intergovernmental relations between national roles in the health system (MoH's and national purchasing agencies) and subnational governments (the owners of most public health facilities) introduces a much greater complexity into health system governance, requiring a greater coordination of national and local financing and resource allocation. It is, however, beyond the scope of this study to explore decentralization issues in detail.

In the three HICs (Estonia, Latvia and Lithuania) included in this study, broader multisectoral reforms drove health reform in the early post-independence period, when the countries were still MICs and faced acute economic pressures and structural problems in many sectors. Their successful multisectoral reform included the commitment to reform public sector governance and management. These broader reforms contributed

to a sustained improvement in economic and fiscal performance which created conducive conditions for reasonably stable policy and strategy for the medium to long term and led to a so-called virtuous cycle (Levy, 2014) in institutional development and governance. This benefited the development and governance of health purchasers and strategic purchasing. In Estonia, the Estonian Health Insurance Fund (EHIF) was seen as one of the most transparent state institutions from an early stage of its development. In Latvia there was a second phase of major multisectoral reform following the severe post-global financial and debt crisis (2008–2009). European and international agencies supported these countries after the restoration of independence and again supported Latvia with substantial *fiscal consolidation* and structural reform in various sectors as a condition of their support after the crisis. This context helped overcome political barriers to making some difficult decisions in the health sector with a general momentum for changes that had wide political support (see Box 2.1). In Latvia's second phase of reform this enabled a rapid shift of purchasing specialized care from inpatient to outpatient settings, pro-competitive methods to bring down prices of off-patent medicines, and progress on implementing a facilities masterplan to consolidate excess hospital capacity.

Box 2.1. Latvia: Crises as a driver for health system reforms

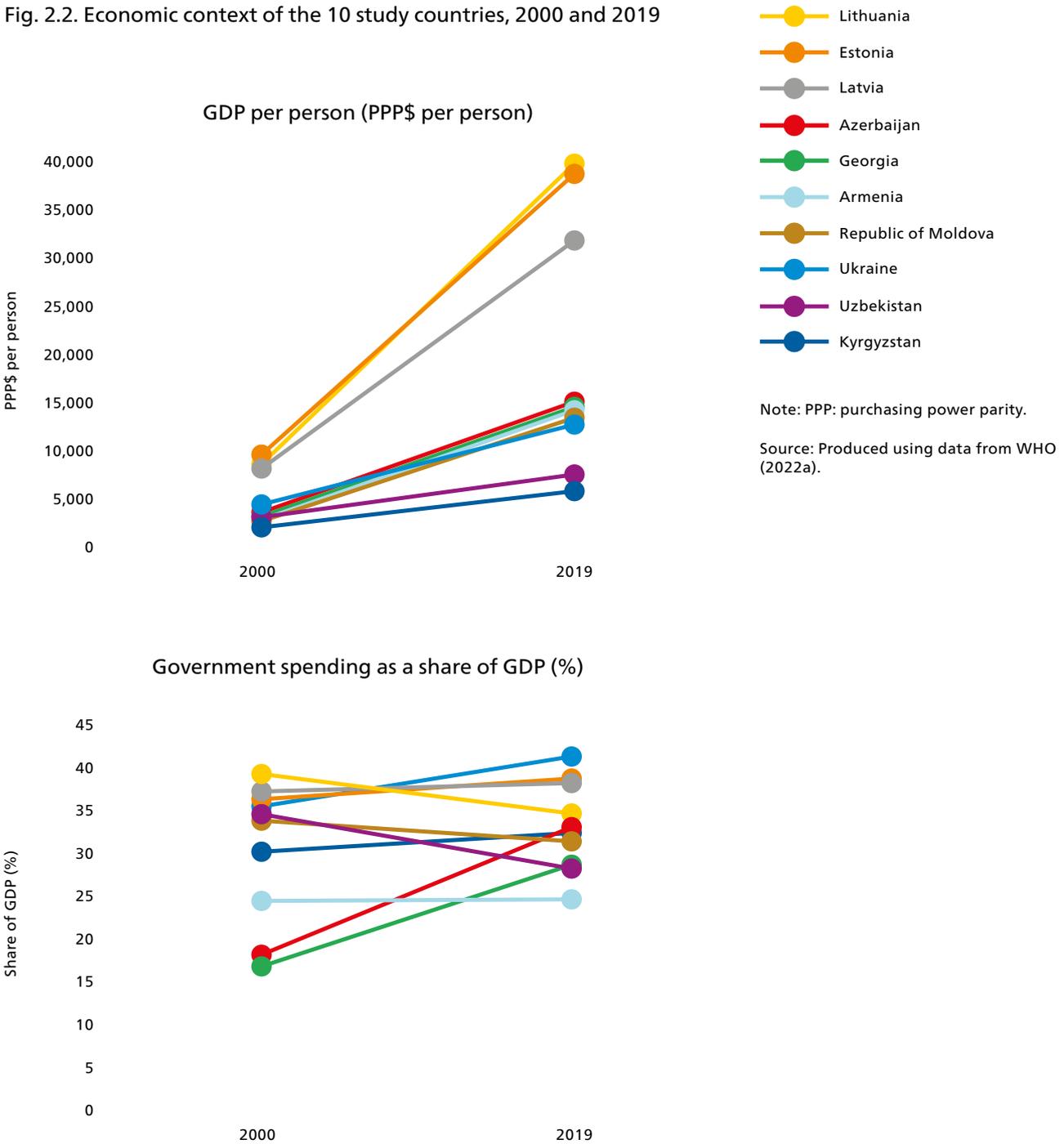
The 2008–2009 financial crisis was an existential crisis for Latvia. The reduction of tax revenues and capital inflows from abroad forced the Government of Latvia to make cuts. There was pressure from outside (conditions on loans from the International Monetary Fund, the European Union and the World Bank) to enforce rapid efficiency gains. The recommendations had been made by these agencies before, but local political forces blocked their adoption. Latvia's commitment to the loan conditionalities provided strong impetus during the crises for the MoH to push through less popular reforms that had been difficult to implement previously. So, despite the financial crisis bringing enormous social and economic challenges, it motivated the MoH, purchasing agency and MoF to work closely with donors on health system reforms. Not all reforms introduced in response to the crisis followed reform objectives and were sometimes influenced by political opportunities, but Latvia still managed to: reduce its substantially excessive hospital capacity, inpatient and secondary outpatient services; prioritize primary care; concentrate state functions into fewer institutions; reduce the number of staff; and rationalize publicly financed pharmaceutical care (Taube et al., 2015).

The current MICs in this study had weaker economic conditions than the HICs and also faced acute economic challenges when they became independent. In most of these MICs, this situation has been exacerbated by armed conflict at some points in the past 30 years, while others have been adversely affected by conflict in neighbouring countries. This and other factors have been part of a wider pattern of slower economic

transformation and institutional reform in many of the MICs in the WHO European Region, of which the causes and consequences have been discussed in previous literature (World Bank, 2002). In some of these countries (e.g. Armenia, Azerbaijan and Georgia), development agencies and pressure from international financiers may have sought to impose reform before the country had built up the necessary domestic political and local technical support for a difficult change: potentially contributing either to a delay in building institutions for strategic purchasing or to changes in purchasing structures and strategic directions over time. The current MICs in this study have not yet experienced the sustained virtuous cycles of improvement in economic performance or public sector governance and management as seen in the HICs, including in the health sector.

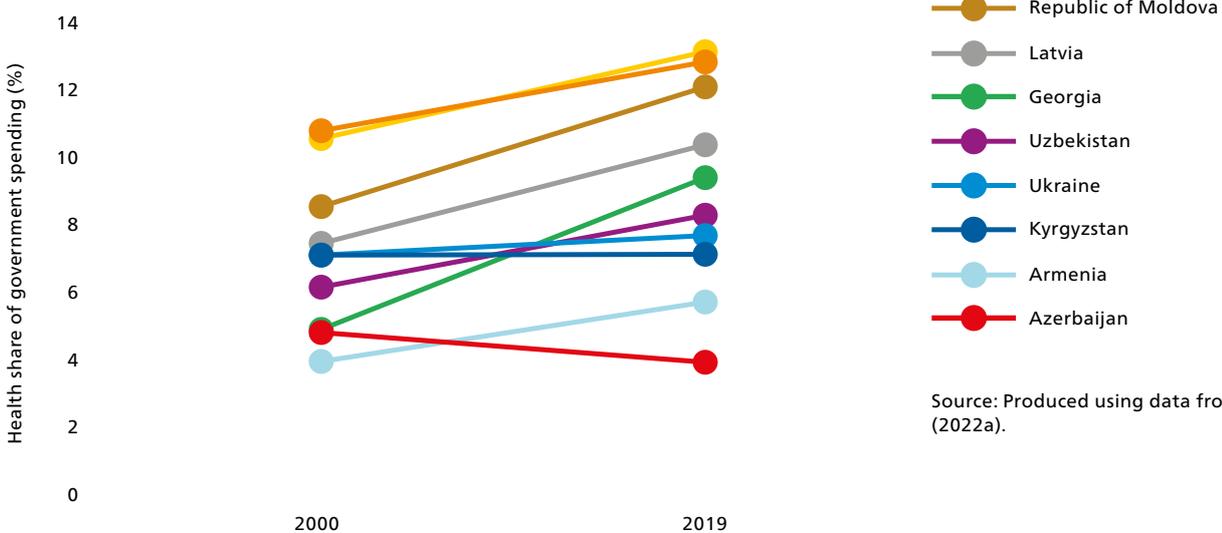
Furthermore, since 2000, economic gaps have widened between the now-high and the still-middle income countries (Fig. 2.2a), although all have experienced growth. A more mixed set of trends is seen in country current fiscal capacity, measured as government spending as a share of Gross Domestic Product (GDP) (Fig. 2.2b). Although fiscal capacity in HICs in general is larger, most of the MICs in this study have a relatively high share of GDP allocated to health compared to MIC averages in other regions.

Fig. 2.2. Economic context of the 10 study countries, 2000 and 2019



Over the past twenty years, almost all the countries have been able to increase fiscal space for health by increasing the priority given to health in government spending or by increasing revenue from health insurance contributions. The health share of government spending increased in almost all countries (Fig. 2.3), although it has remained same in Kyrgyzstan (7.1%) and declined in Azerbaijan (from 4.8% in 2000 to 3.8% in 2019, though it increased in 2020 to 6.5% and in 2021 to 5.0% due to health insurance roll-out and pandemic response). However, the fiscal space for health in government spending has generally increased more in the HICs, resulting in a widening gap between HICs and MICs.

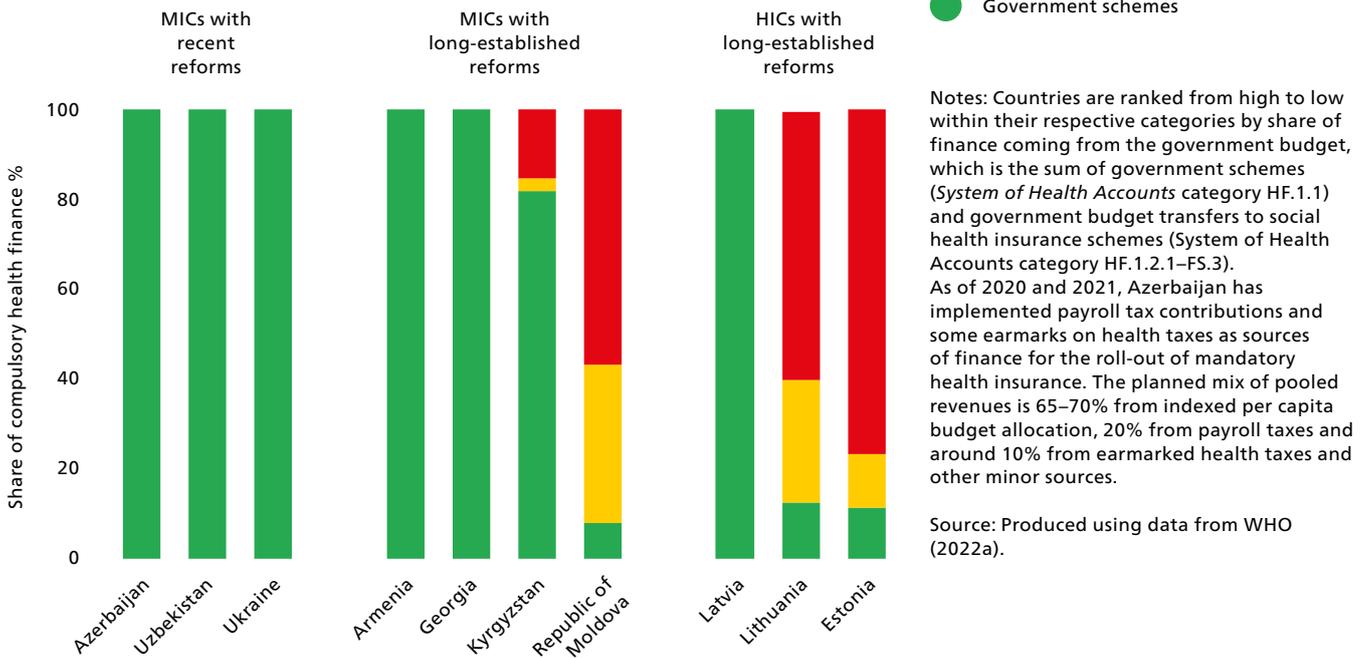
Fig. 2.3. Public spending on health as a share of government spending, 2019 (%)



Source: Produced using data from WHO (2022a).

Strong economic performance in two HICs – Estonia and Lithuania – created conditions in which governments could make a step increase in health spending soon after independence by introducing mandatory health insurance contributions and sustaining growth in revenues and expenditure over time (see Fig. 2.3), creating an environment in which it was easier to achieve governance features that created the virtuous cycle in health purchasing such as credible, medium-term budgets, credible benefit package commitments, and a reduction in informal and other out-of-pocket payments (see Fig. 2.4), compared to countries that experienced low growth and fluctuating macroeconomic performance. This credibility of policy commitments and increased transparency over patient payments are characteristic of countries with stronger governance of purchasing and more effective use of purchasing instruments.

Fig. 2.4. Shares of compulsory spending on health by government and SHI schemes, with: breakdown of SHI scheme revenue into government budget transfers and social insurance contributions, 2019 (%)



In most countries government revenues are the only or dominant source of public spending on health (Fig. 2.4). Three countries – Estonia, Lithuania and the Republic of Moldova – use compulsory social insurance contributions as their largest source of revenues and report not covering the whole population because the entitlement is related to the payment of contributions (although in Estonia and Lithuania social insurance covers a high share). However, the remainder of the population is eligible for some services (emergency services and primary health care (PHC)) through tax-financing, which is pooled and administered by the social insurance agency.

However, out-of-pocket payment as a share of current spending on health is generally higher in the MICs. In 2019 the out-of-pocket payment share was over 25% in all countries except Estonia, and in four MICs it was more than half of current spending on health. In the Caucasus region, the out-of-pocket payment share of current health spending was higher than elsewhere in eastern Europe until 2013 and remains higher in Armenia and Azerbaijan. Since 2013, Georgia has significantly reduced the reliance on out-of-pocket spending with a correspondingly steep increase in government budget allocations to health, as part of a major health financing reform (Fig. 2.5). Medicines remain the main driver of out-of-pocket spending in all the countries under study (Thomson et al., 2019). The role of voluntary health insurance and other sources (e.g. donor funding) in financing health care is marginal, even in Georgia, which consciously sought to develop a private insurance market (Fig. 2.6). The ability of single purchasers to drive change in service delivery and

create incentives for provider performance is very constrained in the MICs with high out-of-pocket spending. There are governance dimensions to the challenge of reducing out-of-pocket spending on pharmaceuticals, including corruption in the relationships between prescribers and pharmaceutical suppliers or retailers, and weak capacity and systems within purchasers for monitoring and protecting *beneficiary* rights.

Fig. 2.5. Out-of-pocket payments as a share of current spending on health, 2019 (%)

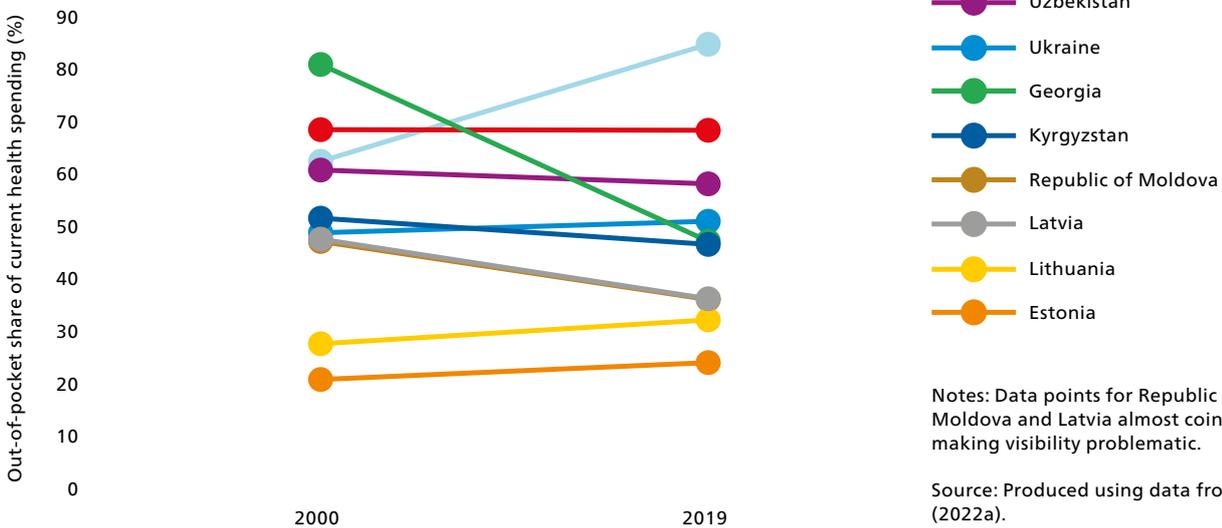
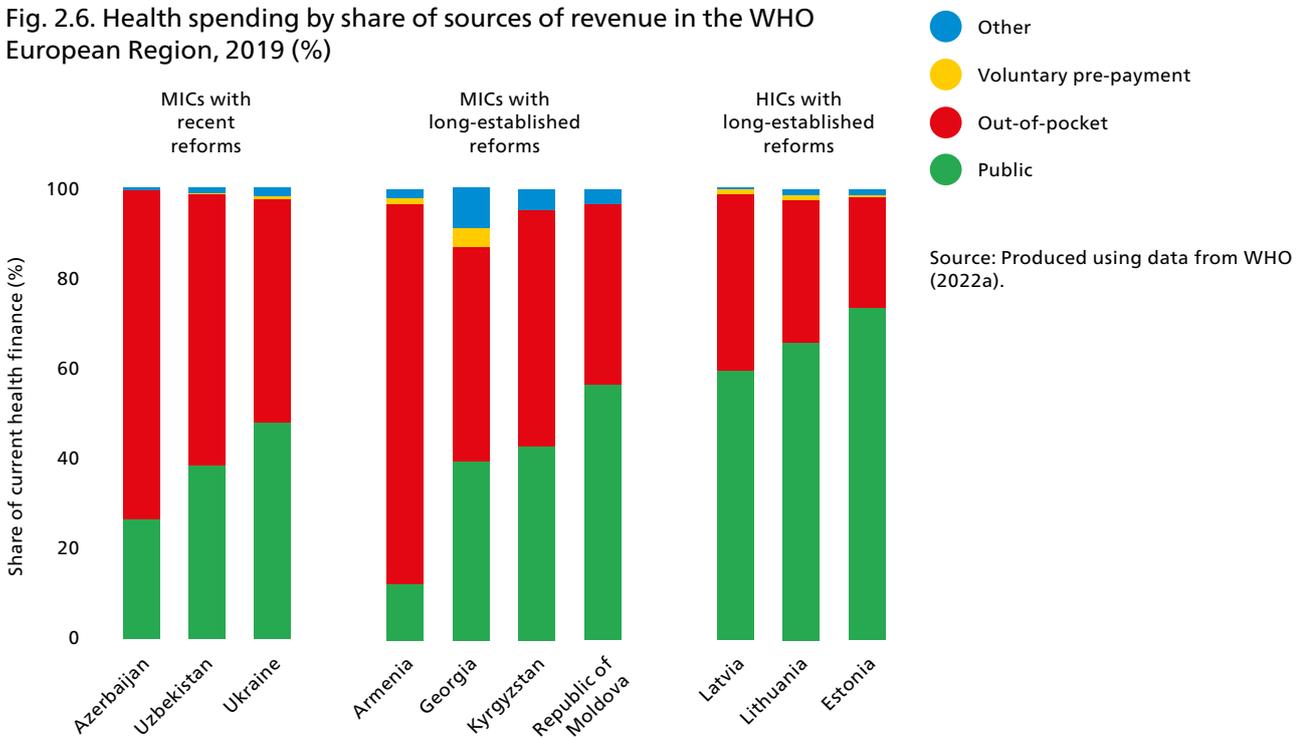
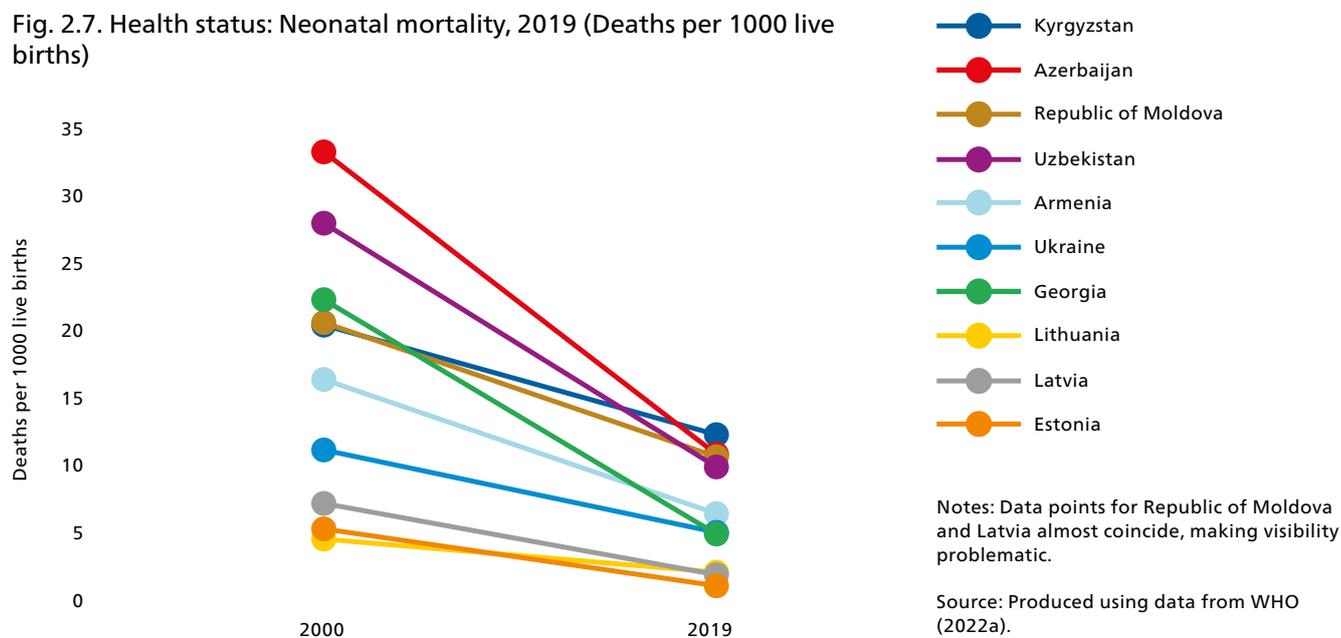


