1 - Background

The rise of chronic diseases in low-and-middle income countries (LMICs) calls for a substantial transformation of health service delivery models and systems. For instance, the management of comorbidities such as diabetes and hypertension requires empowerment of patients, a holistic approach to care management by the first line provider, care and service integration at the health facility level, fluid information sharing and coordination across levels of care and disciplines and within provider networks. Because of rapidly ageing populations in all countries, a crucial dimension of 21st century primary health care will be the ability of health systems to ensure continuity of care for all chronic illnesses and patients with multi-morbidities, for instance thanks to checkups, patient files and longitudinal follow-up.

In too many LMICs, public health centers are tailored to primarily tackle maternal and child health problems. This is important and need to be even further strengthened. However, at the same time, the ongoing epidemiological transition including rapid population ageing calls for a profound transformation in how services are organized and paid for the range of different services in need.

Since the Global Action Plan for the Prevention and Control of Noncommunicable Diseases issued in 2013, there has been greater and more coordinated effort to understand and evaluate the possible contribution of national health systems to manage chronic illnesses and co-morbidities. For instance, in 2014, the European Region Office of WHO issued its “Better noncommunicable disease outcomes: challenges and opportunities for health systems, Assessment guide”. Among other things, the document identifies 15 challenges to be overcome at health system level; several of them relate to institutional arrangements, service delivery and purchasing. The guide also provides an expanded list of individual core services that need to be well integrated into the health delivery system.

But there are still major gaps in our knowledge. So far, there has not been any comprehensive mapping and assessment of how purchasing arrangements contribute to improving the quality of personal health services of NCD management and chronic care.

Purchasing refers to the allocation of pooled funds to healthcare providers for the delivery of health services on behalf of certain groups or entire population. Purchasing arrangements are defined as any institutional arrangement purposely designed to allocate and channel financial resources from
a purchaser to a provider for the provision of health services to reach a health objective. They can target patient groups (e.g. peer educators), individual health workers, health facilities or networks of health service providers. Purchasing arrangements never stand alone: they are part of a larger nexus of institutions shaping patients’ and health service providers’ behavior; their contribution has therefore to be assessed in this specific context, including the service delivery model in place.

There is a wealth of experiences. Indeed, many high-income countries have already managed chronic illnesses through adapting purchasing arrangements, for instance with the introduction of specific pay-for-performance arrangements to encourage providers to focus on quality dimensions. But, as far as LMICs are concerned, the documentation of experiences is much more limited. For sure, guidance is lacking on how purchasing arrangements could contribute to improving quality of care as part of accompanying and supporting the much-required transformation of health service delivery models and systems described above.

In 2022-2023, the WHO Centre for Health Development (WKC) and Health Governance and Financing Department (HGF) of WHO Headquarters, in partnership with the OECD, will implement a comprehensive program of work to address this emerging need. Its main objective is the development of evidence-informed policy guidance on the possible use of purchasing arrangements to contribute to improving quality of NCD management and chronic care, with a focus on the needs of LMICs.

The program of work has started with the commissioning of two reviews of the literature. One focuses on a conceptual specification of quality of care for chronic illnesses, with the reality of LMIC health systems in mind. The second one will focus on the empirical literature of health financing arrangements for quality chronic care. These two desk reviews will inform the conduct of case studies in a number of low-, middle- and high-income countries.

2 - Case studies

Our program of work aims to answer a range of questions, for example :

- Which leverage do purchasing arrangements provide in terms of reform of health service delivery models as one structural determinant of improved quality in NCD management and chronic care?
- How can provider payment methods encourage greater quality of care, especially continuity (e.g. the problem of lost to follow-up) and integration of services?
- Which purchasing arrangements can enhance coordination across levels of care and the public/private sector spectrum?
- Are there purchasing arrangements that ensure or incentivize that medical and paramedical professionals increase or update their knowledge on how to handle NCD and chronic care?
- How can incentives be designed to empower patients in the self-management of their health problems?
- Which information is needed at the level of the purchasers? What are the synergies with the rapid digitalization of the health sector?

