

Strategic purchasing – lessons from four country assessments in Burkina Faso, Colombia, Karnataka (India) and the Philippines

*Aurélie Klein, Vergil de Claro, Narayanan Devadasan, Joël Arthur Kiendrébéogo, Juan Carlos Rivillas
October 2018*

Introduction

Health financing has three core functions; revenue raising, pooling and purchasing of health services. The latter refers to the allocation of resources by one or several purchasing agents to public and private health care providers for the provision of services. There is a growing consensus that a move towards more active or strategic purchasing of health services is a necessary condition for countries to make and sustain significant progress towards UHC (Mathauer, Dale and Meessen, 2017).

The aims of strategic purchasing, broadly, are to guide the allocation of resources to contribute to improving intermediate and final UHC objectives. The intermediate and final objectives that are affected through purchasing mechanisms include: increased efficiency in the use of funds; expenditure growth management; equity in the distribution of resources; improved accountability; equitable access to health services (utilization in line with need); financial protection and improved quality of care (including continuity of care) (Kutzin, 2013, WHO 2010).

An increasing number of low-and middle-income countries seek to make their purchasing more strategic. These processes require a thorough assessment of the current purchasing situations in order to and identify options to strengthen strategic purchasing. To contribute to these reflection processes, a Collectivity group¹ on Strategic Purchasing for Universal Health Coverage was launched jointly by the World Health Organization (WHO), the Institute of Tropical Medicine Antwerp, and the Communities of Practice “Performance-Based Financing” and “Financial Access to Health Services”, with the purpose to develop a practical assessment guide. Based on an initial draft provided by the WHO, the Collectivity group built such an assessment guide for strategic purchasing.

The final draft of this assessment guide was applied in four countries, i.e. in Burkina Faso, Colombia, Karnataka (India) between March-July 2018 and in the Philippines in October 2018. The assessment in Karnataka state focused on the sub-national (state) level, whereas the other three studies looked at the purchasing setup at national level. The studies aimed to explore the strengths and weaknesses in the purchasing set-up and their impact on UHC intermediate and final objectives as well as on health system aspects. The purchasing assessment had four key areas: benefit package, payment methods, information management and governance arrangements for strategic purchasing.

The assessments were based on i) literature review; ii) interviews and discussions with key stakeholders; and iii) quantitative data collection and analysis.

¹ Collectivity is an online collaborative forum for convening practitioners to promote collective learning around development issues and solutions. The forum is hosted by ITM and funded by NORAD. Communities of practice are formed around various topics. Jointly led by the WHO, ITM and the FAHS and PBF communities of practice, the Collectivity group on Strategic Purchasing was launched in July 2017 and consisted of over 80 members. A subgroup of 18 individuals worked on the assessment guide and country studies from October 2017 to October 2018.

The final goal of these assessments was to identify challenges and what worked on the way towards strategic purchasing. The findings clearly identified the opportunities at the country and provincial level to facilitate reforms and dialogue on strategic purchasing for UHC.

This paper synthesises key features, commonalities and differences in the purchasing arrangements of the four countries (section 2), outlines instruments used to move towards more strategic purchasing (section 3), and identifies key lessons for moving towards more strategic purchasing (section 4).

Commonalities and differences

The assessment of strategic purchasing in four very different country settings using the same framework, revealed several surprising commonalities, success factors and struggles related to the purchasing function.

General context:

The four countries included in the case study are at different stages of economic development and have different health system architectures and health expenditure levels (see Table 1). Nevertheless, in all four countries a political commitment to move towards more strategic purchasing exists as underlined by policies aiming at extending coverage to the whole population and changes in purchasing arrangements. As in many countries, health coverage schemes started with risk pooling for civil servants and private sector employees. At the same time, health services were provided through a network of public facilities targeting poorer populations and, in some cases, the informal sector, with user charges or exemption therefrom.