Fig. 2.6. Health spending by share of sources of revenue in the WHO European Region, 2019 (%)



Over the past 20 years, high-level health outcome indicators (such as child and maternal mortality and life expectancy) somewhat converged in the 10 countries, in spite of variation in economic performance, health expenditure and purchasing development, although the HICs continue to rank highest in health outcomes. There are examples of MIC purchasers undertaking strategic purchasing initiatives that contributed to these improvements in health outcomes, in spite of constraints due to their limited share of health financing. They were able to purchase strategically in selected areas, sometimes for limited periods of time before policies changed. For example, Georgia achieved good economic growth, increased fiscal capacity and markedly increased the fiscal priority of health spending. This is reflected in a marked reduction in out-of-pocket payments and improvement in outcome indicators that are influenced by health-care access and quality such as perinatal mortality (Fig. 2.7). Additionally, Armenia managed to improve maternal and child health outcomes in spite of modest economic growth, disappointing trends in fiscal capacity and steeply rising out-of-pocket payments by improving maternal and child health coverage through a targeted strategic purchasing initiative. Furthermore, Armenia and Kyrgyzstan used performance incentives for PHC providers for a period of time to improve health outcomes and wider so called *balanced scorecard* measures of performance in this area of maternal and child health.

Fig. 2.7. Health status: Neonatal mortality, 2019 (Deaths per 1000 live births)



2.2. Politicians, stakeholders and civil society

At the beginning of the major health financing reforms, for most of the MICs in our study, it was important to have a President and/or Prime Minister (PM) who was committed to such reform, or a strong, politically influential Minister of Health with Presidential/PM backing, able to secure large majority parliamentary support (particularly where constitutional change was required). In the three countries that have reformed relatively recently (Azerbaijan, Ukraine and Uzbekistan), a change in political leadership in the government made a critical difference. Strong high-level backing was necessary to push past opposition to reform from stakeholders who had been able to block change for a long time, in each country's specific political context. The MoH in some countries (e.g. Azerbaijan) was not always supportive of reform. At times, national political leaders chose to appoint a new supportive Minister of Health, to overcome past inertia. In all three recent reform countries, caution from the MoF about fiscal and tax implications held back reform for long periods of time. Achieving a constituency of support across the cabinet of ministers (CabMin) and in parliament was particularly challenging in Ukraine, where negotiation and some compromise with parliamentary opponents of reform and proponents of alternative reforms was necessary. Local governments and respective responsible ministers are important stakeholders in Ukraine and it took effort to explain the need to reconcile the centralization of some health financing functions and resource allocation within policies of decentralization.

A stable consensus across the major political parties represented in Parliament on the main features of health system design and strategic direction, as seen in Estonia and Lithuania, is the optimal environment for developing strategic purchasing over time. This has enabled these countries to: maintain a long-term stable strategic direction; make steady incremental progress over time in the development of policy, regulation and strategic purchasing (which requires long-term efforts to achieve visible results); and build and sustain the necessary capacity and systems in the purchasing agency and the MoH. Estonia, Latvia and Lithuania also have relatively high general governance indicators relative to the other study countries. While all countries have seen improvement in most or all general governance indicators over the past 20 years, the gap between Estonia, Latvia and Lithuania and the other countries has not fully closed (see Fig. 2.8 below). Country experts in Estonia and Lithuania noted a political and administrative culture of preferring continuity and incremental change over radical reform: a finding consistent with the proposition that stability and consistency are a key dimension of good governance for mandatory health insurance institutions (Svedoff et al., 2008). However, this is not always the case; the Republic of Moldova has experienced stable consensus and institutional stability but has not taken advantage of this to make strategic progress over time. In this case, stability appears to be associated with lack of pressure on the purchaser to achieve goals and improve performance, in the context of persistently weak general governance indicators.

In countries that have experienced political instability on the other hand, leading to frequent changes in government and ministers of health, this instability was found to act as a barrier to the development of strategic purchasing. This was especially the case when there were also divergent, or even polarized, political platforms and divergent views about the design of the health system across major political parties and different ministers. Political instability commonly led to a lack of consistent policy and strategic direction (e.g. Armenia), changing priorities (e.g. Kyrgyzstan and Latvia) or even reform reversal (e.g. Georgia). Political instability commonly also led to: institutional instability in the purchasing agency, frequent changes of the chief executive officer (CEO) and senior managers; periods of stasis in decision-making due to learning curves for new ministers and CEOs; managers acting in charge in the purchasing agency; staff churn and loss of institutional memory in both the MoH and purchasing agency. Interviewees did not perceive any substantive difference in purchasing activities or results due to the reorganization of purchasing agencies or as a result of different mixes of public financing sources. The radical reform reversals in Georgia required the rebuilding of whole health financing systems and institutions; diverting focus away from the implementation of strategic purchasing and complementary reforms. Some interviewees felt that they should have built more local technical/professional expert consensus and taken more time to seek political consensus and wider local support before embarking on reform. Several of the smaller countries that have successfully maintained their reforms over a longer period of time point to a key group of around 10–12 experts in health reform in the country who form the core of their country's expert consensus. The group work informally to explain and defend the reforms to new governments, ministers, parliamentary committees and are the go-to commentators on health policy in national news media.

In several countries, interviewees spoke of a trend to more so called populist politics, which is associated with the adoption of unrealistic, over ambitious strategies and unrealistic declarative policy commitments. This leads to the situation where civil servants, providers and the population do not expect strategy achievement nor the implementation of policy in the promised time frame, if ever. They therefore do not attempt to hold the government or its agencies – including the purchaser – accountable. Populist politics is associated with unfunded, unprioritized, non-evidence-based policy changes such as additions to the benefits package or tariff increases. Some MIC interviewees described this as a lack of political honesty about the resource gap between the benefits package and the purchasing budget, and the refusal to acknowledge and confront the real level of informal out-of-pocket payments. This leads to a benefits package that is increasingly not credible to patients, a contract and payment offer that is not credible to providers, and ultimately, public mistrust in policy and strategy promises. Another political dynamic noted in some countries was the political culture of each new minister needing to announce new policies, which is in stark contrast with the 20-year time frame needed to fully develop and implement strategic purchasing to achieve improved outcomes.

Stability in system design and strategic direction was stated by country experts as being important to sustain progress in implementing more complex, medium-term strategies for purchasing (see the examples of Estonia, Latvia and Lithuania discussed in Chapter 3). Interviewees from Estonia, Latvia and Lithuania also identified the pressure from civil society voicing higher expectations as a driver of ongoing development of strategic purchasing. For example, the expectation (mediated through news media) of timely and quality care and for reducing out-of-pocket payments, direct use of complaint systems, political advocacy and political representation were seen as important drivers. In Latvia and Lithuania where the purchaser is subordinate to the MoH, the MoH is most exposed and accountable for responding to civil society pressure through its health sector strategies and the strategic objectives it sets for the purchaser. In Estonia, the purchaser is more independent and its Supervisory Board (SB) and management team feel this civil society pressure more directly.

In countries where legislature and governments have not yet developed mature representative and transparent mechanisms for engaging with stakeholders and civil society – mechanisms that are broadly representative, directed at the common good and avoid conflicts of interest – it is harder for the MoH and purchasing agency to manage the processes of stakeholder consultation in the public interest and balance legitimate stakeholder interests. This is a particular challenge in some countries where there is a disproportionate influence of oligarchic private economic interest groups spanning multiple sectors, which are well connected to the political system and/or political party financing (state capture).² It is also a challenge in some countries where appointments to public sector agencies such as the purchasing agency and public hospitals are linked to political affiliation or political connections. Non-transparent influence from powerful private interests (e.g. in the areas of private pharmaceuticals, medical supplies, service provision or health insurance) and lobbying by powerful public institutions (e.g. large teaching hospitals) or professional/specialist associations based on narrow self-interest results in the risk of undue influence on policy and an imbalance in resource

2. This finding on the state capture form of corruption does not correlate well with the improved country scores on the Control of Corruption indicator in the Worldwide Governance Indicators from 2000 to 2020 as shown in Fig. 2.8. Countries like Georgia, which have reduced some forms of corruption successfully, for example, still note this is a challenge for health policy and purchasing.

allocation; creating barriers to the development of the purchasing agency and the strategic purchasing system. Problems that were noted in the interviews conducted included the following.

- Reform choices (e.g. on policy options to use private medical insurance companies to administer publicly financed coverage in Armenia or Georgia or to finance various private providers) are heavily influenced by such interest group pressure.
- Bias occurs in the form of distortion to benefit package design, inflation of contract volumes, and over pricing of tariffs and pharmaceutical prices to favour the private interests of owners of pharmaceutical and diagnostics business, private hospitals or large influential public hospitals, or facilities used by politically connected elites.
- It is difficult to engage in selective contracting (or facility master-planning), enforce minimum standards, or balance competing interests where: private health insurance and private provider interests lobby for deregulated environments (e.g. in Georgia); the purchaser is obliged to contract with any willing provider, public or private (e.g. in Ukraine); or powerful public hospital or specialty interests block changes that could reduce their revenue.

Some country representatives noted that the lack of an independent public health profession in their country and/or the lack of a representative body for primary care also contributed to an imbalance in advocacy for cost-effective and equitable policies and resource allocation. It is common for public health and PHC to have a weak voice compared to hospitals and specialists. An Estonian interviewee noted the importance of hospital stakeholders having a concern for the wider health system – not simply advocating for specialist services. Estonian hospitals and their associations are now recognizing the need for cooperation between hospital and specialist services and PHC and social care, and the need for hospitals to get more involved in empowering PHC.

Fig. 2.8. World Governance Indicators, 2000 and 2020 (scores out of 100 for each indicator)

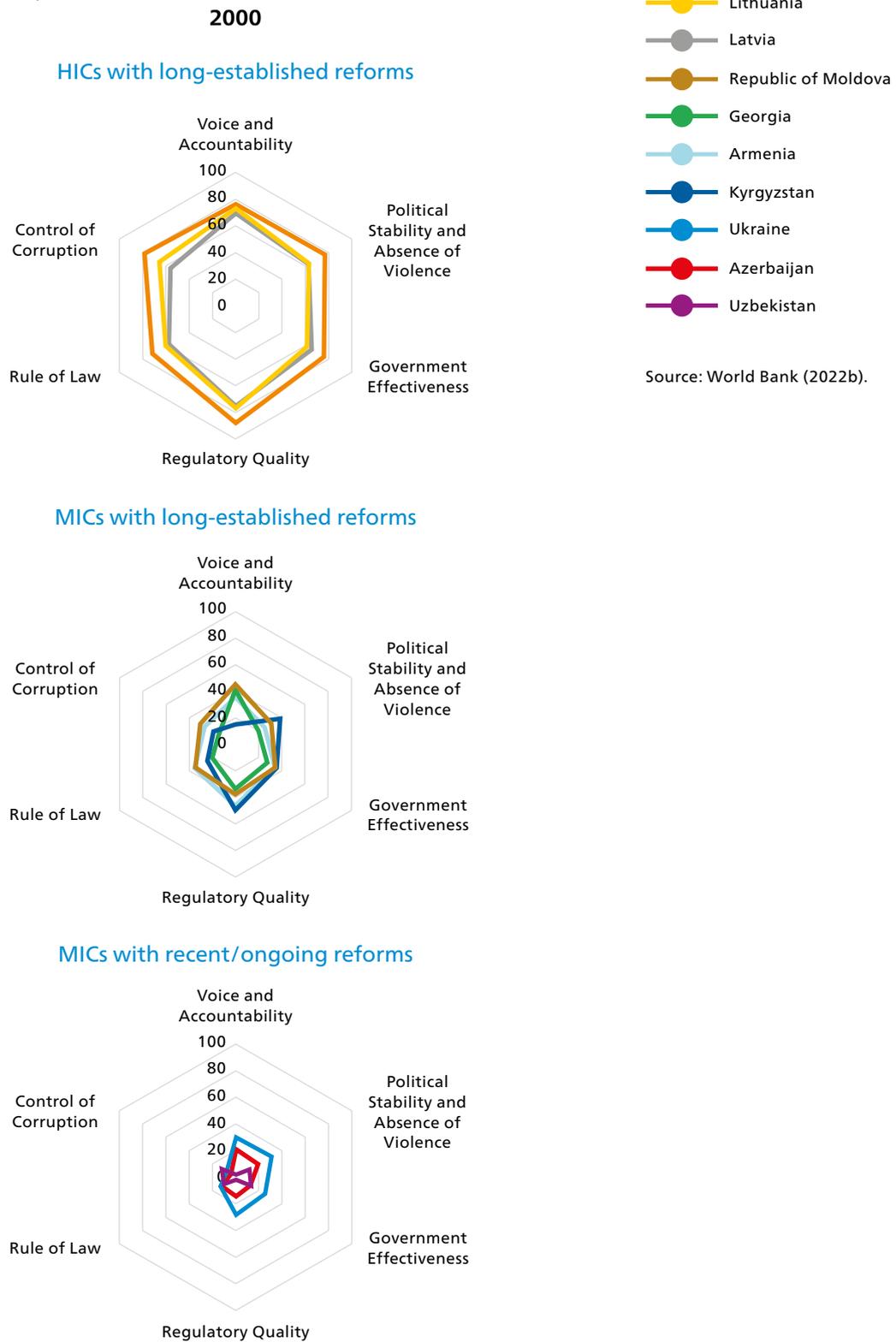
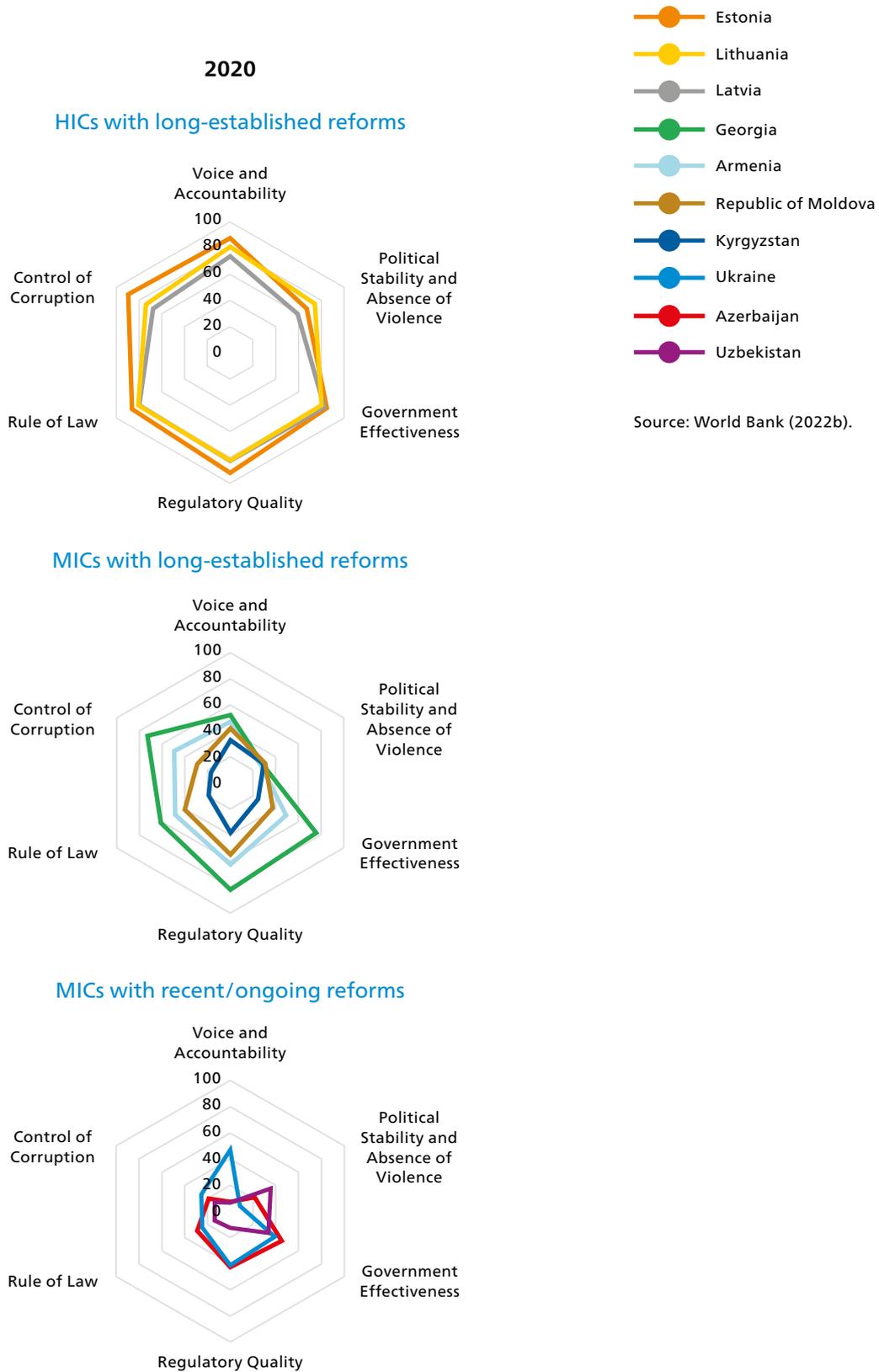


Fig. 2.8. contd



2.3. Public financial management (PFM) and provider autonomy

Almost all study countries have established their purchasers as public sector agencies with autonomy over technical and operational matters. Most have also given their public health-care providers autonomy. When we refer to a purchaser or provider as autonomous we mean that it is a separate legal entity, has its own budget, and has clear authority in law and regulations to carry out specified functions. In the case of autonomous purchasers, this includes the functions of proposing, advising on and implementing health purchasing policies. In the case of autonomous providers, this includes the day-to-day management of health service delivery.

