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SPARC the Change: What the Strategic Purchasing Africa Resource Center Has Learned about Improving Strategic Health Purchasing in Africa

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ABSTRACT

Embodied in the goals of universal health coverage (UHC) are societal norms about ethics, equity, solidarity, and social justice. As African countries work toward UHC, it is important for their governments to use all available resources, knowledge, and networks to continue to bring this goal closer to reality for their populations. The Strategic Purchasing Africa Resource Center (SPARC) was established in 2018 as a "go-to" source of Africa-based expertise in strategic health purchasing, which is a critical policy tool for making more effective use of limited funds for UHC. SPARC facilitates collaboration among governments and research partners across Africa to fill gaps in knowledge on how to make progress on strategic purchasing. The cornerstone of this work has been the development and use of the Strategic Health Purchasing Progress Tracking Framework to garner insights from each country's efforts to make health purchasing more strategic. Application of the framework and subsequent dialogue within and between countries generated lessons on effective purchasing approaches that other countries can apply as they chart their own course to use strategic purchasing more effectively. These lessons include the need to clarify the roles of purchasing agencies, define explicit benefit packages as a precondition for other strategic purchasing functions, use contracting to set expectations, start simple with provider payment and avoid open-ended payment mechanisms, and use collaborative rather than punitive provider performance monitoring. SPARC has also facilitated learning on the "how-to" and practical steps countries can take to make progress on strategic purchasing to advance UHC.

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Introduction

Universal health coverage (UHC) means ensuring that all people have access to the health services they need without risk of financial hardship.[1] Embodied in the goal of UHC are societal norms about ethics, equity, solidarity, and social justice.[2,3] In practical terms, the journey toward UHC requires financial commitments from governments, investments in human resources and health infrastructure, political negotiation and tradeoffs, and stakeholder coalitions. As governments in Africa face major challenges to meeting their UHC commitments —including, most recently, the health and economic crises brought by the COVID-19 pandemic, global inflation, and supply chain disruptions—it is more important than ever for them to use all available resources, knowledge, and networks to continue to bring UHC closer to reality for their populations.

The Strategic Purchasing Africa Resource Center (SPARC) was established in 2018 with funding from the Bill & Melinda Gates Foundation to serve as a "go-to" source of Africa-based expertise in strategic purchasing, which is a critical policy tool that governments can use to make more effective use of limited funds for UHC. SPARC is hosted by Amref Health Africa[a] with technical support from Results for Development (R4D) and the engagement of a growing network of Africa-based institutions[b]. A core aim of SPARC is to strengthen strategic purchasing knowledge, expertise, and institutional capacity in Africa to advance UHC.

Strategic purchasing requires deliberately directing health funds to priority populations, interventions, and services. It involves actively creating incentives so funding is used equitably and efficiently and in alignment with population health needs; using information to determine which health services to cover with public funds; selecting providers to deliver those services; and defining how and how much to pay those providers.[4] The evidence on what it means to make health purchasing strategic has grown tremendously over the past two

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decades.[5–14] Expertise and practical experience implementing health purchasing approaches have also grown considerably, globally and in Africa. However, this growing body of evidence and experience has not been adequately captured to build a practical knowledge base about how to create the enabling systems, policies, and processes for this technically complex and politically challenging endeavor, particularly in Africa.

SPARC has facilitated collaboration among government institutions and technical partners across Africa to bring together the considerable experience and expertise on the continent to fill these practical knowledge gaps through research and evidence generation; real-time learning from policy dialogue, design, and implementation; and collaborative learning among African countries. The cornerstone of this learning has been the development and use of the Strategic Health Purchasing Progress Tracking Framework to map and gain insights from each country's efforts to improve strategic purchasing (Figure 1).[1,15,16] Application of the framework and subsequent dialogue and deliberations within and between countries engaged with SPARC have generated lessons that other countries can use as they chart their own course to use strategic purchasing more effectively to advance their UHC goals. In this paper, we summarize the key lessons that have emerged from SPARC's learning agenda.

Lessons from Africa on Strategic Health Purchasing

Four core purchasing functions are involved in allocating funds to service providers: benefits specification, contracting arrangements, provider payment, and performance monitoring (Figure 1).[1] These functions are carried out, either implicitly or explicitly, in any government health financing system no matter how it is organized (e.g., government budget financing or national health insurance).[7] When they are designed to work together to achieve health system objectives and are facilitated by supportive governance structures, they become the "engine" of strategic purchasing. This can be true in any system, regardless of the level of resources or capacity.[12,17]

The following lessons from the SPARC learning agenda can help countries build that engine of strategic purchasing:

Define Clear Roles and Responsibilities for Purchasing Agencies

Purchasers need explicit institutional mandates for carrying out purchasing functions, with clear roles and clear relationships between institutions to reduce overlaps or gaps in the core purchasing functions.[12,18,19] Also critical is a regulatory environment that supports the core purchasing functions and strategic resource allocation decisions. This is particularly important in