Bringing answers to such questions require a tailored empirical approach to experiences. For that reason, the program of work foresees the conduct of around ten case studies in low-, middle- and high-income countries.

The case studies will build on the literature review findings. They will document a set of experiences on how purchasing arrangements have contributed (or not) to improving quality of personal care of NCDs and chronic illnesses. Studies will focus on interventions with replicability potential in LMICs (or at least key lessons relevant for them).
The unit of analysis for the case studies will be programs\(^1\) with the following inclusion criteria:

- The program, or a component of it, addresses chronic conditions\(^2\)
- It addresses health needs, possibly jointly with psychological, social or economic needs related to the conditions
- A component of the program addresses quality of care
- The program contains one or several purchasing instruments that were introduced and serve to improve quality (input, process or outcome dimensions of quality)
- The purchasing arrangement(s) can be categorized as a policy attempt to innovate in terms of purchasing, with the intention to make the latter more strategic\(^3\)
- The program is rather recent (less than 10 years of existence)
- There is some scientific evidence of impact.

The case studies will document the context of the experiences, the purchasing intervention and its design characteristics (including its fit with the service delivery system in place), the implementation processes and the outcome of the intervention on a set of key metrics, including quality of care and unintended effects. Studies will be carried out by national researchers under the WHO-OECD supervision. A common framework will be used across cases being developed by WHO and OECD. Our ambition is to document different purchasing arrangements and the related quality enhancement effort. Variability across cases will be a criterion of selection.

For their selection of the ten case studies, OECD and WHO will pay attention to these criteria:

- All WHO regions are included
- Across the economic development spectrum (LIC, MIC, HIC)
- Different health (financing) system and service delivery contexts (e.g., national health services, national health insurance, systems with a dominance of private providers)
- Different policy context of the intervention (e.g., embedded within a larger health sector reform)
- Different levels of care
- Different purchasing arrangements or mechanisms (e.g., provider payment methods, performance-based financing, pay-for-coordination, accreditation system, contracting mechanisms, governance arrangements for purchasing, information management and reporting system)
- Interventions tackling different chronic illnesses
- Interventions with different theories of change
- Different status in terms of institutionalization and scale (e.g., initial reform experience versus long term experience).

The case studies will be gathered in a book published by WHO and OECD in 2023. Each case study will stand as one chapter of the book. Various dissemination activities at national and global levels are also foreseen.

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\(^1\) We define program as any coordinated policy action aiming a specific goal. Describing a program entails, among other things, to report on the following dimensions: political emergence, assigned goals, actor(s) coordinating the action, the theory of change and its expression in purposeful institutional arrangements. Programs take place in a specific context, are to be implemented with a mobilization of political, financial, administrative, human, informational, technological and physical resources and are enacted through the execution of actions on a time and space scale for a population. They can be evaluated as for their outcomes.

\(^2\) We have a broad understanding of ‘chronic illnesses’. For instance, once a HIV patient is on anti-retroviral therapy, s/he becomes a chronic patient.

\(^3\) Purchasing is considered strategic when allocations of pooled funds are linked, at least in part, to information on provider performance and the health needs of the population they serve, with the aim of realizing efficiency gains, increasing equitable distribution of resources and managing expenditure growth (https://www.who.int/activities/making-purchasing-more-strategic).
3 - Next steps

At the current stage, the WHO and OECD team are gathering information on possible interesting country case studies. We invite country researchers interested in joining this program of work to complete the form annexed to this note and send it to Bruno Meessen (meessenb@who.int).

As suggested by the criteria listed above, be aware that the WHO and OECD team may not be able to select the intervention you propose (for instance, because of an excessive number of interesting experiences from the WHO region of your country).

Feel free to contact Bruno if you have some extra questions!