The type of systems in place in the public sector for financial management, as well as the governance mechanisms for independent state agencies and enterprises make a large difference to the implementation of health reforms. These systems provide part of the control and accountability environment for purchasers in all 10 countries. A lack of good governance examples in other sectors makes it difficult to create autonomous, well-governed purchaser agencies and providers in a number of MICs. In this context, previous studies have found that the creation of more independent purchasing agencies (or autonomous providers) comes with risks of weak or dysfunctional oversight, while conversely, rigid controls in the PFM system may impede scope for purchasers to set new financial incentives through output-oriented provider payment reform, and leave providers without autonomy to respond to such incentives (Cashin et al., 2017; Barroy et al., 2022).

Health purchasing agencies in all 10 countries have close linkages to the state *budget formulation* and monitoring processes and state revenue collection agencies. In eight of the 10 countries, the treasury account system is used for pooling cash, managing reserves and managing cash disbursements to the purchaser and purchaser payments to providers. Purchaser interviewees stated that they have benefited from PFM and public administration reforms prior to or in parallel with health financing reform. In countries with non-corrupt, efficient treasury management systems, results-oriented public administration, some flexibility around budgets and human resource management, and transparent electronic procurement systems, purchasers have been able to use one or more of these platforms for building transparent financial and contracting operations. In Estonia, Latvia and Lithuania, effective changes to PFM began in the 1990s, with further PFM and public administration reforms having taken place in the last 20 years.

Some MICs experienced periods of severe bottlenecks and corruption in treasury functions in the 1990s, which led to advocacy for allowing purchasing agencies to hold and manage their funds outside the treasury account system. In these MICs, treasury automation and improved cash management took place 10–20 years ago, which helped to address or at least mitigate these problems. In most MICs, government-wide policies then consolidated the accounts and payment processes of independent

public agencies, including purchasing agencies, into the treasury system, in order to pool government-wide cash balances, ensure greater financial control and consolidate accounting for expenditure. This helped countries to address weaknesses in financial management and control systems in the MIC purchaser agencies which had contributed to mistrust in the purchaser on the part of government, parliament and the public. Nonetheless, delays in budget disbursement, cash rationing rules and associated budget bottlenecks by the MoF/treasury continue to be issues of concern in a number of MICs even in cases such as Kyrgyzstan, which have an independent purchaser operating under its own budget law. Two purchasing agencies (in Azerbaijan and Lithuania) still hold their accounts in commercial banks but Lithuania will shift accounts into the Treasury system in 2023; seen as a safer option by the purchaser. Estonia and Lithuania health insurance funds are able to hold reserves but only in the treasury where it becomes part of the MoF's cash and asset management system. In Azerbaijan, although the purchaser does not use the treasury account system, the MoF closely monitors the purchaser's expenditures and cash balances, and also has decision authority over the management of reserves (see Table 2.1).

Table 2.1. Funding flows and PFM arrangements for purchasing agencies

Country group	Country	Part of the treasury system	Main revenue sources	Mid-term budget expenditure framework	Has reserves; retains year-end surpluses
MICs with recent reforms	AZE	Does not apply	Mostly contributions and negotiated state budget transfers on behalf of non-contributors	No	Yes
	UKR	Applies	Negotiated state budget transfers	Yes	1% reserve at beginning of each year; unspent balance not retained at year end
	UZB	Applies	Negotiated state budget transfers	Yes	Yes (but not applied in practice thus far)
MICs with long-established reforms	ARM	Applies	Negotiated state budget transfers	Yes	No
	GEO	Applies	Negotiated state budget transfers	Yes	No
	KGZ	Applies	Contributions but mostly negotiated state budget transfers	Yes ^a	In law, yes (for MHI contributions only); in practice no
	MDA	Applies	Contributions and a fixed share of the state budget	Yes	Yes
HICs with long-established reforms	EST	Applies	Contribution rates and formula-based budget transfers. Negotiated additional budget transfers only in exceptional circumstances.	Yes	Yes
	LVA	Applies	Mostly negotiated state budget transfers, but also small share of contributions	Yes	No
	LTU	Does not apply (will apply from 2023)	Contribution rates, formula-based budget transfers, negotiated budget transfers for delegated functions	Yes	Yes

Notes: Negotiated state budget transfers refer to policies of annual negotiation on the size of the budget transfer as part of the country's annual budget negotiation process. It is distinct from formula-based transfers which use a formula fixed for a number of years and related to variables such as the number of non-contributing beneficiaries or the average costs of care for different categories of beneficiary. The formula may be set according to regulation and may use actuarial estimates.

a. A medium-term expenditure framework is adopted, however, due to shortfalls of revenue to finance the annual Republican budget, is not always fulfilled in practice.

Some countries have taken a long time to reform *input-based* budgeting norms and budget controls in their public health-care providers, which has blunted providers' autonomy and incentives to improve efficiency in response to new provider payment mechanisms. By contrast, the HICs under study gave their health-care providers autonomous status at an early stage of reform, in conjunction with the implementation of new governance and regulation arrangements for providers. In these HICs, the purchaser, MoH and MoF also receive provider financial reports; the purchaser has access to provider financial data for tariff development, the

MoH uses the reports for sector stewardship and the MoF uses them for oversight of the whole public sector financial position and balance sheet.

However, three MICs that also took rapid and radical steps to give substantial autonomy to public providers or (in two of these countries) privatize public health-care providers as part of the package of health financing and wider public management reforms, have had less successful experiences. In these countries, failure to develop effective regulation, transparent PFM systems, governance structures and financial management capacity in providers as part of reform implementation led to problems in the lack of transparency and accountability in health-care providers. Some MICs experienced a loss of access to provider financial data after the providers were given autonomy or privatized, which took these organizations out of the treasury account system. As a result of a lack of attention to setting up alternative mechanisms, the timely production and publication of audited financial reports were not ensured, and transparent governance and accountability of autonomous providers were not put in place. Some purchasers (and owners of providers) have instituted their own requirements for autonomous providers to provide them with financial reports, but these are not always audited or timely.

In some MICs (Kyrgyzstan, Republic of Moldova), in order to make the best use of limited financial capacity, it is the purchaser that has been given the responsibility of monitoring provider financial performance, although in most countries the owner of the health facility (e.g MoH or local government) has this responsibility. In Kyrgyzstan, the purchaser has now also taken on the former MoF treasury's role of authorizing provider *budget execution by line items*, to eliminate duplicative approvals. Conversely, in Estonia the MoF and the Ministry of Social Affairs (MoSA) monitor the financial status of providers.

The lack of regulation or very light regulation of highly autonomous and private sector providers, and over optimism about competition as a driver of good performance in this context was cited as a cause of poor quality and inefficiency of providers in some MICs. Without quality regulation and appropriate economic regulation, it has proved very difficult for the purchaser to incentivize performance improvement.

The lack of transparency and accountability in health-care providers due to these weaknesses in regulation and governance undermines the impact of strategic purchasing and provider payment reform, particularly where there are significant levels of out-of-pocket payments and direct sales of drugs and supplies to patients which are not captured in health information systems nor in the accounting and reporting of the providers, although they may dominate providers' financial incentives.

Recent reformer countries noted the need for public providers to be supported in preparing for greater managerial autonomy from MoH and MoF control, with support required for the transition and in the development of a new reporting and monitoring regime. The reforms involve separating and clarifying the roles of the purchaser versus owner versus quality regulator into three organizations, all of which have some responsibility for monitoring or inspecting providers. Azerbaijan is using a transitional arrangement in which the purchasing agency manages

the provider network through a subsidiary company. This transition arrangement has made the purchaser responsible for any losses public providers make. This has led to pressure on the purchasing agency to delay introducing *output-oriented payment* methods for public providers, which would *place* some of them in financial deficit. However, it has the advantages of ensuring coordination between purchasing reforms and provider reforms to increase efficiency. Another interviewee from a recent reformer country noted the need for the financial modelling of the impact of new provider payment methods on public providers. New payment methods may reduce public provider revenues and increase their volatility leading to a financial risk to owners if this results in provider deficits. Some purchasing methods may create risks to patient service availability in some localities, if facilities, for example in rural areas, are no longer financially sustainable.

Budget formulation processes have proved a more difficult area to reform in MICs than budget execution. Few countries have moved beyond forming budget ceilings for the purchaser based on historic costs with negotiated incremental adjustments, depending on aggregate fiscal conditions and general political priorities. In countries with a predominantly budget-financed purchasing agency, attempting to make decisions on the benefit package, tariffs and contracts within the annual *budget cycle*, precludes much analysis and the development of an evidence-based approach or consultation: a more medium-term approach is needed, ideally aligned with a multiyear budget formation. While many countries had some form of medium-term fiscal framework, this was not actively used in the study MICs: in most years, future changes in the utilization and costs of the benefits package were not projected. Furthermore, most did not have a systematic process for ensuring costing of the fiscal impact of new policies and strategies. As a result, there has not been a systematic, regular approach to quantifying and addressing any gap between the purchaser's budget and the cost of benefit package services, nor has there been any consideration of the adoption of using an actuarial formula to determine the budget subsidy for non-contributing beneficiaries. The long-term commitment involved in a formula-based approach is difficult for MICs with unstable macroeconomic conditions and poor forecasting of government revenues and mandatory contributions.

The two HICs with substantial contribution-based financing of their purchasing agency (Estonia and Lithuania) take a distinctive approach to budget formulation and have a more arm's length relationship to the government's annual budget process. Both countries also rely on budget contributions to the health insurance fund for the economically inactive population, based on stable formulae. This approach, combined with reserve policies, appears to create a more stable medium- to longer-term budget constraint for the purchaser. Regular projections and costing to assess the financial sustainability of the health insurance fund, and to inform periodic revisions to policy on contributions and budget transfers is needed in any case (this is described in the case of Estonia in Box 2.2 below).

Wider performance-oriented PFM and public administration reforms have begun in some of the study MICs over the past 5–10 years, but implementation is still incomplete in most of these. Although some

countries have begun to introduce *programme budgeting* with associated performance indicators, this has not so far been a particularly important enabler of health purchasing reforms such as the introduction of output-oriented or performance-based provider payment. In most countries the programme budgets are used for information only – not as the main basis for *budget approval* or execution. In some countries the programme budget indicators are poorly aligned with the indicators used in the purchaser’s strategies, plans and performance reporting. Among these countries, budget programme design is aligned to health service delivery functions, structures and provider payment streams, which is helpful for monitoring and the accountability of health-care purchasers and providers for performance (it is not the case in many regions globally where health budget programmes are not aligned and are therefore difficult to monitor). However, in Kyrgyzstan, the programme budget categories are no longer fully monitorable: expenditure on the PHC programme is difficult to monitor, since several PHC facilities have merged administratively with local hospitals. Programme budgeting is not seen as a significant accountability mechanism in any of the 10 study countries.

Box 2.2. Estonia: Budget processes and the EHIF's relationship with the MoF

EHIF is a national purchasing agency with earmarked revenues from payroll tax collected by the Estonian Tax and Customs Board. The earmarked tax revenue has been supplemented recently with state budget transfers to cover increasing expenditures. The level of earmarked taxes and formula for state budget transfers to EHIF are defined by law. EHIF faces a reasonably predictable budget constraint due to fixed contribution rates and formula-based budget allocations for non-contributing covered population. The fact that EHIF does not have annual negotiation over contribution rates or budget contribution formula means that these variables are only reviewed occasionally and are major reforms, requiring high-level political commitment in which the MoSA on behalf of EHIF plays a major role in policy negotiation with the government. In this environment, the EHIF SB does take a close interest in the financial sustainability of the fund, as a basis for representations and recommendations to the MoSA. Discussions on how to continue funding health care sustainably are ongoing at the political level.

The basic principles of budgeting are established in the Health Insurance Act and allocations between different services are decided by the EHIF SB. All budgeting processes start with a long-term prognosis of the revenues and expenditures of EHIF which are presented to the SB, including the MoSA and the MoF. The MoF prognose revenues for EHIF and based on the forecast of revenues and expenditures, a four-year budget plan is proposed indicating the EHIF budget position. The SB adopts the EHIF budget and the EHIF budget position is adopted as a part of state budget. As a general rule, the Government and Parliament don't scrutinize the EHIF budget because prior processes make sure to settle all disagreements (e.g. the MoF and MoSA's involvement in the SB). In addition, since the formula for revenues is defined by law, there is also not much room for negotiation for reducing or increasing revenues if these may be needed.

The MoF plays a strategic role in the health sector by managing health finances through the state budget and through its minister's involvement as a member of the SB. The EHIF budget is part of the MoSA programme-based budget. Nevertheless, programme-based budgeting does not play a significant role in influencing strategic decisions on allocation of the purchaser's budget, because the EHIF funding is pooled into two programmes with very general output criteria. Overall, there is no output or results-based *budget monitoring* for EHIF, keeping it accountable for health system developments and health outcomes. EHIF's reports to its SB play a more important role: EHIF's annual report, which is published on its website, describes the explicit output criteria used for planning EHIF's budget annually.

These experiences illustrate the need for MoHs and purchasing agencies to work closely with MoFs in the design and implementation of reform, so as to ensure the alignment between PFM and public administration systems and health purchasing reform. Box 2.3 illustrates this in the case of Kyrgyzstan and notes solutions that were found to misalignments between PFM and health financing and purchasing reform over time.

Box 2.3. Kyrgyzstan: Budget processes and the Health Insurance Fund's relationship with the MoF

Source: Barroy et al., 2022; Hawkins et al., 2020.

When the Mandatory Health Insurance Fund (MHIF) was established as a national pooling and purchasing agency, input-based norms continued to play a role in budget formulation: the MoF reduced MHIF's budget if health facilities reduced beds or staff – removing incentives for efficiency. Budget execution processes also made it difficult to really implement new output-oriented provider payment methods and created rigidities and delays in budget disbursement. Providers had to plan, execute and account for their budgets by four funding sources and detailed input line-items, with long approval processes for changes in allocations; making it impossible to reallocate between sources – introducing further rigidities and fragmentation into the budget.

Following a period of close, cooperative working between the MHIF and MoF, solutions were developed to a number of these problems, within the frame of wider PFM reforms that the MoF had initiated. The MoF concluded that MHIF needed its own Budget Law, separate from the Republican Budget. The MHIF Budget Law shows MHIF revenues from social contributions and transfers from the Republican Budget, and expenditures from these combined sources are disaggregated according to broad categories of services (e.g. general health services and prescription medicines), but under a single line in the *economic classification* for MHIF payments to providers, rather than input-based lines. Kyrgyzstan has not yet fully implemented programme budgeting. The MHIF Budget Law also stipulates that health-care facilities can retain unspent funds at the end of the year.

Many further problems remain: there is still no regular process for using projections of the costs of the benefits package in setting the budget; informal payments and other private expenditure fill the financing gap; there are still delays in the release of cash at the beginning of the year (as in many lower-middle-income countries (LMICs)); and the roles of the MoF, MOH and MHIF are not always fully clear. However, many other bottlenecks and rigidities have been reduced.

2.4. Reforms in public administration

Purchaser agency staff in most countries have civil service status or salaries based on civil service scales. While in some countries there are perceived benefits of this civil service status – to achieve greater stability and reduce the risks of politicization of purchasing decisions – in others public service is not valued or rewarded. In countries such as Estonia where the purchaser is free to hire staff on private labour contracts, there is more scope to recruit skills that are valuable to the private sector such as data, information technology and analytical skills.

Some interviewees noted a climate of punitive accountability and political pressure for public servants, either associated with unreformed or corrupt systems of public administration, audit and inspection, or with a rise in populist politics. Punitive accountability and political exposure of public officials in leadership and senior management make the MoH and purchaser more risk averse and less willing to take initiative on difficult or controversial issues, leading to cautious, incremental strategies of lower ambition. One form of this problem is political mandating of unrealistically short time frames for the implementation and delivery of political results. This may occur even in the absence of short-term election cycle pressures, where there is a climate of punitive top-down accountability without recognition of the need to build understanding and commitment to reform and strategy goals, and to clarify roles and responsibilities among staff at all levels of the purchaser and other implementation agencies. Punitive accountability is seen as increasing the difficulty for the MoH and purchaser in recruiting and retaining staff, particularly those with skills valuable to the private sector. Purchaser institutional governance structures – discussed in Chapter 4 – are also relevant. In countries like Estonia, where EHIF management is clearly accountable to an SB, it may be possible to shield senior managers from short-term political pressures to some extent.

The LMICs reviewed face the greatest challenges in recruiting and retaining staff with skills valuable to the private sector, for multiple reasons. Interviewees from these countries note that the use of donor-financed contractors and consultants to fill these gaps in purchaser capacity have not produced sustainable capacity development. While they might act as an accelerator in the short term, in the longer term they may disincentivize local personnel from accepting the lower pay and greater responsibilities of becoming purchaser (or MoH) staff. Interviewees from one country reported a perceived decline in the competence of the political and administrative elite over the last 20 years since the country underwent health financing reform, as well as a reduction in their public-good orientation, which is important for good governance.

Some countries with established performance monitoring and management systems for CEOs and/or staff of state agencies, have used these as an important instrument for direction, accountability and motivation for the purchasing agency (see Box 4.1 in Chapter 4 for examples). Conversely, in countries where there has been resistance to establishing a proper performance monitoring and management system (e.g. Republic of Moldova), it is more difficult to progress reforms.

2.5. Policy recommendations for strengthening governance determinants at national level

Key country informants were asked about the aspects of the broader economic and political and civil society context, and the PFM and public administration environment that enabled progress in the development of the purchasing agency and strategic purchasing in their country and helped tackle some of the barriers noted above that prevented progress. These are summarized below as recommendations relevant to all countries. Although health sector leaders and agencies have limited power and influence over these broader contextual aspects of national governance, our interviewees identified a number of actions they can usefully take. Examples of countries that have implemented these recommendations, which offer lessons of interest to others, are also provided.

Recommended action to achieve broad-based political consensus

- Build a broad-based constituency of support for health financing system design and ongoing strategy, mobilizing key health stakeholders and wider civil society for support, such as doctor organizations, expert opinion leaders from academia, think tanks, civil society organizations among others, who can help to develop and later explain and defend reform. They can also help to build consensus across major political parties and widen civil society engagement over time. In some countries, such as Estonia and Lithuania, these expert networks helped to engender momentum for change when political opportunity arose, and helped the country to maintain stable policy, institutional arrangements and strategic direction.
- Establish high-level cooperation across government and parliament (between the President, parliament, PM, MoF and MoH) and among development partners in the developmental stages of reform, as has been done in all MICs with long-established reforms as well as Ukraine.

Recommended action to achieve a well-established PFM system and provider autonomy

- Adopt flexible, transparent PFM and planning norms with modern digitized systems and align performance-oriented elements such as programme budgeting with health sector and health purchaser strategies and plans as is the case in the HICs and Ukraine.
- Reform PFM and personnel rules for public health facilities that undermine provider incentives for efficiency (eliminate input norms, relax input-based budget controls, allow revenue retention, ensure complete accounting and reporting for all out-of-pocket payments and drug sales), but increase autonomy gradually, alongside improvements in financial management systems and management capacity as well as new forms of governance and accountability as has been done in the HICs.

- Improve budget formulation through a regular cycle of updates to multiyear projections of utilization and costs of the current benefits package, and MoF-enforced rules to ensure costing and prioritization of new policies and regulations with fiscal impact on the purchaser, as has been done in Estonia and Lithuania.
- Promote transparency in budget formulation, execution, reporting and procurement to build trust and a clean reputation of independent public agencies like the purchasing agency as has been done in the HICs and Ukraine, including by:
 - publishing information on the purchaser's website, including budgets, procurement packages of health services and goods, contracts, and the creation of dashboards for monitoring finance, services, and performance indicators; and
 - publishing clear rules/criteria/specifications for contract awards.

