POLICY BRIEF

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To what extent has strategic purchasing been implemented in middle-income countries, and what are the key factors in achieving its goals?

While striving for universal health coverage (UHC), middle-income countries (MICs) are trying to expand coverage through the effective and efficient use of limited resources. Working towards this goal, public insurance schemes in many MICs have started using strategic purchasing (SP) to pay for patient care.

The aim of SP is to maximise health systems' performance by optimising the allocation of funds to health service providers on behalf of members, and this includes deciding which services to purchase, from who, how, at what rate, and under what contractual arrangements.

SP also involves assessing citizens' needs, setting up service agreements, auditing claims, addressing poor provider performance to ensure that citizens have access to services, and that adequate resources are in place. Successful SP can help to keep schemes financially viable through the optimal use of available funds, and protect members from unaffordable expenditure when they seek care. Essentially, SP encompasses a purchaser's interactions with three key stakeholders: healthcare service providers; citizens (beneficiaries); and

SP requirements to contribute to sustainable insurance schemes:

- input from purchasers and governments
- organisational and institutional capacity to deflect politically motivated demands
- investing in purchaser and research capacity; strong governance; and enabling needs assessments, affordable services and best value for money
- addressing delayed reimbursements and payments
- sufficient government regulation to ensure that resources are used wisely, as well as financial protection for providers, purchasers and service users
- sufficient data, expertise, policy capacity and negotiating power to focus strategies on quality of care and citizen needs
- capacity to accredit facilities and monitor quality of care as well as claims
- governance capacity (stewardship and regulation)
- trust between key stakeholders – especially between government purchasers and providers
- empowering patients through rights

government (regulator of purchasing and provision of care).

In this paper, we looked at the experiences of nine middle-income countries (MICs) where SP is being used in public sector insurance schemes, and examined:

1. which elements of SP the countries had implemented
2. to what extent they had achieved SP goals, such as reducing members' out-of-pocket (OOP) expenses, and their ability to pay providers on time
3. which elements were key to meeting SP goals (by examining the link between the SP elements implemented and the extent to which SP goals were achieved)

METHODS

A systematic qualitative review of literature that followed PRISMA guidelines was conducted, drawing on literature from 2011, when the rate of publications on SP started to increase.

Sampling case studies: Nine countries were purposively selected to include those most commonly studied, as well as a good geographical spread: Iran, Nigeria, China, Mexico, Ghana, Kenya, Thailand, Vietnam, and Indonesia.

Data synthesis and presentation: Data on purchasing arrangements and key features in the different schemes were extracted from 129 articles. An analytical framework was developed to present the synthesis. The core elements of spending were considered (deciding what to buy, from who, and how) – as well as actions that support healthy stakeholder relationships.

MAIN FINDINGS

A cross-country comparison of the findings on coverage, benefits package, performance, purchasing arrangements and governance are summarised in Table 1.

Most of the countries (6/9) under review had more than 70% of the population covered by public sector insurance schemes (Thailand, China, Iran, Vietnam, and Mexico) and offered a comprehensive benefits package (Iran, Thailand, Indonesia, Ghana, Vietnam and Kenya).

The evidence on out-of-pocket payments suggests that insurance schemes, other than Thailand and Indonesia, were failing to protect members against catastrophic expenditure, and that members were wealthier in comparison to the uninsured and therefore able to pay out of pocket when needed. In many of the countries, there were delays in payments of providers (Iran, Mexico, Vietnam, Ghana, Kenya, and Nigeria), and we found evidence of providers refusing to provide care in five of the countries (China, Indonesia, Ghana, Kenya, Nigeria).

Capitation was the predominant reimbursement mechanism for primary healthcare. Less common were performance-based elements (China, Indonesia) and pro-active use of fee-for-service for specific services to increase demand (Thailand). For hospitals, most countries used a varying combination of case-based payment for reimbursement, diagnosis related groups, and fee-for-service for medication and specific procedures.

Table 1: Cross-country comparison

	Coverage	Benefits package	Performance			Purchasing arrangements		Governance				
			OOP	Delays in reimbursements	Reports of providers refusing to provide care	PHC	Hospital	Health policy and legal frame-works	Accreditation	Monitoring claims and services	Patient engagement	Strategies to reduce corruption
Thailand	99%	Comprehensive	11%	Not reported	No	Capitation; FFS	DRGs; FFS	Yes; Yes	Yes	Yes	Yes but poor	Yes
Indonesia	32%	Comprehensive	18%	Yes	Yes	Capitation	Case-based group; FFS	Yes; Yes	Yes	Yes	Yes but poor	Yes
Vietnam	87%	Comprehensive	31-39%	Yes	No	Capitation	DRGs; FFS; per-diem-payment with co-payments	Yes; Yes	Yes but varies/ infrequent	Yes	Not reported	Yes
Ghana	53-60%	Comprehensive	47%	Yes	Yes	FFS	DRGs	No; Yes	Yes but varies/ infrequent	Yes	Yes but poor	Yes
Mexico	85%	Limited	43%	Difficulty paying providers	No	Capitation; historical- and activity-based funding	Line budgets; case-based payments; FFS	No; Yes	Yes but varies/ infrequent	Yes	Yes but poor	Yes
Iran	90%	Comprehensive	55%	Yes	No	FFS	FSS; care-based payments	Yes; Yes	Yes but varies/ infrequent	Yes	Yes but poor	Yes
China	97%	Limited	54-74%	Selective use of DRGs by hospitals	Yes	Govern-ment subsidies	Reimbursement; DRGs; scale payment; FFS; capitation	No; Yes	Yes but varies/ infrequent	Yes	Yes but poor	Yes
Kenya	16%	Comprehensive	29%	Yes	Yes	Capitation	Case-based payment; FFS	Yes; Yes	Yes	Yes but inadequate	Yes but poor	Yes
Nigeria	5%	Limited	90%	Yes	Yes	Capitation; FFS	Case-based payment; FFS	No; Yes	Yes but varies/ infrequent	Yes but inadequate	Yes but poor	Not reported

**OOP: out-of-pocket; FFS: fee-for-service; DRG: diagnosis related groups*

Only Vietnam used per-diem payments at a hospital level. While the reimbursement mechanisms used led to some cost controls the evidence suggested that only two (Thailand and China) pro-actively changed mechanism to encourage a particular response from providers.