Table 1 Health expenditure data for the selected countries for 2015. Source: WHO Global Health Expenditure Database

Indicators	Burkina Faso	Colombia	India	Philippines
Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	5	6	4	4
Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE)	28	67	26	31
External Health Expenditure (EXT) as % of Current Health Expenditure (CHE)	30	4	1	1
Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure (GGE)	7	12	3	7
Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)	36	18	65	54

From a similar starting point, the four countries chose different ways to expand financial protection of their populations. Colombia decided to make health insurance membership compulsory for the whole population and provided state budget transfers to subsidize health coverage for the poor. The system was designed as a competitive multiple payer system consisting of public and private insurers and provincial governments as purchasers. Benefits and payment methods are decided at the national level (Rivillas et al., 2018). The Philippines took a similar approach but kept PhilHealth as a single-purchaser. Coverage of recipients of social benefits as well as of persons aged 60 and above is fully subsidized through state budget transfers. The government also launched a policy to cover patients who cannot

afford to pay at the point of service (de Claro 2018). In Karnataka, a publicly funded scheme, called Vajpayee Arogyashree, was created to provide a defined package of secondary care to people below the poverty line (Devadasan 2018). In Burkina Faso, the formal sector health insurance coverage co-exists with voluntary schemes and free health care policies for selected services and/or population groups including financial support by external partners. A comprehensive health sector reform is planned and aims at creating a single-payer universal health coverage scheme for the whole population (Kiendrebeogo et al., 2018).

In all four countries, this led to a multitude of purchasers. In the case of Colombia, a two-level purchasing arrangement exists. The main purchasers are the Ministry of Health, other ministries and the two major insurance schemes, which are operated by 30 sub-purchasers. These cover around 90% of the population. This competitive purchaser market led to a reduction in the number of insurance schemes (Rivillas et al., 2018). According to the design of the public purchasing mechanisms, PhilHealth has a strong position as a single purchaser. However, funding managed by the agency remains low as a percentage of total health expenditure and is complemented by allocations managed by national and local governments, and by private health insurance (de Claro 2018). In Karnataka, decentralization and fragmentation along population groups and along services multiplies the number of purchasing agencies. At the same time, low levels of public funding and a split into national and state-funded programs as well as health insurance schemes make harmonization politically difficult (Devadasan 2018). Burkina Faso just launched an initiative to re-centralise the purchasing function under a compulsory universal health coverage scheme, but this is not yet operational (Kiendrebeogo et al., 2018).

Provider payment methods:

Despite the different setups in the four countries, mixed and non-aligned payment systems exist in all four countries. All countries are gradually shifting towards results-based payment modalities but still lack a comprehensive approach of aligning payment mechanisms to coherent and strong incentives for service delivery by providers. It is also found that a purchasing arrangement with a clear division of roles and responsibilities between the purchasers and providers facilitates contracting of private providers. The health coverage schemes in the four countries have different mechanisms for and levels of control of provider activity. The mechanisms include general quality control of providers through accreditation, compulsory annual reporting of provider activity, pre-authorisation of treatment and patient feedback after treatment.

In Burkina Faso, public funding is mostly channeled to public providers, and to some extent to private doctors, primarily using line-item budgets or fee for service payments. Performance-based financing has been introduced for certain services in selected areas with external support. However, performance-based financing is not yet institutionalised and harmonized with other financial flows limiting the potential impact of the incentives set by the system and potentially allowing for double funding of services at facility level (Kiendrebeogo et al., 2018).

Colombia uses fee for service payments, capitation and global budgets with a clear output orientation and with a strong intention by the government to move towards prospective payments. In 2017, 50% of all payments were made on the basis of fee for service payments, 40% through capitation and 10% came from global budgets. Funding is mainly public, but largely managed by private health insurance agencies. The Colombian “Compra Eficiente” initiative integrates quality measures into the purchasing decision and links payment to the fulfilment of these indicators (Rivillas et al., 2018).

While national and local governments in the Philippines provide line item budget allocations to public providers, PhilHealth moved from fee for service payments to mostly case-based payments in 2011. A

smaller part of funds is allocated via capitation payments. With a low amount and no connection to performance indicators these capitation payments however do not encourage quality or performance improvements. Importantly, PhilHealth does not only have more flexibility in the use of payment methods but contracts both public (40%) and private providers (60%) (de Claro 2018).