Recommended action to achieve professional, public good-oriented public administration

- Protect the senior technical staff and management of the purchaser agency (and MoH) from undue political pressure either through civil service status (in countries where public service is valued and adequately rewarded), or through having appointment rules and procedures and terms of office for technical public sector agencies, which mitigate the risk of politicization of the purchasing agency, or through the role of an SB to whom purchaser agency management are accountable (see Chapter 4). Country examples of this include Estonia, Lithuania and Ukraine.
- Support the development of mature civil society and stakeholder organizations, and meaningful, transparent processes for balanced, inclusive stakeholder engagement in the public interest that are sustainable over time (e.g. the development of independent academic/think tank/professional consultancies with expertise) and foster broader-based stakeholder organizations (e.g. broad-based medical, nursing, hospital, PHC, public health and patient associations) that can help to achieve consensus and balance among their members and enact and implement rules to control conflict of interest in processes involving sector interest groups. The channelling of lobbying by narrow interest groups into these organizations and processes can help the MoH and purchaser as has been demonstrated in the HICs.
- Foster courage, public-good orientation and proactivity by the purchasing agency itself in defending and explaining reforms and demonstrating the value of the institutional reforms and advocate for the need for continuity in the purchasing agency, even if there is a lack of political and stakeholder consensus, as has been shown in Estonia and Ukraine.
- Foster shared public good objectives among the MoH, purchasing agency management and staff and key stakeholders, as demonstrated in Estonia and Lithuania, by:

- adopting public or non-profit models for health-care purchasers and providers with appropriate objectives; and
- building commitment to universal health coverage goals.

3. Governance at health system level

3.1. Reforms to develop purchasers and strategic purchasing

At the health system level, the government and MoH define goals for improving the health system and population health, then design the system and set policies and strategies directed at achieving these goals. This includes the policy of establishing an institution separate from providers to purchase health services and establishing goals for health purchasing that need to be reflected in the mandates and directions the MoH (and wider Government) set for the purchaser. In the area of health financing and purchasing, among the 10 study countries, there is a gradual evolution and elaboration of goals to higher levels of ambition over time. This evolution can be grouped into three broad phases.

- Phase 1: an initial emphasis on the goals of financial protection and efficiency, through a strategy of introducing a better-defined, better-resourced benefit package, higher health-care worker salaries, and allocating resources more equitably and efficiently using new provider payment methods.
- Phase 2: increased focus on the goals of service optimization and service development to improve quality as well as efficiency, through a strategy of strategic purchasing aligned to service delivery reforms and supported by the development of quality monitoring and provider incentives for improved quality.
- Phase 3: increased focus on improving results for patients, including access, equity and health-care outcomes, aligned with strategies developed with strong public health input, drawing on needs assessment and evidence.

The three study HICs have made progress across all three of these phases, even though they were still MICs when they made substantial steps in Phase 1 and started Phase 2 reforms. The study countries with established reforms that are still MICs have typically made limited progress in the first phase – they still only offer relatively weak financial protection. Some progress has also been made in Phase 2, albeit with large variation both across and within countries, and typically a few initiatives at most have been rolled out relating to Phase 3 of reform.

In Estonia, Latvia and Lithuania, health financing reform in the early 1990s was part of a multisectoral wave of reform which helped propel health financing reform and purchaser development forward. These reforms had the common features of marketization, decentralization, granting of autonomy to public sector agencies or privatization of government functions, but these countries did not apply all the marketizing elements of multisectoral reform to health, and reviewed decentralization elements over time. Table 3.1 summarizes the development of purchasing agencies in these three countries (as well as those made in the other study countries). Notably, Lithuania started its reform at slower speed by piloting new ways of purchasing for five years before implementing a nationwide rollout. Decentralized functions were increasingly centralized

during a second round of organizational reform around 2000 in Estonia and Latvia. At the time of writing, legally independent regional branch funds still operate in Lithuania, though they are subordinate to the National Health Insurance Fund and are now under review. In Latvia, as part of the largescale reorganization and consolidation of public administration in response to the economic crisis, the National Health Service was established in 2011. All three countries chose not to privatize health facilities but gave them some form of organizational and managerial autonomy (Table 3.2). Retaining providers in the public sector as autonomous organizations has given countries more health system levers (administrative regulation and ownership levers) over providers, compared to countries that privatized facilities. Using ownership levers to improve management and efficiency has complemented strategic purchasing and facilitated alignment of goals and values on purchaser and provider sides of the market.

Table 3.1. Development of purchasing agencies

Country group	Country	Key milestones
MICs with recent reforms	AZE	2007: SAMHI 2016: pilots 2021: nationwide implementation
	UKR	2018: National Health Service of Ukraine with regional departments, purchasing PHC 2019: reimbursing medicines 2020: purchasing specialized services
	UZB	2020: State Health Insurance Fund 2021: pilot in one oblast
MICs with long-established reforms	ARM	1997: State Health Agency law and established pilot 1999: nationwide implementation
	GEO	1995: State Medical Insurance Company 2004: targeted social assistance programme 2007: Medical Insurance Programme 2013: State Health Agency with regional departments 2020: National Health Agency with regional departments
	KGZ	1997: MHIF 1997: pilot to finance hospitals (State Health Insurance contribution budget) 2001: pilot to pool State Health Insurance contribution and general budget in MHIF 2005: nationwide implementation
	MDA	2001: National Health Insurance Company with regional branches 2003: pilot in one rayon 2004: nationwide implementation
HICs with long-established reforms	EST	1991: 22 separate (mostly regional) sickness funds 1994: Central Sickness Fund to coordinate regional sickness funds 2001: EHIF with regional departments
	LVA	1993: 35 local government level sickness funds 1996: State Sickness Fund to coordinate regional sickness funds, renamed State Compulsory Health Insurance Agency (SCHIA) in 1998 2002: regional sickness funds merged under SCHIA 2009: Health Payment Centre established 2011: National Health Service with regional branches, replacing SCHIA and Health Payment Centre
	LTU	1992: State sickness fund as a department of the MoH 1992: pilot to finance large hospitals 1996: nationwide implementation 1997: National Health Insurance Fund with regional branches

Table 3.2. Types of providers

Country group	Country	PHC	Hospitals
MICs with recent reforms	AZE	Public non-autonomous health-care providers subordinate to the Administration of the Regional Medical Divisions – by 2021 subordinated to TABIB Plan for public provider autonomy not yet implemented. Mix of public and private providers in the three largest cities	
	UKR	Mix of public and private providers	Dominantly local government-owned autonomous entities plus some central government-owned non-autonomous entities
	UZB	Dominantly public non-autonomous health-care providers owned by state and local governments	
MICs with long-established reforms	ARM	Mix of public and private providers	Mix of state and local government owned autonomous public and private providers
	GEO	Private (urban) and public (rural) providers	Dominantly private providers
	KGZ	Dominantly public non-autonomous health-care providers owned by state and local governments	
	MDA	Mostly public providers	Dominantly central and local government owned self-financing non-profit-making organizations
HICs with long-established reforms	EST	Dominantly private providers	Dominantly autonomous public hospitals owned by central or local governments, or public legal bodies; all hospitals operate under private law as joint-stock companies or foundations
	LVA	Private providers	Dominantly central and local government owned autonomous public hospitals. All hospitals operate as joint stock companies
	LTU	Mix of public and private providers	Dominantly central and local government owned limited-liability legal entities operating under public law

By contrast, some MICs were slower to adopt multisectoral reforms which led to a long delay in health reform (e.g. Azerbaijan, Ukraine and Uzbekistan); while others took a very cautious approach: the Republic of Moldova and Kyrgyzstan retained public ownership and traditional public management of hospitals and primary care centres and have made only incremental moves towards public provider autonomy (Table 3.2). Armenia and Georgia did adopt multisectoral reform but opted for more radical provider autonomy or privatization of public facilities, associated with a weakening of regulator and ownership levers over providers and leading to adverse consequences for financial protection. Georgia, uniquely, underwent a series of radical changes of health financing system design, abolishing the State Health Fund in 2004, introducing a means-tested targeted Medical Insurance Programme in 2007 and then contracting out administration to private insurers. A single purchaser was then re-established in 2013 with a broader population coverage.

While nine of the 10 study countries adopted a purchaser–provider split, giving distinct goals and accountability arrangements to purchasers and providers, as a transition strategy for supporting its public provider network to become autonomous, Azerbaijan transferred ownership and management of its public facilities to a national public legal entity, the Management Union of Medical Territorial Units (usually referred to by its Azerbaijani acronym TABIB), subordinate to the new purchasing agency; the State Agency for Mandatory Health Insurance (SAMHI). In 2022 TABIB became legally separate from, though still organizationally integrated with, SAMHI. It has not yet been possible to introduce new provider payment methods for TABIB facilities except for small additional payments on top of the facilities' line-item budgets (a funds flow for output-oriented bonuses). If this transitional integration becomes prolonged, it is seen as creating a risk of reducing the impetus for reform to public provider management and provider consolidation.

Most countries have introduced provider payment reforms: the development of capitation payment for PHC and case payment for hospitals, and at a later stage, developed some form of quality-based pay for performance (P4P) as part of a blended payment model for primary care (Table 3.3). High-income countries have refined their purchasing methods over time to achieve health system goals, including making greater use of needs assessment for planning volume and mix of services to purchase for different populations; developing forms of blended payment systems; and refining their P4P schemes. Selective contracting has proved difficult in most of the MIC countries and Latvia, in part due to governance related reasons, such as concern about risks of corruption in selection and lobbying by politically connected providers.

As noted in Chapter 2, a lack of consistent vision for system design and strategy in the MoH over time was seen as an obstacle to progress in countries with less political stability. Some MIC interviewees described golden periods when progress in phases 2 or 3 of strategic purchasing occurred, interspersed with periods of stasis or even erosion of progress. These golden periods were associated with stronger MoH–purchaser cooperation; a strategic vision and strong leadership in one or both of these organizations; and a strategy owned by both of these agencies and the broader government, supported by aligned external development partners. During these periods there was commonly a multipillar reform strategy, with coordination between purchasing development and other pillars of the strategy, such as provider network optimization and quality improvement.

Table 3.3. Purchasing methods

Notes: Latest information available. FFS: fee-for-service; DRG: diagnosis related group.

Country group	Country	Payment method in use			Selective contracting
		PHC	Outpatient specialist care	Inpatient acute care	
MICs with recent reforms	AZE	Capitation (so far mainly used in private sector)	FFS (so far mainly used in private sector)	Case-based payment (so far mainly used in private sector)	Purchaser contracts services from public providers and some private providers; as a transition measure, input-based funding used for public providers with new payment methods used at the margin for bonus payments; purchaser does not yet define the mix and volume of care; purchaser can contract services from private providers
	UKR	Capitation and P4P	Blended model of global budget, capitation and FFS	Blended model of global budgets and case-based payment	Purchaser contracts services from all providers who meet service standards and apply for a contract; purchaser does not yet define the mix of care based on population need; purchaser can contract services from private providers
	UZB	Line-item budget and global budget with plan to introduce capitation (pilot)	Line-item budget and global budget with plan to introduce capitation (pilot)	Blended model of global budgets and case-based payment	Purchaser contracts services from all public providers in pilot region; purchaser does not define the mix and volume of care; purchaser does not contract services from private providers
MICs with long-established reforms	ARM	Blended model of capitation and P4P	Capitation (urban polyclinics) and FFS for rural PHC clinic subcontracts with polyclinics	Blended model of global budget, FFS and case-based payment	Purchaser contracts services from all providers who meet service standards and apply for a contract; purchaser can define the volume of care; purchaser can contract services from private providers
	GEO	Capitation (urban) and salary (rural)	Capitation	Case-based payment	Purchaser contracts services from all providers who apply for a contract; purchaser does not define the volume of care; purchaser can contract services from private providers
	KGZ	Capitation. P4P was abolished during pandemic	Capitation	Case-based payment	Purchaser contracts services from all public providers; purchaser does not define the mix and volume of care; purchaser contracts services from private providers for haemodialysis
	MDA	Capitation. P4P was abolished during pandemic	Capitation	Blended model of DRG (acute care), per diem (phthsiology), FFS (chronic care, radiotherapy), and global budgets (emergency units, psychiatry, narcology)	Purchaser can select providers and define the mix and volume of care; purchaser can contract services from private providers
HICs with long-established reforms	EST	Blended model of capitation, FFS, P4P, and additional allowances	FFS	Blended model of FFS, per diem, DRG, and lump-sum payment for preparedness	Purchaser does not have to contract all providers, except Hospital Master Plan hospitals and PHC providers with enrolled patients; purchaser can define the mix and volume of care; purchaser can contract services from private providers
	LVA	Blended model of capitation, FFS, P4P and additional allowances	Case-based payment and FFS	Blended model of fixed budget, per diem, and case-based payment	Purchaser can select providers and define the mix and volume of care; purchaser can contract services from private providers
	LTU	Blended model of capitation, FFS, P4P and additional allowances	Case-based payment and FFS	Blended model of DRGs, provision of centrally purchased medical goods and reimbursement of some expensive medical goods purchased by hospitals	Purchaser cannot select providers; purchaser defines the mix and volume of care; purchaser can contract services from private providers

3.2. Alignment between national health strategies and health financing reforms

Most countries have some form of health strategy and a cycle of three, five or 10-year strategies, but there is a wide variety of experience in the role strategies play in aligning or driving progress in strategic purchasing (see Table 3.4). In many countries, national strategy is not aligned or consistent with purchaser strategies and plans, or only aligned on paper without real dialogue or negotiation between the MoH and the purchaser.

Interviewees from the MoHs and/or purchasing agencies in a number of countries noted the importance of using data for needs assessment and conducting reviews of evidence in the development of evidence-based strategy. In particular, for strategic purchasing, it was seen as important to develop evidence and needs-based service delivery models to drive contracting strategy and other purchasing policies. In most countries, the MoH plays the lead role in developing the health strategy and in reviewing and developing service delivery models. The MoH then works with the purchaser on the health financing pillar of the strategy, to support desired changes in service delivery.

Table 3.4. Health strategy development

Country group	Country	Health strategy (latest available)	Health financing and/or purchasing agency strategy (latest available)
MICs with recent reforms	AZE	Health strategy under development	National Concept of Health Financing Reform in 2008
	UKR	National health strategy 2030 drafted	Health Financing Reform Concept, 2016; purchasing agency's strategy under development
	UZB	Concept on health development of the Republic of Uzbekistan 2019–2023, health strategy under development	Presidential resolution on service delivery and health financing reform in the Syrdarya Region, 2020, purchasing agency's strategy under development
MICs with long-established reforms	ARM	Health strategy under development	Under development
	GEO	National health strategy adopted in 2022	Health financing chapter in national strategy
	KGZ	Healthy person – prosperous country, 2019–2030	Previous purchasing agency strategy now out of date and no longer used
	MDA	National Health Policy 2007–2021, new strategy under development	Previous purchasing agency strategy now no longer valid but update ongoing
HICs with long-established reforms	EST	National Health Plans 2020–2030	Purchasing agency strategy 2020–2023
	LVA	Public Health Strategy 2021–2027	No specific strategy developed
	LTU	2014–2025 Lithuanian Health Strategy	MoH three-year strategic plan with integrated purchasing agency activities; purchasing agency annual (operational) plans

In several countries (e.g. Azerbaijan, Estonia and Kyrgyzstan) with more independent purchasers, the purchasers develop their own strategy and planning documents, in line with the MoH's national health strategy but also drawing on wider sources of analysis and evidence used in the purchaser's own needs assessment. In Estonia and Kyrgyzstan, the strategy is approved by the SB; in Lithuania, by the Minister of Health; and in Azerbaijan by an informal oversight group of Ministries, chaired by a Presidential adviser.

Purchaser representatives noted that more concrete, specific planning documents made more difference to the purchaser than high-level strategies expressed in terms of outcomes, without setting out the causal mechanisms to bring about change. Some purchasers' own strategies aligned their language and presentation with the national health strategy, but they did not perceive the national strategy as playing a strong steering role.

In some countries, multiple separate strategies exist in the health sector and are not aligned with the health *purchasing strategy* (e.g. separate strategies for particular diseases or subsectors within the health sector), which means the potential for using purchasing to drive improvement in these areas is lost. MICs with extensive development partner support (including one county using a sector-wide approach (SWAp))³ have been able to make greater progress when development partners align with a single multipillar strategy and coordinated reform.

Countries without a national health strategy or health financing strategy, which rely only on annual planning and budgeting are at a disadvantage. The lack of a formal strategy may reflect more profound weaknesses in leadership and capability. In the case of Georgia, for example, in spite of a creditable political commitment to invest more in health in 2013, a comprehensive multipillar strategy for reform was only approved in 2022. The lack of strategy prior to this meant that required structural changes, and improvements in efficiency and outcomes were not addressed at the time of the 2013 step increase in resources.

3.3. Alignment of policy commitment with budget

The lack of alignment of health financing policy and strategy with resources, and a weak prioritization of the investments in reform proposed in strategies is noted in most MICs, leading to the chronic underfunding of benefit packages over time. As noted in Chapter 2, weaknesses in budget formulation and analysis of trade-offs by the purchaser, particularly in the study MICs, has contributed to a pattern of tariffs that are not cost-reflective, and result in implicit rationing or additional costs for patients. Providers often request informal payments from patients and ask that they buy drugs and supplies that should be covered by the benefits package. In most of the MICs where these payments account for a large share of revenue, they dominate provider incentives. In the earlier phase of reform, some LMICs failed to commit

3. A SWAp is a method of coordinating external development assistance in which most or all development partners agree to base their aid programmes for a sector – such as health – on the Government's strategy and budget plans and, to the fullest extent possible, disburse their funds through the Government's budget execution systems and adopt a single coordinated process of monitoring and review. Development partners in the SWAp may also pool their funds in a single Trust Fund administered by one development partner on behalf of others. Kyrgyzstan adopted a Sector-Wide Approach for health.

adequate budget for even a very basic benefit package. However, the context of disappointingly slow economic growth over the post-independence period in most of the MICs reviewed confronts countries with very difficult choices, in the face of an unsustainable legacy of health infrastructure, staffing and a (theoretically) very comprehensive benefits package. Capacity and transparency weaknesses in purchasers contribute to these problems, but political and economic context play a major role. The result of this lack of alignment is a situation in which the purchaser cannot be held accountable for delivering the benefits package, and the implementation of accountability mechanisms to beneficiaries (such as complaints mechanisms) would become overwhelmed.

Accountability is undermined both by the failure to maintain real purchasing power of health budgets and by policies that weaken targeting of protection to the poor (e.g. in Kyrgyzstan).

Countries that were able to mobilize a step increase at the outset of reform were better placed to win support and demonstrate benefits to citizens and health-sector stakeholders. Estonia and Lithuania were able to mobilize substantial additional revenue early in reforms through the adoption of a new tax – mandatory health insurance contributions. In most of the MICs this strategy has not been feasible due to high levels of informal economic activity, which is not yet able to be captured in the tax administration system, combined with much lower rates of average economic growth than the study HICs.

3.4. Shared accountability for results of health strategy: issues arising from the sequencing of reforms and implementation strategies

Health financing reforms in all 10 countries are – explicitly or implicitly – part of multipillar health reforms. Many of the objectives of reform require coordinated action by several health sector institutions. The purchaser has shared accountability with these other institutions in the achievement of results. Slower implementation of service delivery reforms or other pillars of reform, compared to financing reforms locks resource allocation into inefficient and poor-quality services, constraining the scope for the purchaser to achieve results, and hence be held accountable. Examples of these problems cited by MIC interviewees included that:

- political pressure to delay consolidation and quality improvement in the service delivery network leads to pressure for the purchaser to finance inputs of loss-making public providers and to contract substandard providers;
- a delay in developing quality and safety regulation and standards for providers can force purchasers to develop their own criteria and standards – which may lead to role overlap and conflict over the role of the purchaser versus that of the MoH;

- delays in implementation of health-care provider information systems can limit the scope for the purchaser to monitor contract quality, or introduce performance-related payments into their contracts; and
- purchasers may be pressured to offer contracts to private providers before necessary complementary policies are in place, such as balance billing regulation, quality regulation, and pooling of capital expenditure in the purchaser fund.