In terms of governance, Indonesia, Iran, Vietnam, Kenya, and Thailand had policy frameworks in place to guide health system and strategic purchasing reforms. All review countries had legal and regulatory frameworks that established the schemes, set the direction for purchasing and service provision, and established institutions to implement strategic purchasing and associated reforms. However, there is variation in how these frameworks were constituted and operationalized.

All review countries had some form of health facility accreditation, but in most countries there were reports of considerable variation in their implementation by region, and by frequency (Nigeria, China, Vietnam, Mexico, Ghana, Iran). Similarly, all review countries had instituted a strategy for monitoring claims, although it varied in complexity and degree of implementation. Reasons for inadequate monitoring ranged from limited capacity (Kenya) to the influence of politicians and other beneficiaries of a dysfunctional system (Nigeria).

Across countries, patient engagement channels functioned poorly, and therefore patient feedback was not used to improve the system. Of greater concern, patient awareness of their rights, entitlements and how to access benefits, were poor.

Multiple measures to prevent fraud were introduced in all review countries except Nigeria.

Key elements of success

The measures outlined in Table 2 contributed to the countries in this study using SP with varying degrees of success.

Thailand and Indonesia managed to keep OOP expenses relatively low (11% and 18%) through expenditure caps, gate-keeping and reimbursement reforms that changed provider incentives – as well as their research capacity, engagement forums between purchasers and providers, international standards for accrediting facilities, and clinical audits of services.

Health technology assessment units for researching services to purchase were rolled out in five countries. Other successes included: independent governance structures providing oversight; greater levels of monitoring being enabled by e-claim processing; and some claims monitoring being implemented across all nine countries – despite great variations in complexity and execution.

Challenges hampering SP's impact

On the whole, we found that SP's full potential had not been realised in the countries studied, mainly due to a lack of purchaser and research capacity, poor governance, and mistrust between key stakeholders (purchasers, providers, and citizens).

Examples of difficulties with its implementation included:

- delayed reimbursements
- failures to provide services listed in benefit packages providers not honouring essential services, often due to delayed purchaser payments

Table 2: Key elements of strategic purchasing	
Purchasing and cost-control arrangements	• limiting benefit packages – e.g., setting overall limits, adjusting payment rates per service, and having budgetary caps on expenditure • reimbursement mechanisms that enable cost control – e.g., capitation and diagnosis-related group reimbursements • gatekeeping – e.g., using predefined lists of health services that allows for referrals • decentralisation enabling more engagement with patients and providers – to encourage participation in committees and boards, and learn more about their views and values
Containing OOP	• ensuring that appropriate services provided and charged for at appropriate rates, preventing providers from charging excessive co-payments or informal fees • auditing facilities and quality of care to ensure quality care and to avoid members seeking care elsewhere • engaging with providers and members to monitor whether their needs are being met
Governance of purchasing	• putting in place policy and legal frameworks as well as oversight bodies • provider accreditation • monitoring claims and services – e.g., through e-claims processing, electronic health records and clinical audits • minimising corruption – through payment reforms, adjusted regulatory frameworks, increased accountability and auditing systems like Indonesia's Public Research Anti-Corruption Clearing House and Corruption Eradication Commission
Research capacity	Performance indicators and up-to-date data help purchasers to: • identify appropriate services • hold primary providers accountable • minimise opportunistic behaviours • audit facilities and care • promote healthy engagement with providers and members to determine whether schemes are meeting their need

- resource shortages leading to service delivery failures
- high OOP costs– e.g., due to delayed purchaser payments and limited SP elements (like caps on expenditure)

Partial implementation of SP measures combined with high population coverage often led to delays in paying providers and higher OOP expenses.

A tightrope to support sustainable schemes

SP is no mean feat while navigating historical patterns, prices and volumes – and purchasers often lacked sufficient data, expertise, policy capacity, and negotiating power to broker quality of care and serve patients' needs. Offering a broader perspective, research in European countries highlighted how high income countries have also battled to implement SP reforms.

WRAPPING UP

The findings in this paper show that while MICs are pressed to control costs given limited public funds to provide health coverage for all, insurance schemes may benefit from well-executed SP measures that cap expenditures, limit corruption, apply gate-keeping, and more. It also shows that research capacity and audits are key to keep OOP expenses low, while securing appropriate services at appropriate rates.

With challenges ranging from delays in payments to failures in delivery, successes in crucial purchasing reforms however may at times be fragile at best. Significant investment in research capacity is therefore recommended, as well as an emphasis on strong governance, and regular engagement between purchasers, providers and citizens to build trusting relationships.

Source: Sumankuuro, J., Griffiths, F., Koon, A. D., Mapanga, W., Maritim, B., Mosam, A., & Goudge, J. (2023). The experiences of strategic purchasing of healthcare in nine middle-income countries: a systematic qualitative review. International Journal of Health Policy and Management, 12.

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