Traditionally, Indian governmental agencies used predominantly line-item budgets, giving little incentive for efficiency improvements at the facility level. Vajpayee Arogyashree, Karnataka's state-level health coverage scheme is an exception. The scheme is implemented by an semi-independent trust and is contracting mainly private providers that are reimbursed with procedure-based payments. Across the schemes in the four countries, Vajpayee Arogyashree has the strongest quality focus, as payments are conditional of patients providing feedback on their experience in receiving health services. As in Colombia, pre-authorisation by the purchaser is needed for providing hospital services (Devadasan 2018).

Benefits design:

Primary health care services are provided without cost-sharing or have lower co-payments, at least for vulnerable groups, across the four countries. Across the four countries, benefit packages defined by separate purchasing agencies seem to be more clearly defined. A clearly defined benefit package responds to identified population needs and is less driven by service availability. A stronger split between purchaser and provider also seems to encourage selective contracting. In each setting, some form of provider performance monitoring exists but this is often rather weakly linked with payments. The schemes with a greater extent of purchaser autonomy are found to have set up more explicit reporting requirements and tend to have better complaints mechanisms for patients than when services are funded and provided directly by the ministry of health.

In Burkina Faso, a purchaser provider split exists for the health insurance schemes for formal sector employees, community-based and voluntary health insurance, but their overall population coverage is limited. For health services provided at public health facilities, effective benefits tend to depend on availability of skilled staff, medicines, equipment and other supplies. As a result, the deployment and planning of human resources for health, a key condition for availability of primary health care services, becomes a main factor influencing the actual delivery of services that are covered in principle. As part of the preparatory work to introduce a national agency managing the new universal health coverage scheme, costing and actuarial studies were commissioned, which will provide a good basis for moving towards a more strategic definition of benefits taking into consideration affordability and societal preferences. (Kiendrebeogo et al., 2018).

In Karnataka, the health coverage schemes follow different logics of benefits design. On the one hand, the benefit package of the government-funded primary health care are driven by service and health worker availability, similar to the situation in Burkina Faso. On the other hand, the Vajpayee Arogyashree scheme, with an effective purchaser-provider split and a clear mandate, is similar to the Colombian setting. A clear process for benefit revision exists, and performance monitoring of providers responds to accountability demands by members and funding agency (Devadasan 2018).

PhilHealth has a benefit package which has a strong focus on inpatient health services. In 2017, over 90% of its expenditures went to inpatient care. Co-payments are high and most outpatient drugs, including for chronic diseases, are not covered, and thus PhilHealth's financial protection is limited. However, the introduction of a no-balance-billing policy for vulnerable groups as well as a specific list of high cost treatments which are provided free of charge to certain groups at selected facilities are

aimed at reducing out-of-pocket spending. Moreover, PhilHealth adds new benefits on a yearly basis. The institutionalisation of a systematic health technology assessment process is ongoing (de Claro 2018).

Colombia has a well-defined package of benefits, which covers the whole population. When it was harmonised across the contributory and subsidized schemes, the package rationale also shifted from an implicit package to a negative list defining which services are excluded. This enhanced equitable access to health services and also to new health technologies, in line with the statutory law of 2015, which defines health as a fundamental right that must be protected and demands health care being accessible. At the same time, a standardized process for revising the package was developed. This process is based on criteria for assessing new technologies and gives a strong role to the Technological Health Assessment Institute and the Institute for Food and Drug Surveillance whose responsibilities also include negotiations and centralised procurement, price control of medicine and assessment of budgetary impact (Rivillas et al., 2018).