Some countries have planned to implement complementary reforms in a logical sequence from the outset of reform planning, with reform pilots combined with some crucial complementary reforms such as facility autonomy, information technology development, PHC service delivery reforms and the introduction of referral systems. These countries used the pilots to work out the practical aspects of effective sequencing and realistic time frames for reform implementation. Where piloting is accompanied by evaluation of the reform model before nationwide roll-out, it can also help to win the support of the MoF and economic stakeholders (see the example of Azerbaijan in Box 3.1.)

Box 3.1. Azerbaijan: Demonstrating net benefits of reform in an evaluated pilot^a

When Azerbaijan's President made it a priority in 2016 to improve health coverage, reduce out-of-pocket payments and improve sector efficiency, the MoF and Ministry of Economy wanted assurance that the risks of complex health financing reform that required increases in public expenditure and taxes could be managed in such a way that the expected benefits of the reform would indeed be achieved. SAMHI therefore implemented purchasing pilots in two rayons (Yevlakh and Mingechevir) covering a population of 229 900 people, followed by a third (Agdash) a year later to make the case for reform. The pilots were evaluated independently and they showed promising results in the areas of improved access to and utilization of services, increased productivity of health facilities, reduced financial burden of patients, higher salaries for health workers, and increased population and health worker satisfaction. Based on the good results seen in the pilots, the Government of Azerbaijan agreed to roll out mandatory health insurance and purchasing reforms nationwide from 2020. The design and experience gained in these pilots also provided practical lessons in how to implement nationwide roll-out, such as the need to appoint strong hospital managers and provide advice and support to providers to adapt to new contracts and payment methods, the need for monitoring to ensure salary increases for workers were accompanied by reductions in requests for out-of-pocket payments from patients and the need for optimization of services and the provider network.

a. The information presented in this box is based upon an unpublished study by the World Bank in 2018 entitled *An Assessment of the Mandatory Health Insurance Pilot in Azerbaijan: Issues and Options for Scaling Up and Sustainability*, which was distributed to the Azerbaijan authorities and relevant partners.

3.5. Monitoring and review cycles

Most countries with health strategies or health financing strategies have a more-or-less formal process of monitoring/review of the strategy, but there is not always clear assignment of responsibility, time frame, and follow up of delays or failures of implementation. In some countries, the review cycle is largely driven by development partners but not owned by successive Ministers of Health nor connected to the accountability mechanisms to motivate or sanction the purchasing agency (and other implementation agencies) to deliver. In more successful cases the monitoring and review cycle is linked to the accountability structures and mechanisms for the purchaser and other implementation agencies (discussed in Section 5 below). In these countries, the purchaser's oversight body and mechanism play a role in driving strategy and ensuring implementation.

3.6. Policy recommendations for strengthening governance at health system level

The health purchasing agencies in the three study HICs have been able to use their advantage of sustained high levels of economic growth (on average) over the last twenty years to achieve progressively more ambitious goals. The countries each show some similarities in their drivers of reform, such as a growing role of civil society and broader stakeholder engagement, and the use of health needs analysis and evidence to inform and review strategies. All three HICs use formal strategies and monitor and review them in a systematic cycle. They have also been able to use political opportunities and external financial support alongside strategic purchasing to push forward some challenging structural reforms, either in a steady incremental process or in periodic big pushes for progress.

While most MICs were able to make a step increase in health financing to launch change at the beginning of reform implementation, and a few have been able to use coordinated external support for some structural change, they have generally had difficulty sustaining progress – particularly the LMICs. There was wide variation among the MICs in the drivers and barriers for developing strategy, achieving and sustaining ownership of the strategy in place, translating it into well-sequenced implementation plans, and institutionalizing monitoring and review. Unstable policy, strategic and economic conditions accounted for some of the barriers, but some countries found ways of making progress in some areas of health financing reform, and for some periods of time in spite of these challenges. Recommendations for strengthening governance at the health system level derived from these experiences are summarized below.

Recommended action to achieve coherent policy design, implementation, and evaluation

- Use evidence and expert analysis and advice to develop the Health Reform vision and to develop and update national health strategies directed at meeting national health goals to make it easier to defend to different governments, ministers and the public over time as has been done in the HICs, Georgia's 2013 reforms, Kyrgyzstan's cycle of national strategies and in recent reformers.
- Institutionalize regular monitoring, with reviews/evaluations/impact assessments of health and health financing strategies, with a linkage to the accountability framework for the purchasing agency (and other agencies responsible for implementation). Use periodic reviews/evaluations of system performance, with independent input from non-governmental institutions and experts to challenge/motivate the system to better performance as has been carried out in Estonia and Lithuania as well as in Kyrgyzstan's reviews and evaluations in earlier phases of reform.
- Ensure coordination among development partners over policy advocacy and allocation of aid, and align these with local strategy and build support among local experts to ensure ongoing ownership as in Kyrgyzstan's SWAp experience.

Recommended action to align policy objectives with the budget

- Mobilize a (sustainable) step increase in public financing for health at the outset of reform if possible; use the opportunity of increases in resources to make structural change and use evaluation to demonstrate the benefits of this change to doctors, patients and policy-makers, as has been done in Azerbaijan, Estonia, Georgia (in 2013), Kyrgyzstan, Lithuania and the Republic of Moldova.
- Maintain a realistic/credible level of funding for the benefits package through sustainability analysis, more transparent and evidence-based methods in its development and tariff and budget formulation to match needs; or through actuarial formulaic methods where conditions are stable enough; or through expenditure targets (for maintaining general government expenditure, fully executing the budget, allocating adequate share to essential non-wage care costs (e.g. medicines)); or through setting a high payroll contribution rate as the main source. Country examples where realistic funding has been obtained include Estonia, Lithuania and the Republic of Moldova.
- Transition to accountability for delivery of a credible benefits package by phasing out unrealistic funding and tariff levels for priority services if the whole benefits package is unaffordable and it is not feasible/acceptable to ration transparently – but note the importance of sustaining the realistic tariff over time and monitoring to ensure out-of-pocket payments are reduced. Country examples of this challenge include Armenia and Ukraine.

Recommended action to achieve prioritized and sequenced reform implementation

- Transition to accountability for delivery of health sector strategy results by developing some strategic purchasing interventions and include a focus on key health goals (e.g. aim to reduce NCD burden) from the outset of reform (even if on a small scale) to set direction for institutional development and governance for strategic purchasing as was done in Ukraine.
- Develop a transparent, evidence-based service delivery model for the right services to address disease burden – to inform/drive strategic purchasing as in the HICs.
- Transition to joint accountability for results by piloting multipillar reform in regions with good prospects for implementation, including prior investment in infrastructure, equipment and training; using evaluation to make the case for rolling out nationwide reform as has been done in Azerbaijan.

4. Governance of the purchasing agency

4.1. Autonomy and lines of accountability

The most common model for purchasing agencies among the 10 countries is that the purchaser is a separate legal entity, accountable to the MoH or accountable to the government/President via the MoH, and with autonomy over technical and operational matters. When a purchaser is referred to as autonomous in this document, the meaning is that it is a separate legal entity, has its own budget, and has clear authority in law and regulations to carry out specified functions, including that of proposing, advising on and implementing health purchasing policies. This model has been stable for more than 20 years in a number of countries.

Typically, among the 10 study countries, autonomous purchasing agencies do not have the authority to make decisions on the aggregate level of their expenditure or contribution rates – which are subject to the MoF, government and legislative approval in all countries. In countries where the purchaser is financed mostly or wholly from transfers from the state budget, the MoF may also have the right to approve allocation of the purchaser budget to a few broad categories of services. However, autonomous purchasers have considerable influence and flexibility over the allocation of its budget to particular services and contracts and highly autonomous purchasers are also able to initiate or propose health financing policies; analysing and advising the MoH on financing aspects of policy proposals and designing operational details for implementation. These highly autonomous purchasers commonly have authority over contracting – subject to certain criteria and processes approved in regulations. Countries vary as to whether they give the purchaser the function and authority to decide on provider payment methods and set tariffs and reimbursement rates. In some countries, the MoH and MoF approve provider payment methods and tariff policies and rates, based on technical proposals and analysis from the purchaser (see Table 4.1 on decision rights of purchaser). Many country interviewees expressed the view that the form of purchaser autonomy described above makes the country better placed to develop strategic purchasing.

Conversely, overregulation with too much control of the purchasing agency inhibits the development of strategic purchasing. For example, a lack of sufficient flexibility for the purchaser in contracting is found in some countries, with legislative provisions that prevent selective contracting or the proactive setting of the volume and mix of services in contracts.

Six of the 10 study countries have subordinated their purchasing agency to the MoH, or to the government via the MoH (or in the case of Georgia, the ministry responsible for health; the Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs). Subordination and accountability to the MoH does not necessarily mean direct day-to-day control over the purchaser's functions or loss of technical and operational autonomy, though in practice this is the situation in Armenia and Georgia. However, where the MoH owns most or all of the public providers and also oversees the purchaser, the purchaser-provider

split is less clear and the Ministry faces conflicting objectives (to ensure efficient purchasing, but also to ensure viability of the public provider network). Estonia's purchaser, EHIF, is perhaps the most autonomous of the 10 countries, and is formally subordinate to an SB. Because the SB is chaired by the Minister of Health, the MoH can exercise a significant steering role through the SB, but in a forum that also brings together the influence of the MoF, employers and beneficiaries.

The position of Kyrgyzstan's MHIF was formally subordinate to the government rather than the MoH until 2021, but the MHIF requires the MoH's approval (and sometimes that of the MoF) on any policy or administrative matters that require regulation or legislation. The MoH is also the Deputy Chair of the MHIF's SB. In 2021 the government subordinated the MHIF to the MoH as part of wider Government restructuring of agencies, though the MHIF management team members retained their seniority. In practice, Kyrgyzstan's MHIF was less autonomous than EHIF prior to this recent change – indicating that formal subordination does not determine autonomy – autonomy depends on the allocation of functions and decision authority to the purchaser. In Kyrgyzstan's case, the division of responsibility between the MHIF, MoH and MoF was less clear than in Estonia.

Four countries began with a more independent purchaser, subordinate to the government or President, but later subordinated the purchaser to the MoH either as part of wider public administration reforms of government agencies or, in one country, in response to corruption on the part of the purchaser.

Table 4.1. Status of purchasing agency

Notes: Countries differ in terminology used. Purchasers are legal entities in all countries except Armenia. Estonia appears to have the highest degree of autonomy in law and practice. It is difficult to assess the formal level of autonomy without detailed legal analysis, looking not only at the purchaser's own law but at other organic laws that apply to it.

Country group	Country	Name	Year of purchaser establishment (year of implementation)	Legal status as of now	Line of accountability
MICs with recent reforms	AZE	SAMHI	2007 (nationwide 2021)	Autonomous state legal entity	President
	UKR	NHSU	2018	Legal entity (central executive body) operating under public law	Government (via MoH)
	UZB	State Health Insurance Fund	2020 (pilot in 2021)	Autonomous state legal entity	SB and President
MICs with long-established reforms	ARM	State Health Agency	1997	Subdivision of the MoH	MoH
	GEO	National Health Agency	2020 (2013–2020 under the Social Service Agency)	State agency – legal entity	MoH
	KGZ	MHIF	1997 (nationwide 2005)	Independent semi-governmental organization – legal entity	Government (via the MoH and MoF) until 2021; MoH since Feb. 2021
	MDA	National Health Insurance Company	2001 (nationwide 2004)	Autonomous state legal entity	Government, with roles for the MoH in policy and some implementation rules
HICs with long-established reforms	EST	EHIF	1992 (current legal status 2001)	Autonomous legal person in public law	SB
	LVA	National Health Service	2011	State agency – legal entity	MoH
	LTU	National Health Insurance Fund	1992 (current legal status 2003)	Public authority established under the Law – legal entity	MoH

Interviewees from four countries expressed the view that subordination of the purchaser to a MoH with a substantial role in the ownership of health facilities can make it more difficult for the purchaser to pursue strategies for paying providers (particularly hospitals) for outputs and results, rather than inputs, because of political pressure to support loss-making providers rather than rationalizing the provider network – though this is acknowledged to be a hard political task in any country. The purchaser can support this task but cannot lead or drive it. Rationalizing the provider network usually requires MoH or wider government leadership, parliamentary support and wider constituency building. On the other hand, subordination to the MoH may make it easier to coordinate purchasing decisions with service delivery and development decisions, and other pillars of the health strategy.

Some countries have experienced recurrent debate and conflicting views over the subordination of the purchasing agency to the MoH. Where there is recurrent conflict between the MoH and the purchasing agency over subordination, progress stalls on the development of the purchaser and strategic purchasing. Problems may arise where there is functional fragmentation and unclear or overlapping roles between the

MoH and purchasing agency, which contributes to conflict and unhelpful competition. This can lead the MoH to obstruct or delay the adoption of improved regulation for purchasing policies needed by the purchaser in order to make progress in strategic purchasing.

Informants indicated a number of dysfunctional patterns to avoid in the respective roles and the subordination relationship between the MoH and the purchasing agency.

- **The purchasing agency takes on the role of a policy authority**

In some countries the purchasing agency was under pressure to take on policy roles, which should normally belong to the MoH, because of a lack of engagement by the MoH in health financing reform, or slow progress in complementary policy areas such as quality and safety standards, development of service delivery models or medicines policies. The risk over time with this is that the purchasing agency can be blamed for political decisions, rather than acting as a technocratic and operational agency. In some countries the purchaser was perceived by the MoH to be exceeding its mandate.

- **Giving the MoH no formal stewardship role over an independent purchasing agency**

There was support across many countries for giving the MoH a clear and formal role in health financing policy; setting strategic objectives for the purchaser and overseeing performance. Where the purchaser is relatively independent, the MoH needs this formal role to be able to exercise health system governance and stewardship at the system level. Where the purchaser is directly subordinate to the MoH, clarifying and formalizing roles and working practices is desirable – to avoid the risks associated with micromanagement. One country recommended that it is desirable to have the Minister of Health as Chair or Vice Chair of the SB of an independent purchaser to avoid this risk.

- **MoH applies hands-on management to the purchasing agency**

This is the opposite situation to above, where the MoH manages the purchaser's operations on a day-by-day basis rather than stepping back to focus on policy, strategy and performance (supported by data and analysis) and leaves the purchaser with a very narrow operational role with no autonomy or even influence over most purchasing decisions (see Table 4.2 for further details on decision making authority for health purchasing). In the small number of countries of the 10 where this applies, the MoH is the purchaser in reality, and the purchasing agency cannot be held responsible for strategic aspects of purchasing. Interviewees suggested this pattern of interaction developed in situations where the MoH or wider government had low trust in either the capacity of the purchaser or its integrity, leading to too much regulation and control of the purchaser. Two countries referred to periods of corruption in the purchaser leading to mistrust and this excessive control by the MoH or MoF.

In some countries, this hands-on approach was a feature of the earlier stages of implementation, where the MoH itself was under great political pressure to ensure rapid and successful implementation of reform. But over time, it can lead to unclear, overlapping roles between the MoH and the purchaser, conflict, politicization of purchasing decisions, and the lack of development of purchaser capacity and strategic purchasing.

The most independent purchaser in our study – EHIF – has an SB which has substantial decision authority at the SB level, and more circumscribed decision authority at the management level. Decisions on health financing policies and aggregate annual expenditure (i.e. the benefits package and use of reserves) are made by the Government. Decisions on contribution rates are discussed at Social Partners' Association meetings by the Government, employers and employees and decided by Government and Parliament. Even where EHIF does not have authority, it plays a role in conducting analysis and formulating policy recommendations.

- Under its SB, it has the authority to make policy recommendations on health financing policies and regulations to the Government via the Minister of Health and Labour, including on the benefits package, payment methods and tariffs.
- The SB can and does commission sustainability studies and make representations based on these to the MoSA which inform Government discussion with social partners of contribution rates and budget contributions (see Box 2.2 above).
- Under its management board, EHIF has also authority to make decisions on contracting.

EHIF's board composition and decision-making processes by design have an equal balance of interests between those traditionally opposed to budget expenditure increases (the MoF and employers), and those traditionally advocating to increase the scope or depth of coverage or the covered population (MoH, beneficiaries). The EHIF SB composition appears to lead to a strong focus on efficiency measures to make the best use of EHIF funds in the short to medium term (see Box 4.1 below for further details on EHIF SB decision rights). An important feature of EHIF's governance structures in its stability over time is that roles, functions, and decision authorities of SB and management, and the decision authorities of the MoSA, MoF, Government and Parliament are clearly set out in legislation.

Box 4.1. Estonia: SB composition, chairing and decision rights

The EHIF SB composition and tasks are regulated in the Estonian Health Insurance Fund Act and EHIF statutes. EHIF SB includes six members:

- two state representatives: the Minister of Health and Labour^a and the Minister of Finance;
- two employer representatives: at the proposal of the Estonian Employers' Confederation and appointed by the Government; and
- two beneficiary representatives: one member at the proposal of the Estonian Trade Union Confederation and one member at the proposal of the Estonian Chamber of Disabled People and appointed by the Government.

The Minister of Health and Labour is the Chairman of the Board by virtue of office. The members of the Board shall elect a Deputy Chairman from amongst themselves. The Minister of Finance is appointed *ex officio*, with the remaining board members appointed for three years with a one-time possibility of re-election. There are strict requirements for SB members to avoid conflict of interest; for example, there is a neutrality requirement which entails that SB members cannot have any connection to organizations related to health service delivery, pharmaceuticals or medical devices, and they need to have good reputation and necessary knowledge to fill the position.

In 2018 the EHIF SB formed a permanent advisory committee on strategic issues in the development of the EHIF to get direct feedback from interest groups about plans and upcoming decisions. There are nine members in the committee, with representatives from health-care provider associations and medical, nurse and family practitioner associations as well. This committee meets a few days before the EHIF SB meeting and gives opinions about upcoming decision drafts.

The SB approves organizational matters, strategic documents, business processes and objectives, including:

- the EHIF's four-year development plan, annual budget and regular reports;
- maximum waiting times;
- selection criteria for contracting;
- changes in the structure of EHIF;
- selection (or removal) of the chairman of the management board and management board members;
- remuneration of EHIF management; and
- the designation of an auditor.

a. In Estonia, for some periods, the MoSA has two minister positions – minister of health and labour and minister of social affairs. During these periods when the MoSA has two minister positions, the minister of health and labour is the chair of the SB. When there is one minister position, the Minister of Social Affairs is the SB chair.

The SB also makes recommendations on health financing policies and the draw-down of EHIF reserves to the Government through the Minister of Health and Labour for approval. The SB is consulted before the Government may borrow from EHIF mandatory reserves.

The SB has to meet at least once every three months, but in practice, the meetings are held mostly on a monthly basis. EHIF management prepares meeting materials and must submit them to board members at least one week prior to the meeting. The SB decisions are publicly available on the EHIF website.

Prior to 2018 September, the SB used to have 15 members with similar tripartite representation of state, employer and beneficiary representatives. It was also allowed to have health-care providers and stakeholders with interests among SB members. This larger membership guaranteed a broader representation of different viewpoints and values, but it was determined that it was more difficult for management to find sufficient support for its proposals. The decrease in SB members increases the risk of a pro-private provider orientation if the elected government (the MoSA and MoF) is also pro-private.

Some of the interviewees emphasized that the level of purchaser autonomy needs to take country context into account. They recommended caution about giving the purchaser high autonomy in countries with low capacity, a context of weak PFM and weak governance in the wider public sector, poor rule of law and poor control of corruption. They also point out the need for the country to have a framework for ex post accountability with a focus on results, as an important pre-condition for giving the purchaser the kind of autonomy under an SB seen in, for example, Estonia.

Table 4.2. Decision-making authority for health purchasing

Country group	Country	Annual budget	Benefit package	Provider payment methods	Provider payment rates	Contract terms
MICs with recent reforms	AZE	Parliament	Government	SAMHI	Government	SAMHI
	UKR	Parliament (one line), Government (detailed)	Government	Government	Government	Parliament (principles), Government (detailed regulation, sample contract)
	UZB	Cabinet of Ministers	President (principles), MoH	President (principles), State Health Insurance Fund SB	President (principles), State Health Insurance Fund SB	President (principles), SB (contract terms)
MICs with long-established reforms	ARM	Parliament (by programmes)	Government	Government	Government	MoH
	GEO	Parliament	Government	Government	MoH	Government
	KGZ	Parliament (separate budget law)	Parliament (broader level), Government (health services), MoH (outpatient medicines)	Government	Government	Government (template), MoH (input norms), MHIF (volumes, subsidies to deficit providers)
	MDA	Parliament (by programmes, separate budget law)	Parliament (broader level), Government (detailed)	National Health Insurance Company and MoH	MoH and National Health Insurance Company joint order, Government (medical staff salary level)	Government (sample contract), MoH and National Health Insurance Company joint order
HICs with long-established reforms	EST	Parliament (one line), SB (detailed)	Parliament (broader level), Government (health services), EHIF (outpatient medicines)	Government	Government, MoH (methodology)	Parliament (principles), SB (selection criteria), Management Board (contract terms, financial part)
	LVA	Parliament	Government	Government	Government	Government (principles), NHS and MoH
	LTU	Parliament (separate budget law, broader level) Compulsory Health Insurance Council (detailed)	Parliament (broader level), MoH (detailed)	MoH	MoH	MoH (general rules), Director of the National Health Insurance Fund

4.2. Oversight

Where purchasing agencies are subordinated to the MoH or accountable to the government via the MoH, the primary responsibility for steering and monitoring purchasing agencies rests with the MoH. This is the case in all countries except Azerbaijan, Estonia and Uzbekistan, where oversight is carried out by the SB (Estonia, Uzbekistan) or an informal inter-ministerial committee (Azerbaijan). In addition, the general laws governing PFM and public administration, and sometimes provisions in the law governing the purchaser, usually give specific responsibility to the MoF in oversight of revenues and expenditures. In Estonia and Azerbaijan, the Minister of Finance or the MoF representative is a member of the SB or interministerial committee and exercises financial oversight in this forum. The MoF's role in monitoring purchaser budget execution is greater in

countries where the purchasers are substantially or wholly financed from taxation, and especially in countries where the MoF uses the Treasury account system to ration or prioritize cash disbursement when the government is facing a shortfall of revenues (see Chapter 2 for examples).

Kyrgyzstan's MHIF has three-way accountability to the MoH, MoF and an SB, however, the SB plays a relatively limited role in approving matters that are not regulated by law or regulation. The MoH and MoF play a much more powerful role in approving MHIF proposals on matters that are regulated by law and in approving budget formulation, overseeing budget execution and collecting programme budget performance indicators for the MHIF.

Among the 10 countries, only Estonia has an SB that has functioned effectively as the primary governance body of the purchasing agency over the long term. In this case, as discussed above in more detail in Box 4.1, the Minister of Health chairs the SB, the Minister of Finance is also on the SB and they use the SB as the forum in which to discuss EHIF management team's proposals for both matters governed by law and those delegated to EHIF. For example, the respective roles of the MoH, MoF and Cabinet of Ministers (CabMin) in approving policy proposals on the benefits package and the use of reserves are set out clearly in statute. Interviewees indicated that it has been important that the MoH, MoF and CabMin are self-disciplined in following the decision-making processes set out in law and regulations, which delegate certain responsibilities to the SB, and do not intervene in management of the EHIF outside SB business processes.

Apart from in Estonia and Lithuania, in the established purchasers that have, or have had, an SB, the SB has lacked effectiveness often due to a cultural context of personalized accountability to the President/PM (i.e. to the person who appointed the CEO of the purchaser), which leads to informal decision processes that bypass the SB and are less transparent. If this accountability relationship is too informal and personal, it can be dependent on individual personalities, leading to clashes when personalities involved change. Alternatively, the accountability relationship may be influenced by non-professional aspects such as social standing and clan-based/local relationships, increasing the risk of poor governance decisions, for example, the risk of appointment of less capable and experienced leadership in the purchaser. Direct personalized accountability of the purchaser CEO to the President/PM has benefits in driving initial reform, but interviewees from several MICs with long established reforms noted that it can lead to risks later as leadership changes and as Presidential/PM priorities change over time.

Other factors mentioned in interviews with representatives from smaller MICs were a lack of suitable governance models in the country, lack of people with appropriate skills and board experience, and multiple lines of accountability (e.g. legislation and regulations in Kyrgyzstan were not amended to give the SB clear authority or define its role in decision-making processes vis-à-vis the MoH and MoF – leading to duplication of oversight and accountability processes).

All countries with experience of SBs noted the challenges of managing conflict of interest and balancing interests among members, of engaging

passive members (a particular challenge with civil society organization/beneficiary representatives) and of the low health sector knowledge of some members.

In several countries where the purchaser is now directly accountable to the MoH or accountable to government via MoH (Latvia, Lithuania and Ukraine), there is an Advisory Council that advises both the purchaser and the MoH, monitors the purchaser and is consulted on health financing policy. These advisory councils can provide a means of consulting stakeholders and building some consensus among stakeholders, while avoiding the conflict of interest that would result from putting some stakeholders on an SB. One country (Ukraine) designed its purchaser with a Public Control Council of civil society representatives to provide oversight, with a focus on transparency. This Council is free to speak publicly and publish findings, but without a formal role in governance. EHIF also has an advisory council made up of stakeholders, which advises the SB and management team. Some of its members are health-care provider stakeholders who used to be members of the SB, but in order to avoid a conflict of interest, with the SB as a governance body, it was decided to put these representatives on a separate body without a formal governance role, which the EHIF can use for stakeholder engagement (see Box 4.1 above and Table 4.3 below).

Table 4.3. Oversight bodies

Country group	Country	Supervisor/ Advisory body	Role of board	Appointment of governing body chair	Term of governing body chair	Appointment of governing body members	Term of governing body members (fixed/not/ex officio)	Monitoring of financial reports
MICs with recent reforms	AZE	No. Transitional interministry group chaired by the President's Health Advisor appointed by President						President's office, Cabinet of Ministers, MoF
	UKR	Public Control Council of civil society representatives	Advisory	Council elects the Chairman from their composition by a simple majority vote	Two years	Government based on public internet-based voting	Two years	MoH
	UZB	SB	Supervisory	First Deputy Advisor to the President	Ex officio	Government	NA	SB
MICs with long-established reforms	ARM	No						MoF, MoH
	GEO	No						MoH
	KGZ	SB	Advisory	Vice Prime Minister	Ex officio	Government	Ex officio	MoH, Government
	MDA	Administrative Council	Advisory	Usually the State Chancellery representative	Ex officio	National Health Insurance Company director in line with the Government regulation	Four years (one time re-appointment possibility)	Administrative council, Government
HICs with long-established reforms	EST	SB, six members (two state, two employer, two beneficiary)	Supervisory	By EHIF law, Minister of Health	Ex officio	Procedure is defined by EHIF law, Government appoints	Ministers of Health and Finance – ex officio Employers and beneficiaries representatives for three years (one time re-appointment possibility)	SB
	LVA	Yes. National Health Service Advisory Body	Advisory					MoH
	LTU	Compulsory Health Insurance Council of stakeholders	Advisory	Elected amongst the members (mostly MoH)	Two years (one time re-election possibility)	MoH Order	Two years (one time re-election possibility)	MoH

4.3. Accountability mechanisms

An accountability framework defines what goals and requirements the purchaser is accountable for, how purchaser performance is monitored – the monitoring framework (i.e. indicators and periodicity of reports) – how internal control and compliance with regulations is ensured, and what the incentives or sanctions on the purchaser management are to avoid, or in the case of, shortfalls in performance or non-compliance with regulations. The monitoring framework ideally should contain a balanced set of indicators (e.g. access indicators like waiting times, efficiency, and expenditure control indicators) to encourage optimal trade-offs within available resources. Transparency requirements are part of the framework as are internal and external audits. The processes and criteria for the appointment, and dismissal, of the purchaser CEO and senior management team and the performance assessment system for purchaser staff should also ideally be linked to the accountability framework and form an important part of the incentives and sanctions regime. Accountability of the CEO and agency is weakened where CEOs are subject to frequent turnover and at risk of arbitrary dismissal unrelated to attributable performance – such as dismissal based on punitive, populist approaches to accountability. Among the 10 countries, most of these elements of an accountability framework were present in the three HICs, and many are present or under development in Ukraine, but the accountability framework is so far patchy and incomplete in the other MICs under study.

In more autonomous purchasers with an SB, the SB plays a central role in defining and operationalizing the accountability framework for the management and staff of the purchaser, while the SB itself is accountable to the government and stakeholders. A pre-condition of the effective and fruitful operation of a more independent purchaser, is a clear division of roles and decision-making authority between the MoH (or equivalent policy and regulatory body) and the purchaser as an executive, operational agency. Purchasing agencies that are subordinated to the MoH and less autonomous may feel less pressure over their performance from stakeholders, who tend to lobby/engage with the MoH or government. Less autonomous purchasing agencies, subordinated to the MoH, lack external pressure for accountability from politicians, the public and the governance body to overcome inertia and risk-aversion. Subordinate, non-autonomous purchasing agencies can more easily shift responsibility to the MoH. By contrast, stakeholders tend to have a more direct engagement with more independent purchasing agencies (via representation on the SB, patient and provider complaints systems, and consultation and negotiation over how to address challenges in health service provision), so the purchaser is under pressure from these sources to be effective and to defend its actions publicly. This means that for subordinated purchasing agencies with reasonable autonomy, the MoH has to take responsibility not only for oversight but also for motivating/driving the purchaser's performance through the accountability framework. This can work and is demonstrated to varying extents in Latvia and Lithuania and is progressing in Ukraine. However, in other MICs with weak and patchy accountability frameworks, the MoH's approach to driving purchaser performance more often involved

hands-on intervention and lower purchaser autonomy (e.g. in Armenia, Georgia and the Republic of Moldova).

Countries vary in what it is that they hold the purchaser accountable for, and what they monitor. Many interviewees from the studied MICs stated that oversight focuses on expenditure control (by the MoF), compliance with laws and regulations (by the MoH, MoF and various inspectorates) and monitoring of a number of output indicators (such as volume of cases or consultations). There is often a lack of monitoring and accountability for progress on the implementation of strategic goals and policies. For the two purchasers with very little autonomy and a very narrow implementation role, the purchaser does not have any strategic goals and is accountable only for compliance with budget execution rules and regulations.

MICs vary as to whether: the purchasing agency has a clear and balanced monitoring framework; their reporting addresses results relative to strategic goals or is focused narrowly on finances; their oversight body/agency actively reviews reports; and their reports are published. The HICs have well developed frameworks, but the least autonomous purchasing agencies (in Armenia and Georgia) have the most limited reporting and weakest public accountability, with oversight largely focused on PFM process compliance.

The HICs have been able to develop result/outcome indicators (to a varying extent) as part of the suite of performance objectives and measures for the purchasing agency and its strategic plan; and a monitoring framework that looks at both outcomes and expenditure control, which helps to drive strategic purchasing (as is the case in Estonia and Lithuania). In Estonia, EHIF sets objectives and reports to its SB using some result indicators, including a balanced set of measures of access and efficiency. The SB uses these alongside financial and output indicators in holding the management of the purchaser accountable (see Box 4.1 above and a published case study (Savedoff et al., 2008)). MICs have mostly found it difficult to introduce results-oriented monitoring or have not attempted it. Ukraine and Kyrgyzstan have begun to develop some result/output-oriented indicators for the purchaser in the context of programme budgeting reforms but interviewees noted that their indicators so far are not ideal and the use of programme budgeting indicators as part of accountability frameworks is not yet well developed – they are used primarily to inform the legislature. Ukraine is currently working on the development of its own monitoring framework to complement its organizational strategy.

Representatives from three countries (Estonia, Lithuania and Georgia) report the benefits of having a reformed state external audit body that focuses on broad based performance – i.e. on strategic and policy issues, results and value as well as carrying out a financial audit. At the other end of the spectrum, representatives from Kyrgyzstan report a negative impact of external auditors/inspectorates/prosecutors, which focus on input and compliance audit with little understanding of the goals and mechanisms of strategic purchasing; this also imposes very heavy compliance burdens on the purchaser and public providers.

Some MICs still lack timely and transparent information on purchasing agency expenditure, revenue and reserves, which is needed to enable monitoring by Parliament and civil society and analysis and review by independent academe. A commitment to the timely transparent publication on their website of all financial and non-financial reports and procurement documents, as well as the publication of data, has been helpful to Ukraine’s purchaser, as a means of establishing its reputation with government ministries (such as the MoF) and civil society (see Box 4.2 for the example of transparency provisions in Ukraine). Table 4.4 below summarizes the monitoring, reporting and performance framework in the countries studied.

Table 4.4. Reporting and auditing arrangements for purchasing agencies

Country group	Country	Publicly available annual reports	The responsible entity for monitoring activity/ performance	Internal audit	External audit
MICs with recent reforms	AZE	Yes	President’s office	Yes	Yes (commercial independent audit firm selected by SAMHI management and Chamber of Accounts of the Republic)
	UKR	Yes	NHSU public control council	Yes	Yes (State Audit Service and Accounting Chamber)
	UZB	No	No	Yes	Yes
MICs with long-established reforms	ARM	No	MoH	No	Yes (only state audit on state budget execution)
	GEO	No	MoH	No	Yes (only state audit on state budget execution)
	KGZ	No	No	Yes (but transferred to MoF in May 2022)	Yes
	MDA	Yes	Government	Yes	Yes
HICs with long-established reforms	EST	Yes	SB	Yes	Yes (the commercial audit firm selected by the SB Audit Committee audits financials, periodic thematic audits by State Audit body)
	LVA	Yes	MoH	Yes	Yes (only state audit on state budget execution)
	LTU	Yes	MoH	Yes	Yes (State Audit body)

Box 4.2. Ukraine: Enhancing transparency to tackle corruption

When the National Health Service in Ukraine (NHSU) was established as a single purchaser in Ukraine, the anticipation was to strive for a high level of transparency to tackle the risk of corruption in the health sector. One of the key principles to enhance transparency is to make information about contracting and payment widely and conveniently available. In order to achieve this, multiple mechanisms are used.

- All contracts with providers are published on the NHSU website.
- Impersonal open data about the implementation of the Program of Medical Guarantees (PMG) is made available on their website to encourage the wide use of data to enhance accountability and to create various applications and services (NHSU, 2022a).

The NHSU annual reports include information about the key strategic activities and implementation of the PMG and are made publicly available on the NHSU website (NHSU, 2022b).

- User-friendly data dashboards are created for monitoring PMG implementation and provider performance. For example, dashboards on PHC performance indicators were made publicly available in early 2022 (NHSU, 2022c).
- During the first year of the reform, the NHSU conducted daily briefings on Facebook about the contracting process and details of benefit packages targeting health-care providers and patients. Later, daily briefings were replaced by weekly briefings.
- The NHSU Academy was established under the NHSU with the main function of training health-care managers and health professionals. As of January 2022, the NHSU Academy has about 150 000 registered users, with nearly 75 000 doctors having completed the training course on clinical coding related to the introduction of the diagnosis related system (NHSU, 2022d).

Since the invasion of Ukraine on the 24 February 2022, the NHSU and providers have had to make several adjustments to business processes for contracts, payment and reporting, but the availability of information and transparency continue to be important for the NHSU and the country in general.

In Estonia, the SB has a performance agreement with the purchaser's CEO and senior management team, which incorporates output, process and result indicators. EHIF staff are paid bonuses which depend on the achievement of agreed performance goals. Azerbaijan, Lithuania and Uzbekistan have agreed work plans with time-bound actions and indicators, defined in either Presidential resolutions (Azerbaijan, Uzbekistan) or

agreements with the purchaser (Lithuania) which are used to drive the implementation of the government's health financing strategy and policy commitments, creating accountability for the government's reform programme or strategy implementation. In Azerbaijan and Uzbekistan, accountability is currently focused on the achievement of milestones in the early implementation of reform (nationwide in Azerbaijan, but still at the pilot stage in Uzbekistan).

Reformed public administration systems for state agencies provide part of the basis for the accountability framework in some countries where the purchaser does not have an SB. Ukraine uses performance agreements with the purchaser's CEO (under state legislation for all state executive agencies) and the CEO can be dismissed based on a lack of performance against this agreement. Lithuania has a performance management system for all purchaser management and staff, under a general framework applied throughout the public sector. Future promotion and associated future increases in pay are influenced by these performance assessments. Where these indicators are based on realistic plans and aligned to the government's health strategy, they can be effective in securing accountability for strategy implementation. Representatives from both Lithuania and Ukraine see a need for more development of result indicators (see Box 4.3 below on performance agreements in Estonia, Lithuania and Ukraine).

In countries where the purchasing agency CEO is at risk of dismissal for political reasons whenever the government or Minister of Health changes, this creates conditions where accountability of purchaser staff and pressure to work effectively toward organizational goals are weakened.

Box 4.3. Estonia, Lithuania and Ukraine: Performance agreements with managers and staff

In Estonia, the EHIF SB agrees on performance objectives for the CEO and his/her deputies. On the basis of review of performance against these objectives, the SB approves bonus payments, with EHIF staff also receiving bonuses. The objectives include result indicators, such as measures of improved access, in addition to outputs or tasks to be completed.

The Director and staff of Lithuania's National Health Insurance Fund are civil servants. Under a civil-service-wide performance appraisal system, all staff agree performance objectives with their manager at the beginning of the year and their performance is appraised at the end of the year. While there are no bonus payments, a good performance appraisal can lead to faster progression through the pay scale and a higher likelihood of promotion. The Director of the National Health Insurance Fund also agrees annually with the Minister of Health the one-year operational plan for the organization, with defined objectives and performance indicators. The setting of objectives is linked to the electoral cycle, to translate the platform of the newly elected government into a plan of action. The MoH reviews performance and progress towards these objectives each year. The indicators used are mostly outputs and tasks to be accomplished. The state audit body conducts annual performance audit which encompasses more than just financial performance and reviews the effectiveness and achievement of system-wide objectives.

Ukraine is the only study MIC that has a system of annual performance agreements for the head, deputy heads and staff of its purchasing agency, NHSU. All civil servants have their performance agreement, and for the NHSU Head and deputy heads it is signed by the Minister of Health and sent to the Cabinet. As in Lithuania, this is a requirement by civil service law for all public sector organizations in Ukraine, and it is clearly linked to the implementation of the Government's policy programme. The system is still at an early stage; indicators are not yet overly results-oriented and some unrealistic objectives are sometimes imposed. Our interviewees suggested a need for a more participatory and transparent process for agreeing on objectives. For 2021, the objectives of the NHSU head were:

- to develop the PMG (the benefit package) for 2022 based on analysis and forecast of health needs of the population;
 - to calculate the expected revenues of the providers for each package of care to make a further analysis of the provisions of the President's Order on the basis of an expected salary of 20 000 Ukrainian hryvnias for doctors and 13 500 Ukrainian hryvnias for nurses and to take into account these expected salaries when defining the provider payment rates for 2022; and
 - to introduce coefficients into the price tariff for hospitals that are used for teaching interns.
-

4.4. Policy recommendations for strengthening the governance of purchasing agencies

There is consensus on the need for the MoH to have a clear role as the lead health policy agency and in stewardship over the purchaser, but there is also consensus on the benefits of giving the purchaser independence as a technical and implementation agency, and to have the autonomy to propose and advise on health financing policies. Formal clarification of new roles is needed to minimize role overlap and conflict between the MoH and purchaser, and the development of a rich body of regulation over time is also needed to help underpin the development of strategic purchasing.

Among the countries studied, there are good examples of more independent purchasers, in which the CEO and management team is accountable to an SB. There are also good examples of independent purchasers that are subordinate to the MoH or to the government via the MoH, but which make use of advisory boards as a forum for consulting stakeholders. Either model can work. The most successful experiences over the longer term with SBs and advisory boards are found in countries where the Minister of Health chairs the board.

There is consensus that it is desirable for purchasing agencies to have a clear accountability framework, and for this framework to focus on strategic goals and results, in addition to outputs, processes and financial control. In practice, most MICs have found it difficult to make progress in developing and implementing systems of accountability for strategic goals and results.