Information management system:

In the four countries, it is found that health information systems are quite fragmented. Health insurance agencies and various ministries may collect general patient or demographic data. Public health information systems, often under the ministry of health, would collect information related to morbidity and mortality. Ministries of finance require reporting on provider income and expenditure. Finally, larger hospitals have their internal health information management systems. In addition to this functional fragmentation, there is also a problem of geographical fragmentation in the four countries, since data is collected at local or provincial level but not accessible at national level or vice versa. Adequate information management systems ideally collect comprehensive information on health services received, costs, and are interoperable with other sub-systems. A prerequisite to do so is existence of standardized data collection, which allows for exchanging information between systems, as is the case in Colombia. The country studies suggest that interoperable information management systems require leadership from outside the health sector, either by an entity specifically in charge of information technology, collection of statistics, or registration of citizens.

In Karnataka, several health information systems are in place that store health service related data by different ministries and sub-national governments. Yet, these monitor program implementation and accounting rather than performance of providers. As a result, the different schemes have developed their own patient databases. The only scheme using data for performance monitoring is the Vajpayee Arogyasharee (Devadasan 2018).

In Burkina Faso, reliance on external funding aggravates the fragmentation in health information management. This consists of the national system collecting aggregated patient data, the public financial reporting system, the free health care policy management system, the information management system of the performance-based financing scheme and the health information management system of the Ministry of Defence, which provides health services to military personnel and dependents. The development of a patient-centred hospital information management system, which started in 2017, should improve data availability in the medium term. However, weak capacity and a weak information technology infrastructure limit progress (Kiendrebeogo et al., 2018).

The Government of the Philippines has developed an eHealth Strategic Framework and Plan 2014 – 2020 that provides a roadmap towards a more integrated health information system. However up to now, data collection remains fragmented. PhilHealth collects the largest part of health-related

information in the country. However, it has not yet adopted the technology and developed the capacity which would allow to process big data. Fragmentation combined with a limited strategic approach on data collection means that access to timely, reliable and complete health information remains a challenge for policy makers (de Claro 2018).

Since 2012, the Ministry of Health and Social Protection of Colombia has been centralizing health service delivery data in a data warehouse, the National Information System for Social Protection. It allows for different information systems to be interoperable and offers a unique opportunity for interaction between population health data and payment related data. Data on health outcomes and vulnerable populations is available and disaggregated by geographic levels. (Rivillas et al., 2018).

Governance arrangements in strategic purchasing:

All four countries have policies stating the countries' commitment to achieve universal health coverage. This objective is reflected in purchasers' goals but tends to be less explicit at subnational levels. The country studies show the importance as well as the challenges of developing overarching coordination mechanisms and of ensuring sufficient skills and capacity of the different actors to fulfill their mandates effectively. The lack of a coordination and steering mechanism also makes it more difficult to harmonise multiple purchasing arrangements so as to align payment incentives for providers. Coordination should also reach beyond the health sector as in all four countries it is recognised that health actors such as the ministry of health and purchasing agencies will not be able to become strategic purchasers without working with the ministry of social welfare, finance, or the ministry in charge of regulating private providers and purchasers. Coordination is important because the overall budget for most purchasers is determined by the ministry of finance or an oversight body. The regulatory framework for purchasing of health services tends to reflect the overall regulation of the public sector especially where initiatives for more efficient allocation of public funding such as more competitive and transparent public procurement or program-based budgeting are implemented. Finally, building awareness and understanding of strategic purchasing remains challenging in all settings.

In Colombia, one of the main difficulties for coordination arises from the multiple purchaser market. The "Administrator of Resources of the General System of Social Security in Health" established with a mandate of managing health financing at national and sub-national level, contributed already to better coordination and reduced operational cost. The National Superintendence of Health in charge of supervision of both public and private health insurance agencies, also contributes to strengthening accountability of purchasers (Rivillas et al., 2018).

Fragmentation in the purchaser market in the Philippines results from overlapping mandates between the Department of Health and PhilHealth. The PhilHealth Board of Directors, chaired by the Secretary of Health, determines provider payment mechanisms, benefit package design and approval of the annual budget, yet it is struggling with providing technical directions for more strategic purchasing. The Universal Health Care Bill under development aims, inter alia, at improving the purchasing function. The Bill clarifies roles and responsibilities, introduces global budgets, expands the no balance billing policy and stipulates the selection criteria for members of the Board of Directors of PhilHealth and it also specifies the use of PhilHealth reimbursements to public providers for facility or service improvement (de Claro 2018).