While effective performance review systems for the purchaser CEO and managers (and staff) are often recommended as a way of creating incentives for the purchaser to meet its goals and plans, only two HICs in our study have been able to implement them effectively, in one case as part of a wider public sector system. However, one MIC (Ukraine) is at an early stage of trying to do this. The HIC representatives in our study spoke of the important role of civil society and health sector stakeholders in putting pressure on the MoH and purchaser to improve performance and results. Other countries spoke of the disincentives of environments in which the purchaser CEO and senior management are at risk of dismissal every time there is a change of Minister, particularly where this is a frequent event.

The main recommendations emerging from our country interviews for effective purchaser agency governance, to support and drive the development of strategic purchasing, are summarized below.

Recommended action to achieve autonomy of the purchasing agency

- Give the purchaser some autonomy to initiate and influence health financing policy proposals (for MoH/government approval) and autonomy (decision-making power and flexibility) over operational details of policy and how to implement operational aspects of purchasing, as has been done in the HICs.
- Give the purchaser its own budget, ideally with a functioning multiyear framework and with the flexibility to reallocate across particular services and contracts, within a single line or a few broad categories of services as demonstrated by Estonia, Lithuania and the Republic of Moldova.
- Define clear roles and decision-making processes for the purchaser, MoH, MoF and CabMin in policy and strategy regulation, in order to avoid too much autonomy over policy matters, which can lead to conflict and misalignment of strategy (e.g. over quality standards), as has been done in Ukraine, for example.
- Set the level of autonomy and level of control, based on the capacity for governance processes (e.g. reporting, meaningful oversight, internal audit) and the cultural/political context of the country (e.g. transparency and personal/informal approaches to governance processes), as has been demonstrated in the cautious and gradual approach Kyrgyzstan has taken to autonomy, for example.

Recommended action to achieve sound legal framework for strategic purchasing

- Develop a sound legal basis for strategic purchasing and guiding processes (of the purchaser, MoH, MoF, CabMin, legislature and stakeholder representatives) in health financing policy and purchasing, but balance against the risk of rising bureaucracy – with Estonia and Lithuania representing examples of this.
- Ensure some flexibility in the legal framework to respond to genuinely urgent issues without primary legislation (e.g. COVID-19 and war) within defined parameters, but avoid too much flexibility for political intervention to modify the benefits package, resource allocation and contracts (e.g. in response to lobbying by narrow interests), as has been the case in Ukraine, for example.

Recommended action to achieve robust accountability framework

- If the purchaser has an SB, make sure the board members have suitable skill sets and experiences for steering, oversight, accountability and balancing stakeholders, and a statutory basis for its role from the outset with enforced rules to avoid conflict of interest, as has been demonstrated in Estonia.

- Whether the purchaser has an SB or not, define the accountability framework for the purchaser and the roles of the MoH, MoF, CabMin, civil society and advisory bodies. If there is no SB, consider using the PFM and public administration systems if these have been reformed to focus on results, not just financial control and compliance, with Lithuania and Ukraine providing examples.
- Adopt regular monitoring, evaluation and accountability for implementation at the beginning of reform as has been done in Azerbaijan, Kyrgyzstan and Uzbekistan, but do not allow closer monitoring during the initial period to become a permanent pattern of hands-on, day-by-day control.
- Develop and use a rich set of goals and indicators of results, quality, outcomes and impact for the monitoring of the purchaser by the oversight body/bodies and for public reporting – not just finance, process and output indicators, with Estonia and Lithuania providing good examples of this.
- Require transparency from the purchaser (and MoH) in the processes for designing and deciding on the benefits package, tariff and contracting, and commit the purchaser to publish all policies, plans, reports and data, as is the case in the HICs and Ukraine.
- Consider how to ensure that the purchaser feels (legitimate) direct pressure for accountability from citizens, beneficiaries, patient organizations, health professional associations and provider associations to do as much as possible with available resources and has an incentive to make progress on strategic goals, as has been done in Estonia and Ukraine, for example.
- Protect the purchasing agency CEO and senior management from politically motivated dismissal (e.g. through granting civil service status and processes), or including management appointment within the role of the SB, to maintain the agency's reputation as neutral and technocratic, and to retain senior management experience, with Estonia, Lithuania and Ukraine providing examples of this.

5. Cross-cutting conducive factors for effective governance

5.1. Leadership

Some country representatives identified leadership attributes that made a difference to progress in strategic purchasing namely, post stability, competence, health sector understanding and experience, courage and social good-oriented values. In some countries, high standing, through being a member of a respected family/clan, is also important to effectiveness, though obviously, only when combined with the leadership attributes already mentioned. Countries vary in how high the profile of the purchaser director is. Some interviewees attributed strong progress in reform and strategy to a strong, capable, higher-profile director of the purchasing agency. Higher-profile leadership is more common among the more independent purchasers or during periods when the purchaser has been more independent. By contrast, in the two purchasers with very little autonomy, leadership capacity and profile are relatively low.

In countries where the purchasing agency CEO is at risk of dismissal for political reasons, whenever the government or Minister of Health changes (either because of term limits matched to the election cycle, or because of a general practice of political appointments), a loss of institutional memory and established relationships can occur, as well as a passivity and caution about making decisions. It also leads to periods of stasis while there is no permanent appointee in charge. As noted in Section 4, it also weakens accountability for performance. Conversely, civil service status for the purchaser CEO provides stability across changes of government, as seen in Lithuania and can create career path incentives within the wider civil service. Giving an SB responsibility for appointment and dismissal can help to reduce the risk of politicization of these processes, particularly in regard to the CEO, and can align the responsibility of CEO performance review with the responsibility for setting objectives and monitoring oversight of the purchasing agency. Table 5.1 summarizes the appointment responsibility for CEOs of purchasing agencies across the 10 study countries.

Estonia, Latvia, Lithuania and Ukraine have a mandatory public competition for the selection of the purchasing agency CEO, and clear minimum requirements for the appointee are set out in legislation or regulation. However, this process does not require high levels of health sector knowledge and experience in Estonia, nor does it protect the CEO from dismissal when governments or ministers change in Latvia, where the purchaser Director is a civil servant, appointed (following competitive process) and dismissed by the Minister of Health. The MoH is involved in the recruitment process in some way in most countries – either directly as the appointing authority, or via participation in government commissions that conduct competitive recruitment and select candidate short-lists, or via membership of the SB. This involvement should provide a mechanism to bring health sector knowledge to the recruitment process and can also help to mitigate the risks of poor relationships between the MoH and the CEO. However, in some countries the MoH has not been involved in the process, at least in the initial stages of health financing reform, when the MoH may be unfamiliar with the role and functions of a purchaser and the related competencies required, and in some country cases may not be fully supportive of the reform. Some of these countries without MoH involvement in CEO appointment have drawn on Presidential Health Advisers to bring health sector knowledge to the recruitment process.

Table 5.1. Appointment of purchasing agency management

Country group	Country	Appointment of management body chair/CEO/Director	Term of management body chair/CEO/Director
MICs with recent reforms	AZE	President	Fixed for 7 years
	UKR	Government	Fixed for 5 years
	UZB	Government	Not defined
MICs with long-established reforms	ARM	MoH with the consent of PM	Not defined
	GEO	MoH	Not defined
	KGZ	PM	Not defined
	MDA	Government	Fixed for 4 years
HICs with long-established reforms	EST	SB	Fixed for 5 years
	LVA	MoH	Not defined
	LTU	MoH	Fixed for 5 years

5.2. Organizational capacity

There are certain important attributes that country representatives identified for a high-capacity purchasing agency namely, critical mass and skill mix of staff, decision-making quality, data and information technology skills and the ability to innovate and manage change effectively.

A critical mass of staff is needed for strategic purchasing, including in subnational offices, in order to negotiate contracts, actively monitor and follow up contracts and to engage local stakeholders and manage change when strategic purchasing is directed at changing patient pathways and service delivery models. Some countries in our group simply have a too lean structure to do more than carry out basic contract and payment administration. Kyrgyzstan has even reversed some reforms (by merging PHC facilities with hospitals and eliminating performance-based payment for PHC) in order to reduce the workload arising from the number and complexity of contracts the MHIF has to manage: the country lacks the level of skills and quantum of staff to innovate, initiate or maintain strategic purchasing. At national level, the analytical capacity to analyse population health and provider performance data is scarce in MICs, even absent in several smaller MICs, including those where the purchaser has minimal functionality and autonomy. The lack of total staff is often related to a very limited budget and the share for administration, though restrictions on the numbers of posts are also a constraint in MICs (Table 5.2).

Table 5.2. Capacity of purchasing agency

Notes: *ratios calculated by authors using population data from WHO (2022a). Other data in this table were obtained where available from the annual reports (see CNAM (2020) for the Republic of Moldova and EHIF (2020) for Estonia) or for other countries, from unpublished data obtained via personal communications from country purchasers in 2022. The number of positions and administrative budget in the purchasers are subject to change every year and sometimes within the year.

Country group	Country	Number of positions (per 1 million population) (2019*)	Number of regional departments	Share of staff in regions (%)	Applicability of civil service regulation	Share of administrative expenditure of purchasing agency's budget (%) (year)
MICs with recent reforms	AZE	340 staff positions (34.0/M) (2021)	11	Not available	Does not apply	Up to 2.0% permitted
	UKR	322 (7.3/M) (2021)	5	18%	Applies	0.3% (2020)
	UZB	46 in presidential decree (for pilot only), with 25 filled (2021)	1 (pilot oblast)	11%	Partly applies	1.0% (2022), up to 2.0% permitted
MICs with long-established reforms	ARM	70 (23.3/M) (2021)	No local departments	Not available	Applies	Ranges from 0.3%-0.5%
	GEO	439 (100.8/M) (2021)	10	40%	Applies	Not available
	KGZ	277 (43.3/M) (2021)	8 (124 staff)	71%	Partly applies	1.1% (2021 plan)
	MDA	295 (109.3/M) (2020)	5	48%	Does not apply	1.0% (2020)
HICs with long-established reforms	EST	194 (149.2/M) (2020)	4	66%	Does not apply	1.0% (2020)
	LVA	212 posts (111.6/M) of which 116 civil servants (2020)	5	Not available	Applies	0.7% (2020)
	LTU	475 (169.6/M) (2021)	5	67%	Applies to majority of staff	1.0% (2020), up to 2.0% permitted

Analytical and information technology skills, along with competencies in evidence review and synthesis, are vital to strategic purchasing. They are necessary along with other disciplinary skills for needs-based planning and contracting; results-based performance measurement and monitoring; generating and publishing data for performance monitoring; good quality decision-making to underpin and prioritize changes to the benefits package; making changes to tariffs; and to commission new pathways, new care models or revised service standards. A lack of staff with technical skills valuable to the private sector is a consequence of salary scale restrictions for civil servants or state agencies in a number of countries, although in the HICs this is not such an acute concern because public sector salary scales are closer to market rates. Because medical staff in hospitals are able to supplement their salaries with informal payments or so called kick-backs from prescribing in most MICs, it is also difficult for the MoH and purchaser to recruit staff with clinical medical training, leading to a situation where providers "have more brain power" than the purchaser. This means that providers can tap a much larger number of skilled staff with knowledge relevant to consultation and negotiations with the purchaser.

Good-quality decision-making requires more than skills, competencies and data. It requires a number of the elements covered in Chapters 2–4. Namely, it requires a rich body of regulation to ensure transparent decision-making processes and methods; regulation that is adopted as a result of using evidence, analysis and appropriate methodologies. Regulation adoption also needs to be accompanied by practical advice on implementation from the purchaser as well as patient perspectives, and needs to be informed and tested through meaningful, balanced stakeholder engagement. This is important for needs assessment and for decisions on the benefit package, on prioritization and rationing, on budget allocation and on strategies for containing costs through creating incentives for technical and allocative efficiency measures. In addition to these capacities, purchaser managers and their governance bodies need to have incentives to make good-quality decisions, through the accountability mechanisms discussed in Chapter 4.3.

A lack of implementation capacity in the MoH and Purchasing Agency is a constraint when ambitious and complex reforms have been undertaken by an MoH and purchaser with only a small national complement of staff – often relying on around 20 people for carrying implementation as well as policy responsibility. Options for bringing in more personnel to roll out implementation in many countries has relied on major consultancies financed by development agencies, although one MIC has used government funds to secure this extra support.

Some HIC and MIC interviewees also pointed to the need for purchasers (and MoHs) to make more use of external domestic experts in academic centres, think tanks and local economic consultancies. In some countries, this lack of external expert involvement is not simply due to budget limitations, but to caution about involving independent experts in policy development. Most countries spoke of the value of learning from other country experience at the design stage of reform and also later when major new initiatives or developments are planned. The three HICs have benefited from regular exchanges of experience among their purchasing agencies. Donor-financed contractors embedded in or working alongside the purchaser have not led to sustainable capacity or skills transfer in the studied countries. Interviewees from Kyrgyzstan found that the MoH and MHIF are too reliant on donor-financed international experts to implement the recommendations of development partners, and that international consultancy advice is too fragmented and insufficiently aligned with the policies and processes of the Government, reducing the institutional benefit of external consultants.

The HICs now have a lot of data, including increasingly sophisticated data on quality and other result indicators, yet some HICs report they still do not make enough use of the data they collect. Some MICs have no systematic, reliable data on provider quality and efficiency to provide an objective basis for performance related payment, selective contracting or other strategic purchasing measures, although most now have some PHC performance data, often through initiatives supported by development agencies as part of vertical programme monitoring or as part of P4P projects. There can be difficulties for purchasers (and the MoH) in negotiating access to autonomous and private provider data for the purposes of costing and tariff development.

In MICs, the data quality problem is related to the lack of capacity and incentives for providers to submit complete and accurate data. Most MICs have too little staff capacity in the purchaser to carry out adequate data verification, except for financial data in the Treasury system which is subject to state audit. As a result, in the majority of MICs, purchaser contract monitoring focuses mainly on the financial data of providers, not on result or performance monitoring.

Duplication of data collection and reporting exists between purchasers and MoHs and other health agencies in some countries, leading to unreconcilably different data for the same or similar data elements and sometimes to inconsistent messages about sector performance and progress on strategy. Barriers to sharing data have been longstanding in countries with poor relationships and a climate of mistrust between the MoH and purchaser.

A small number of MICs are still engaged in manual transactions for business processes that can be automated. Some MICs – including some LMICs such as Ukraine – have demonstrated that it is affordable and feasible to automate business processes, even at low resource levels.

5.3. The quality of relationships between the purchasing agency, MoH and MoF

The quality of the purchasing agency's relationships with the MoH and MoF was mentioned by many interviews as one of the most critical conducive factors for effective governance.

Most interviewees gave strong emphasis to the importance of stable, cooperative relationships between the MoH and the purchasing agency, although two countries noted a risk of reduced transparency if the MoH and purchaser CEO are so close that checks and balances are weakened.

Governance features conducive to cooperative relationships identified in interviews include that:

- the purchaser is independent in technical matters and day-to-day operations but is either accountable to the government via the MoH, or the Minister of Health is chair (or vice chair) of the SB of the purchaser (although during the implementation and start-up phase of reform when many policy issues need to be resolved between the MoH, MoF and sometimes other Ministers, there are advantages in having a senior representative of the President/PM chair the oversight body);
- law and regulations give the MoH a clear role in approving health financing policy while ensuring that the purchaser actively contributes and is able to influence the policy; and

- there is stability in the CEO and senior management group in the purchaser.

Some aspects of a mature approach to MoH-purchaser relations involve informal aspects of working practices, including:

- joint working groups;
- mutual respect in behaviour (e.g. one CEO of a purchaser interviewed said, “We never criticize each other publicly”); and
- cooperative networks at multiple levels meet regularly (e.g. CEO/ Minister, senior civil servants/purchaser managers, technical staff in working groups).

Commonly cited causes of noncooperation and conflict in the MoH-purchaser relationship included:

- a lack of understanding or lack of consensus on health financing system design after changes of government and ministers;
- law and regulations do not give the MoH a clear role in financing policy and purchaser stewardship, leading Ministers to feel they have lost leverage over health system resource allocation;
- the Minister of Health mistrusts the purchaser due to low capacity and unresponsive performance, or in some cases to corruption and private interests on either side of the relationship leading to competition to control *rent seeking* from the purchaser’s large share of public resources for health;
- a frequent turnover in the Minister of Health, senior MoH staff or purchasing agency CEO and senior staff; leading to steep learning curves about how to work with reformed system policy levers (this learning period is longer for appointees without health system knowledge); and
- situations where a practising medical doctor is appointed as a minister or CEO and thinks like a doctor or provider: engaging more with specific clinical issues or specific purchasing decisions affecting their specialty or facility than with health system or health financing policy (the most challenging scenario is one where the appointee has private interests in particular providers or in private medical insurance).

Having an MoF that is actively engaged with health financing reform and the subsequent functioning of the purchasing agency is helpful. Some countries have been able to find solutions to PFM barriers to strategic purchasing when the MoF was actively engaged and had policy staff who understood both the health and financing sectors and who were interested in improving efficiency and results (not just in controlling spending). Conversely, in those countries where the MoF expenditure departments lack capacity to engage with the content of health expenditure, it has been difficult to get the required engagement in solving PFM barriers and bottlenecks.

In some countries, the MoF is the main monitoring agency of purchaser performance with finances, high-level resource allocation and programme budget indicators playing a key role in governance, particularly where there is no SB or where the MoH has not embraced its role in holding its agencies accountable. It is not ideal for the MoH to leave the role of purchaser monitoring to the MoF, because it can lead to divergence or mixed messages in the purchasing agency's lines of accountability (between the MoH and MoF).

In each of the study countries, the MoF is rarely engaged with issues regarding longer-term financial sustainability of the purchasing agency and its benefits package. The MoF appears generally to be more disengaged over financial sustainability (and reluctant to consider use of budget projections based on forecast utilization of benefit package services) in fiscally challenged countries, especially LMICs with a large gap between budget and current costs of services. In these countries, the MoF tends to dominate in government decisions on setting the budget ceiling and usually relies on historic spending plus/minus an increment. In countries with substantial shares of mandatory contributions, the MoF appears more interested in projected levels of contributions than projections of expenditure. In countries with very financially independent purchasers financed substantially by payroll taxes, the MoF focuses on decisions on revenue sources and reserves, not the strategic content of expenditure or the impact of purchasing decisions, in spite of the introduction of programme budget indicators.

In the 10 countries studied, all three arms of the triangular relationship between the MoF, the MoH and the purchasing agency are important. Where the purchaser is subordinated to the MoH, tax-financed and on-budget, the MoH usually leads in budget negotiations, with the purchaser providing technical support – making close MoH–purchaser cooperation vital. Interviewees identified some examples of the MoH competing with an independent purchaser for a relatively larger share of the health budget in budget negotiations, rather than advocating for an increased total health budget.

The MoFs of the recent reformer countries have been actively engaged and have shown an interest in efficiency improvement. They have been alert to the PFM, the control and accountability risks of increased provider autonomy, and they have also shown concern about the risks of provider deficits as a result of the introduction of new payment methods and provider competition, and the associated risk to overall government finances. This has forced purchasers to consider transition issues for the public provider network. It takes time for loss-making public providers to increase their efficiency. Interviewees from several countries noted that the purchaser had been pressured to subsidize loss-making providers. Such transitional measures can become long-term subsidies which lock in inefficient resource allocation and would slow progress towards achieving some of the benefits of strategic purchasing.

5.4. Policy recommendations for strengthening leadership, capacity and the quality of relationships among key institutions

Leadership and capacity (including data and skills) of the purchaser are not only important for managing and carrying out strategic purchasing, but also for governance. For example, the kind of data needed for value-based, patient-centred and performance-oriented purchasing is also needed for meaningful accountability, based on a balanced set of indicators and supplemented with analysis and evaluation of purchasing strategy and purchaser performance. Subnational office capacity in the purchaser affects the capacity for purchasing, but also affects governance-related activities of local stakeholder engagement, and robust contract monitoring and data validation or audit.

The importance of constructive relationships between the purchaser, MoH and MoF was a dominant theme in all of the interviews conducted. Conflict and power struggles between the MoH and the purchaser have been a recurring problem in some countries, to the detriment of governance at health system and purchaser agency levels and progress on strategy. A lack of MoF engagement in the content and objectives of health purchasing – even the efficiency objective – has been more common than not among the countries studied, even where the MoF has initiated programme budgeting and related indicators. Where the MoF has engaged in reform design, it has, however, helped to resolve or avoid PFM bottlenecks that work against the development of purchasing.

Country key informant interviewees were asked for conclusions and recommendations about factors in the areas of leadership, capacity and relationship quality that enabled progress in the development of effective governance for strategic purchasing in their country. Recommendations emerging from the interviews are summarized below.

Recommended action to achieve good leadership

- Seek to recruit, retain, train and develop leaders in the MoH and purchaser (including in the SB and managers) with health system knowledge and strategic vision; mandate use of clear job competencies and meritocratic appointment processes; provide good induction processes for ministers and purchaser CEOs to ensure an understanding of how to work with the health financing and health system architecture (e.g. senior policy seminars); pay attention in recruitment to values and motivation – particularly integrity and courage, as has been the case in Estonia, Lithuania and Ukraine, as well as in Kyrgyzstan over particular periods of time.

Recommended action to achieve adequate capacity of the purchasing agency

- Train purchasing agency staff from the outset of planning for reform, as was done in Armenia, Azerbaijan, Kyrgyzstan and Ukraine. But also ensure an adequate number of skilled staff at national and subnational level at later stages. Adopt human resources policies in the purchasing agency to assess applicant values, commitment to public good objectives and non-corruption, as well as skills and experience, as demonstrated by the HICs as well as Ukraine.
- Encourage and facilitate the MoH and purchasing agency to tap independent expert capacity to supplement and complement in-house capacity. Armenia, Azerbaijan, Latvia and Lithuania provide positive examples of this. This can come from academic units, teaching hospitals or international experts to assist with advice and analysis on initial policy/system design and, in areas that require scarce specialized technical expertise, on an ongoing basis. Use these experts in the independent review of policy and implementation to develop cycles of learning and improvement that can assist governance and enable management bodies to make better quality decisions.
- Learn from other countries with longer experience and exchange experiences with peers. In MICs this can come from development agency technical support and study visits to help the country discuss policy choices based on the awareness of good examples. In both HICs and MICs, regular exchange of experience with similar countries is helpful to support cycles of learning and improvement, as the three neighbouring HICs have engaged in and most of the MICs.
- Give priority and urgency to digitalization, data availability, use of data by purchaser and the alignment and sharing of data across different agencies when planning and implementing health purchaser reforms, as has been done in the HICs.

Recommended action to achieve quality relationship with the MoH and MoF

- Foster a good, constructive relationship and collaboration between the purchaser and MoH, while also considering the need for the two agencies to provide checks and balances against a lack of transparency in countries with weaker general governance. Countries with experiences that illustrate this point include Latvia, Lithuania and the Republic of Moldova, as well as Armenia and Kyrgyzstan in certain periods.
- Seek to engage the MoF in reform design and in the content of health financing policy, as a potential lever for improving efficiency and public sector performance. Providing training opportunities for MoF staff working on health matters is a useful enabler. Country examples of this include Kyrgyzstan and Ukraine (both recently) and Uzbekistan.

6. Conclusions

Over the past 20–30 years of offering technical advice on the establishment and development of health purchasing agencies in the 10 countries studied, WHO and other development agencies (such as the World Bank and the Health Systems Governance Collaborative) have provided advice on good practice legal and governance frameworks and institutional capacities and have facilitated intercountry learning. This current study has borne out that this advice has been helpful and relevant. Our study findings support recommendations in previous relevant publications that good governance for health purchasers requires consistency and stability; coherent decision-making structures that align accountability and authority; a clear legal framework and enforced rules; supervision structures and monitoring; and transparency and information disclosure (Greer et al., 2016; Savedoff et al., 2008). However, this study indicated that there are very nuanced views regarding the common recommendation in previous literature for stakeholder representation in the governing bodies of purchasers and participation in decision-making. The importance of balanced representation and avoidance of conflict of interest on the governance body was emphasized in our findings, along with an emphasis on the knowledge and experience needed for exercising governance. Stakeholder consultation and seeking consensus was seen as a vital input to decision-making, but only when there are institutions and processes for balancing stakeholder input and focusing it on the common good.

Many countries, particularly the MICs in our study that have experienced slower growth and a more challenging period of socioeconomic and political change since independence over the past 20–30 years, have found it difficult to implement key aspects of good practice governance frameworks or to sustain their effectiveness over time. The HICs in our study which have experienced more rapid transition and growth were able to put good governance frameworks in place while they were still MICs and enhance them over time. This study has identified some of the persistent reasons for the difficulties many MICs face that lie beyond the purchasing agency and its institutional governance but has also identified some conducive enablers that countries were able to use to mitigate some of these difficulties in governance and foster progress in strategic purchasing. Nonetheless, there are some very entrenched and persistent country-level barriers to which no solutions have been found among the current MICs in particular, which appear likely to remain difficult until more extensive political and civil society changes take root.

Purchaser independence and governance structures

In the design of corporate governance arrangements for purchasing agencies, WHO and other international partners have generally recommended giving the purchaser technical and operational independence from the MoH, while maintaining the role of the MoH as the lead policy agency for the sector and clarifying roles and decision-making authorities in law, regulation and standard operating procedures. In the two most developed strategic purchasing agencies (both in HICs), this independence was balanced by a well elaborated, transparent legal basis for strategic purchasing and its processes, and a well-developed accountability framework using a rich set of result-oriented goals and indicators.

However, the study found an example (Lithuania) of a purchaser that is subordinate to the MoH, but still has technical and operation independence, significant financial autonomy and an accountability framework consistent with this. However, some risks and disadvantage were noted from direct subordination to the Minister of Health compared to the clearer purchaser–provider split with a more independent purchaser accountable to an SB; notably a risk of greater pressure to protect loss-making or lower-quality public providers and a risk of too much insulation from stakeholder and civil society pressure for better performance. Only one HIC, Estonia, has effective purchaser governance under an SB. In the two MICs with long-established SBs, the SBs play only a limited role in governance. In practice, there are stronger lines of control exercised by the MoH or MoF or both. In these countries, governance arrangements (along with the implementation of contracting and provider payment reform) exhibit isomorphic mimicry – institutions and governance structures that look like a purchaser–provider split with an independent purchaser have been created adopting institutional design based on international recommendations (Andrews et al., 2017), but, in reality, pre-reform patterns of decision-making on resource allocation, oversight and control have persisted through parallel, sometimes informal lines of control and influence. The lack of SB functionality in these countries is in part due to political and cultural contextual factors – a personalized and informal approach to accountability to powerful ministers and other political actors. But there has also been a failure to really introduce a rule-based system that functions as envisaged regardless of the individual personalities in key roles. There has also been a failure to define clear new statutory roles and authorities in legislation for the SB, MoH and MoF in some countries and/or a failure to reform and align pre-reform regulation and control practices with the reform model. Without these things, governance has remained weak.

In some countries with no purchaser SB, an external advisory board with civil society and stakeholder representation plays a role in monitoring the agency and has been used to play a positive if modest role in supporting governance by promoting transparency or by facilitating meaningful stakeholder and civil society engagement with purchasing decisions.

Where the purchaser does not have an SB that takes primary responsibility for overseeing the accountability framework, some countries make more-or-less effective use of the accountability frameworks within reformed PFM and public administration systems, such as using relevant performance indicators in the programme-based budgets for the purchaser and using strategically aligned performance agreements for the purchasing agency and its CEO and staff. Countries where PFM and public administration reform took place before or alongside health financing and purchasing reform were better able to make progress. There is clear potential to build on PFM and public administration reforms as they develop over time, with more realistic, reliable, aligned, results-oriented indicators and systematic monitoring, review and feedback cycles.

A recurring issue raised by all study countries is the frequency and adverse impact of misunderstandings or disagreements with the MoH or wider government about the independence of the purchasing agency. In two

countries, such disagreements have led to reduction in the purchaser's role to a purely administrative payment and accounting role under the hands-on direction of the MoH, with no scope to carry out strategic purchasing and with vulnerability to political intervention in operational aspects such as contracting. Our study found this purchaser governance scenario to be clearly inimical to the development of a well governed strategic purchaser. Close monitoring of purchasing agencies can be appropriate during the early design and implementation phase or in response to serious failings such as evident corruption, but this became a lasting state of affairs in some countries where the MoH had little interest or ability to build up purchaser capacity and governance and then step back from day-to-day intervention.

Purchaser autonomy and capacity

International advice on the establishment of independent purchasers has often emphasized the need to graduate the level of autonomy given to the agency to the level of capacity in the agency and in wider stewardship institutions (the MoH and MoF in particular). Purchasing agencies in most of the MICs have had too lean staffing, particularly at subnational level for some key aspects of strategic purchasing that involve delegated discretion – notably engagement with local stakeholders and negotiation with providers. At national level, most countries have benefited from learning from other countries in the region with similar reforms, but not always with necessary adaptation to local context and capacity. A number of interviewed country experts see the potential to make better and more regular use of domestic expertise in national universities, think tanks and technical consultancy firms to mitigate persistent skilled capacity limitations in the purchasing agency and to support more sophisticated forms of governance, which require expert analysis to underpin the development of strategy and performance monitoring frameworks.

Purchasing agencies that invested early in digitized business processes and in the development of electronic data collection have proved to have advantages for governance, namely for automated elements of verification and audit of provider claims, for transparency through timely online publication of contracting, expenditure and other reporting and open data.

Accountability and independent purchasers

Weaknesses in accountability of MIC purchasing agencies range from fixable problems (such as absent accountability frameworks or monitoring processes), to more complex challenges at health system level (such as gaps in other pillars of health sector strategy that put pressure on the purchaser to fill gaps and lead to a tendency to blame the purchaser for areas of policy and health system performance that they cannot be reasonably be expected to deliver due to deeper rooted political contextual issues (such as a lack of government-wide institutions and processes for transparency, accounting for resource use, reporting on performance, meritocratic and non-political appointment/dismissal of heads of agencies, and accountability for agencies and their

management). In these countries, transparency and accountability in the purchasing agency's processes was highly dependent on the integrity and capacity of the individuals appointed as CEO of the purchasing agency and as the Minister of Health.

Both good and bad country experiences pointed to the value of rules and processes that protect the CEO of the purchasing agency from politically motivated, arbitrary dismissal, alongside formalized performance agreements, direct or indirect performance rewards and sanctions for misconduct. Some countries emphasized the importance of making sure the purchasing agency is not so protected that it is complacent and lacking courage to support difficult but necessary decisions. The purchaser needs to feel direct pressure for accountability from citizens, beneficiaries and stakeholders (such as credible, broadly representative professional and provider associations).

Transparency and stakeholder engagement

The ability of the MoH and purchasing agency to manage the input and influence of stakeholders in policy and purchasing decisions, both transparently and constructively is limited by powerful forces beyond the health sector in some countries. Some countries have very powerful, politically connected economic stakeholders with interests in the health sector, which can deploy high-level political intervention in health policy, resource allocation and contracting decisions, contrary to stated strategic priorities or principles. There are also examples of politically well-connected, dominant public sector institutions distorting health purchasing decisions to their own advantage. The countries reporting the most constructive relationships with stakeholders have developed broader-based health sector stakeholder organizations, which help balance narrow interests, and which have a professional culture that shares the strategic goals and values of the MoH and purchasing agency, reinforced by active civil society pressure over health sector performance.

The impact of political and policy instability

At national level, a lack of national policy consensus, sometimes associated with political instability, has led to repeated challenges to health financing policy settings and/or politically-driven institutional instability in the leadership and management of the MoH and purchasing agency. These conditions lead to periods of stasis, even in higher capacity HIC settings, or reversal in the development of strategic purchasing and the purchasing agency. An important countervailing factor in several countries was the existence of a stable group of around 10–20 influential health financing reform "champions" across a range of institutions in the country who have explained and defended the reform model and the purchaser to successive new governments and ministers over many years, some also engaging in advocacy to ensure capable, respected purchaser leadership. Among the countries that have implemented a single purchaser only recently, after many years of a lack of policy consensus for reform, the strong support of the President and/or PM for health reform has finally allowed these countries to overcome obstacles in purchaser implementation.

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Annex 1. Glossary of terms

Autonomy of public providers or public purchasing agencies: Giving autonomy to public sector agencies is a reform of public sector organization that delegates day-to-day operational decisions from the Ministry or supervisory agency in the public sector hierarchy to the managers of the organization (letting managers manage). Many countries have given greater autonomy to public health-care providers and public purchasers from the Ministry of Health (or local government) under reforms carried out in the past 20–30 years. Autonomous health-care providers and purchasers in different countries have a diverse range of legal forms and governance structures. There is also diversity in the extent of autonomy to make decisions and manage resources that is delegated to agencies referred to as autonomous.

Balanced scorecard: A balanced scorecard is a tool for measuring and monitoring the performance of an organization that captures all the important dimensions of the organization's performance. If the organization has a strategy that sets objectives and identifies planned resources, the balanced scorecard would usually contain indicators or metrics to measure progress on the objectives set out in the strategy and the use of resources relative to plan.

Beneficiary: In the context of this report, a beneficiary is someone who is entitled to have their health care covered (paid for) by the public purchasing agency. In countries where the purchaser is called a Health Insurance Fund (or similar), beneficiaries are also referred to as insureds or as the covered population.

Benefit package: In the context of this report, the benefit package is the set of health services that the public purchasing agency is obliged to purchase (pay for) for their beneficiaries. The benefit package may also specify any user charges or co-payments that the beneficiary must pay when they access care under the benefits package. The benefits package may also define specific exclusions – services that are not paid for by the public purchasing agency.

Budget cycle⁵: The budget cycle refers to the life of a budget and encompasses the following four phases:

5. Glossary definitions of public financial management terms are drawn from: World Health Organization (2022). How to make budgets work for health? A practical guide to designing, managing and monitoring programme budgets in the health sector. H el ene Barroy, Mark Blecher and Jason Lakin, editors. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/item/9789240049666>, accessed 22 December 2022).

1. Budget formulation: The government formulates the draft budget. This phase comprises: i) the modelling of the economy based on the macroeconomic forecast and estimation of revenue; ii) decisions on sector expenditure ceilings (upper limits); iii) the formulation and negotiation of sector expenditure budgets; iv) the release of the pre-budget statement with budgetary priorities and policies; and v) cabinet approval of the proposed budget.

2. Budget approval: The legislature reviews and amends the budget and enacts it into law. The Minister of Finance tables the budget and revenue proposals. The responsible legislative committee reviews the proposal, then reports to the legislature. The legislature may propose amendments to the proposed budget, then votes the budget into law.

3. Budget execution: The government collects revenue and spends money in line with the enacted budget law. The funds are transferred to spending agencies such as the MoH, which deliver services according to the budget. These agencies produce in-year and year-end reports on their spending of the allocated funds.

4. Budget monitoring or oversight: The Supreme Audit Institution audits the budget accounts of the spending agencies. The legislature reviews the findings. The legislative Public Accounts Committee makes recommendations about the audit findings. The legislature can demand the government take action to correct any issues or irregularities.

Economic classification: Economic classification is the categorization of expenditure by economic category (e.g. compensation of personnel, goods and services, subsidies and transfers, and investment in or consumption of capital).

Fiscal space and fiscal capacity: Fiscal space is the room in a government's budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy.⁶ Fiscal space must exist or be created if extra resources are to be made available for worthwhile government spending on health or other areas. A government can create fiscal space by raising taxes, securing external grants, cutting lower priority expenditure, borrowing resources (from citizens or foreign lenders), or borrowing from the banking system (and thereby expanding the money supply). But it must do this without compromising macroeconomic stability and fiscal sustainability—making sure that it has the capacity in the short term and the longer term to finance its desired expenditure programmes as well as to service its debt.

6. Heller P (2005). Back to Basics – Fiscal Space: What It Is and How to Get It. Volume 42, Number 2. In: Finance and Development. Washington D.C: International Monetary Fund (<https://www.elibrary.imf.org/view/journals/022/0042/002/article-A010-en.xml>, accessed 22 December 2022).

Fiscal consolidation: If a government decides to take policy action to reduce its budget deficit and reduce its levels of debt, this is referred to as a policy of fiscal consolidation. The converse policy is fiscal expansion.

Governance framework: A set of rules and authority structures that set objectives or direction for an organization, determine how an organization is managed and the nature of accountability of the managers to their owner or founder. There can also be a governance framework for a sector or subsector, which sets rules and authority structures for setting direction and accountability arrangements for multiple organizations in the sector. In this case, the framework may be looser, but is likely to specify rules and mechanisms for relationships among the organizations in the sector (e.g. for coordination or competition).

Input-based budgeting: Input-based budgets present expenditures by inputs or types of resources and detailed lines, which are typically based on economic classification (e.g. salaries, utilities, medicines, maintenance and capital investment) or administrative classification (e.g. directorates of the MoH or different public health-care providers). This budgeting format is usually accompanied by hierarchical controls over these categories of expenditure with little managerial discretion and limited ability to make reallocation between lines.

Line items: Line items are discrete items of expenditure such as fuel for primary care facilities or dialysis equipment for district hospitals.

Output-oriented payment: Output-oriented payment refers to a number of different practices used by purchasers to pay health-care providers according to the quantity and mix of services provided, or according to the number and mix of patients receiving services. The payments may include a component of payment-for-performance. Output-oriented payment shifts the emphasis away from strict control over line-item budgets of health care, with higher levels of discretionary spending power for budget holders to choose the mix of inputs and translate these into outputs, outcomes and impact.

Programme budgeting: Programme-based budgeting classifies the expenditure in the government budget by programme, meaning that expenditure is classified by policy objectives or outputs and the centres of responsibilities to implement them (e.g. maternal health, primary health care or palliative care), regardless of their economic classification. Programmes reflect the policy objectives of the country and budget for the resources applied to achieving those objectives. Programme budgets are often accompanied by performance-based budgeting, which links funding to the intended results by making systematic use of performance information. Performance-based budgets range from presentational, where performance information is merely presented in the budget or other documents, to performance-informed, which takes into account performance results in the budget *formulation process*, to full performance budgeting, which aims at allocating resources based on results to be achieved.

Public financial management (PFM): PFM refers to the set of laws, rules, systems and processes used by sovereign nations and subnational governments to mobilize revenue, allocate public funds, undertake public spending, account for funds and audit results.

Purchaser (or purchasing agency): This report uses the terms purchaser or purchasing agency to refer to public sector organizations which manage a pool of public funds to pay health-care providers for services for some or all of the country's population. In countries where these organizations are financed in part from mandatory payroll contributions, these are usually called Health Insurance Funds or Sickness Funds (or variants on these terms). In countries where the purchaser is financed only from government budget allocations, these have various titles, such as National Health Service.

Purchasing strategy: The purchasing strategy or strategic plan is a document produced by the purchaser describing its medium-term objectives and plans, and the resources it will apply to them. The strategy usually includes performance indicators or metrics to measure progress towards these objectives. The purchaser strategy is usually approved by the Supervisory Board (if there is one) or the Minister of Health and/or other responsible Ministers.

Rent seeking: So called rents are returns received for an activity that is in excess of the minimum needed to attract the necessary resources to that activity, for example, by obtaining prices or wages that are above the level that could be obtained by open, transparent processes of competition. Rent seeking is a behaviour directed at obtaining these excessive returns.

Semashko model: The Semashko model was the model used for organizing health facilities in the former Soviet Union. Health facilities were public, financed from the government budget, and organized under each level of government: primary care and hospitals under rayons (districts), more specialized hospitals and dispensaries under oblasts (regions) and highly specialized facilities under central government.

Strategic purchasing: Strategic, or active, 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. The objectives are to enhance equity in the distribution of resources, increase efficiency, manage expenditure growth and promote quality in health service delivery, and enhance transparency and accountability of providers and purchasers to the population.

System of health accounts: The system of health accounts is an international accounting framework for systematically tracking health spending. It establishes an integrated and comprehensive methodology for tracking health expenditure through a set of uniform accounts comparable across countries. The framework, which focuses on final consumption, tracks resource flows through the health system from its sources (funding sources, financial arrangements), patterns of provision (providers and factors of provision), and through to its use (health-care functions, diseases/programmes). The framework and its definitions and methodology are described on the WHO website.⁷

7. World Health Organization (2022). Health Accounts. In: World Health Organization/ Health topics [website]. Geneva: World Health Organization (https://www.who.int/health-topics/health-accounts#tab=tab_1, accessed 15 December 2022).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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