In Karnataka, the existing regulatory framework applying to providers and purchasing agencies is limited. Therefore, the Vajpayee Arogyashree scheme has developed its own regulations that apply to

providers if they want to be contracted. This includes clinical guidelines, accreditation, and reporting and accountability mechanisms. The trust itself is accountable to the Department of Health and Family Welfare of the State of Karnataka (Devadasan 2018).

The governance arrangements for the purchasing of health services in Burkina Faso are undergoing significant changes as part of an overall health sector reform. A new universal health coverage scheme and agency have been created. A technical secretariat within the MOH will be in charge of policy coordination and will also host a technical working group focusing on resource mobilization and allocation. Once these mechanisms are operational, it is expected that existing coordination gaps will be closed (Kiendrebeogo et al., 2018).

Successful policy instruments to move towards more strategic purchasing

In the four countries, a strong political will exists for moving towards more strategic purchasing as indicated by current initiatives to improve governance arrangements, legal frameworks, and capacities of purchasing actors. In each country setting, various policy instruments have been introduced to put this vision into practice. These instruments are described below along the various areas related to strategic purchasing.

Provider payment methods

Decision making space on payment methods and selective contracting

When the state of Karnataka launched a new state budget funded scheme for covering secondary health services for the poor, a separate and semi-independent purchasing agency based on a not for profit trust was created to manage the scheme. It is headed by a senior government official, has senior government officials on its board and is supervised by the Chief Minister. Yet, there is sufficient autonomy and decision-making space. For example, the agency head set up a competitive purchasing mechanism by allowing all providers, private and public, to be contracted if they fulfill the scheme's criteria. As a non-governmental entity, the trust can use case-based payments and contract the most suitable public and private providers. (Devadasan 2018).

Strong willingness to move towards prospective and out-put oriented payments

The purchasers in Colombia use a mix of payment mechanisms including capitation, output-based payments such as DRGs as well as case mix based global budgets as prospective payments. Political willingness to move towards prospective payment is important to encourage providers to use funds efficiently. Comprehensive information is critical to make strategic use of prospective budgets (Rivillas et al., 2018).

Use of patient feedback in the payment process

The Vajpayee Arogyashree scheme in Karnataka is the only scheme in the four countries that puts strong emphasis on patient feedback. To get their payment claim approved, providers need not only to receive a pre-authorization and submit patient records but also a feedback from the patient on the service provision. Even though positive patient feedback is not necessarily an indicator of clinical quality, it is important to increase users' trust in the system. Especially for schemes targeting vulnerable population, strong engagement of the stakeholders will be important to improve equity in access to services (Devadasan 2018).

Benefit package design

Harmonisation of benefits

One objective of the Colombian health sector reform of 1993 was to increase equitable access to health services by ensuring entitlement to a harmonized benefit package for the whole population. Difficulties in harmonizing the packages of the contributory and the subsidized schemes led to a revised definition of the package. Instead of a positive list (indicating the services covered), the package was defined by a negative list (listing all services not covered). (Rivillas et al., 2018).

Development/ clarification of a basic service delivery package as an entry point for developing/ harmonizing payment rates

Which services should be included in a benefit package are important policy decisions, which are influenced by service availability and the costs of these services. As providers are paid by various payment methods, these should be aligned across the purchasing agencies. In Burkina Faso, a process to develop a basic service package, available at each level of the health system, facilitates the decision of which services are covered by the universal health insurance and how to pay for them. (Kiendrebeogo et al., 2018).

Extending benefit definition to co-payments to reduce out-of-pocket payments

Over 90% of the Filipino population is member of PhilHealth. However, out-of-pocket payments continue to account for more than half of total health expenditure in the Philippines partly because of co-payments required under the PhilHealth scheme. To improve financial protection especially for the poor, PhilHealth introduced a no balance billing policy. Providers are not allowed to charge any co-payment for patients covered by this policy. A draft law currently under consideration proposes to extend this policy to 90% of the beds in public hospitals, 60% of government owned and controlled corporations' hospitals and 10% of private hospitals (de Claro 2018).

Information management system

Unified national information management system for hospitals

Burkina Faso has multiple data collection systems, as outlined in the previous section. All these sub-systems require input from health facilities leading to a significant administrative burden for providers. The Ministry of Health in Burkina Faso responded to this challenge by taking the lead in the development of a national information management system for hospitals. Discussions on the system started in 2017 to get agreement among all stakeholders on the structure of the system (Kiendrebeogo et al., 2018).

Standardization of data to allow consolidation in a national data warehouse

The process of standardizing and consolidating data in central data warehouse has been another important conducive factor for strategic purchasing. The development of such a data repository is a significant achievement but does not yet provide standardized reporting or assessments of quality of data. In addition, financial data and information collected at the sub-national level are not yet included (Rivillas et al., 2018).

Integration of health information as a part of a broader eHealth strategy for the health sector

In 2014 the Department of Health in the Philippines adopted an eHealth Strategic Framework and Plan 2014 – 2020. This provides a roadmap towards a more integrated health information system and an

overall governance framework and also underlines the need to develop the necessary infrastructure. In 2015, the Department of Health and PhilHealth began to collaborate on standardizing terminologies and reporting formats and streamlining data collection. The initial focus was on PhilHealth's primary care benefits to optimize the use of the various electronic medical systems used by health providers. It also aimed at providing an integrated data access via a single electronic platform called the Philippine Health Information Exchange (de Claro 2018).

Governance arrangements for strategic purchasing

Strengthened coordination of the purchaser market through the creation of new agencies

Both Colombia and Burkina Faso aimed at improving strategic purchasing as part of their wider health sector reforms. In Colombia, where the contributory and subsidized schemes, are implemented through a number of sub-purchasers, coordination is crucial. The creation of the "Administrator of Resources of the General System of Social Security in Health" was a step towards strengthening coordination. (Rivillas et al., 2018).

Burkina Faso took a different path. The launch of a universal health insurance scheme and the creation of an agency in charge of its implementation aims at integrating existing schemes under one single payer. Given the scope of this reform and necessary adjustments in the legal, institutional and governance framework as well as the need to develop capacities, the implementation is expected to take several years. (Kiendrebeogo et al., 2018).

Getting the legal frameworks right through the development of a universal health care bill

Fragmentation, overlapping or unclear mandates of different purchasers, lack of regular benefits revision and high out-of-pocket payments were key challenges in the Philippines. These challenges could not be addressed by the DoH only or PhilHealth. The universal health care bill will allow to address these points and as primary legislation, will set the basis for implementing policy measures (de Claro 2018).

Strengthening of purchaser autonomy

One of the novelties of the Vajpayee Arogyashree scheme in Karnataka was that it created a semi-independent purchasing agency in charge of the implementation of the scheme. This new governance arrangement allowed for a purchaser-provider split and gave managerial autonomy to the purchaser. At the same time, representation of senior officials from the State Department of Health in the oversight board ensures some control by the State Government on the use of public funds (Devadasan 2018).

Increased competition between purchasers to reduce the number of purchasers

The Colombian Government made enrolment in the health insurance scheme compulsory while increasing competition among purchasing agencies as well as providers respectively. Health insurance agencies were subject to rankings on quality, efficiency and scope of services provided. Competition among providers was enhanced by allowing purchasers to provide services through their own provider network for only up to 30% of the monetary value of all services they purchased. The result of this increased competition was a 40% decrease in the number of purchasers between 2013 and 2018. Disappearance of less performing purchasers from the market, likely contributes to efficiency (Rivillas et al., 2018).

Capitalise on government-wide initiatives of strengthening public budgeting or procurement to support the purchasing function in the health sector

The Government of Burkina Faso moved to programme-based budgets in 2017. This change was preceded by policy and administrative changes including the strengthening of sector plans, adjusting responsibilities for budget execution and building management capacity of ministries. The focus on specific indicators for budgeting and monitoring is expected to facilitate strategic purchasing (Kiendrebeogo et al., 2018).

Conclusion and way forward

The following key issues, which were crucial for all four countries on their way to more strategic purchasing, also underline how the various areas related to strategic purchasing are interwoven.

- As shown in all countries, purchasing is characterised by a multitude of actors operating at both national as well as sub-national levels. An overarching coordination mechanism is needed to ensure alignment across purchasing agencies, but also across health financing functions and the specific purchasing areas. Collection of information and management of incentives set by provider payment mechanisms are only two examples where coordination is needed to move towards more efficient purchasing. This coordination also needs to be reflected in mandates of key purchasing actors to avoid overlapping functions among ministries, mandatory health insurances schemes and private bodies.
- Moving towards more strategic purchasing is a step by step approach. Even if a country decides on a comprehensive reform of its purchasing system, implementation is a gradual approach, as the examples from the four countries show. Capacities of all actors, especially purchasers and providers, will have to be strengthened. There is a need to understand the purchasing market structures, driving forces and the interest of involved stakeholders, in particular that of health workers both in the public and private health sector. Hence, there is a need to develop training and skills in health financing at all levels of the health system.
- Payment systems rely on health information systems but can also help strengthening the later. Effective design and implementation of payment systems encourage the generation and use of new data which in turn allows to improve payment systems over time. The health information management architecture needs common standards of data collection. Systems have to be able to talk to each other. Information management was a cornerstone in each of the four country cases.
- The definition of benefit packages has broader implications. Effective alignment between benefit package review processes and the adjustment of provider payment methods is needed. A disconnection may result in barriers, which in turn lead to inequitable access to the health services and undermined quality and efficiency as intermediate goals of UHC.

The key lesson from the case studies is that progress towards more strategic purchasing is possible at any level of development and for whatever type of health system. It requires political will and vision, leadership to manage its dynamics, and must be accompanied by capacity strengthening.

Acknowledgments

Special thanks are due to Inke Mathauer for launching this work stream and overall guidance. Special thanks also to the following persons for the piloting of the assessment guide and the drafting of the four country reports: Vergil de Claro, Narayanan Devadasan, Ana Cristina Henao, Yamba Kafando, Joël Arthur Kiendrébéogo, Daniela Lopez, Juan Carlos Rivillas, Charlemagne Tapsoba, S. Pierre Yameogo. Valuable comments on this synthesis report from Danielle Bloom, Adanna Chukwuma, Inke Mathauer, Juan Carlos Rivillas, Martin Sabignoso are gratefully acknowledged.

References

Colombia Compra Eficiente. (accessed 14/08/2018)

De Claro, V. 2018. *Rapid Assessment of Strategic Purchasing in the Philippines. A Country Case Study*. Manila

Devadasan N. 2018. *Strategic purchasing in India. A case study of the Vajpayee Arogyashree scheme*. Institute of Public Health, National Health Systems Resource Centre, Suvarna Arogya Suraksha Trust. Bangalore.

Kiendrebeogo J A, Kafando Y, Tapsoba C, Yameogo S P. 2018. *Evaluation de la fonction d'achat stratégique du système de santé du Burkina Faso – Principaux résultats*.

Kutzin J. 2013. *Health financing for universal coverage and health system performance: concepts and implications for policy*. Bull World Health Organ 2013; 91: 602-611
<http://dx.doi.org/10.2471/BLT.12.113985>.

Mathauer I, Dale E, Meessen B. 2017. *Strategic purchasing for UHC: Key policy issues and questions. A summary from expert and practitioners' discussions*. Geneva: World Health Organization; 2017.

Rivillas J C, Lopez D, Henao A-C, Mathauer I. 2018. *Rapid Assessment of the purchasing arrangements in Colombia*. Bogota.

WHO. 2010. *Health financing. The path to universal health coverage*. World Health Report 2010. Geneva: World Health Organization.