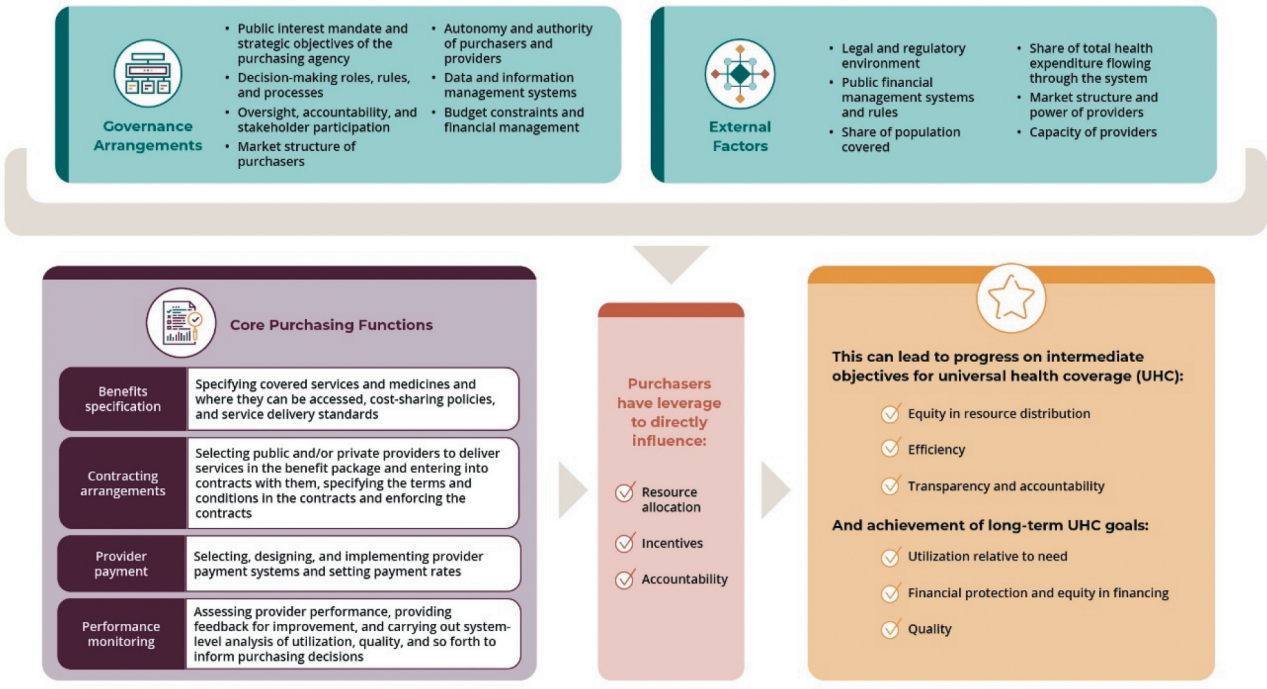

Figure 1. Strategic health purchasing progress tracking framework.

countries with multiple schemes that operate concurrently, and more than one agency involved in purchasing. Fragmentation can be further reduced by unifying information systems to provide an integrated view of all schemes, link information across programs and patients, and harmonize how core purchasing functions are carried out across schemes.[4] Many African countries have yet to effectively integrate health information systems at all levels of care and ensure interoperability[20]; this limits the availability of data and evidence to make timely decisions and results in duplicative data collection by health facilities.[7,12]

Benefits Specification is a Pre-condition for Contracting and Provider Payment to Work Well

All the countries engaged with SPARC define a package of services and medicines that are covered by pooled government funds.[12] This essential benefit package is then adapted by other schemes in the country. However, the package is generally defined broadly and is not well matched to available resources.[15] Strategic purchasing requires that the benefit package be explicit and serve as the basis for contracts between purchasers and providers.[18,19] The benefit package becomes an even more strategic tool when it includes clear expectations, rules, and obligations for providers, in the form of service delivery standards and gatekeeping requirements, and when it includes links to clinical guidelines.[12,21] It can also serve as the foundation for capacity development for providers that fall short of expectations. Furthermore, when the benefit package is clear and explicit, provider payment can be linked to delivery of services in the package and provider performance, in what is known as *output-based payment*.[7,12,16,17,22]

Use Contracting Arrangements to Set Expectations and Ensure Accountability

Contracting is a powerful tool to communicate to providers what is expected of them, including standards for service delivery and quality of care. Contracting is also important for holding providers accountable for achieving set quality benchmarks.[12,14,16,17] Contracting is relevant not only for insurance-based systems but also schemes financed by the government budget; it should include clear standards for accreditation and inclusion of providers, expectations for capacity, and accountability for use of resources and quality of care.[12,23,24] The role of private-sector providers in providing essential health services (including primary health care) in low- and middle-income countries is well documented.[25–30] Contracting can be a means to increase participation of the private sector and increase the range of providers that beneficiaries can access.[31,32]

Start with Simple Provider Payment Mechanisms

Most of the countries engaged with SPARC have moved toward output-based payment in at least a subset of financing schemes, but they still mostly rely on fee-for-service payment, which is frequently accompanied by inefficiencies, cost escalation, and administrative burdens.[7,12,16,33]

Bundling provider payment for primary health care, such as by using capitation payment, may be a first step to improving equity and efficiency in resource allocation.[7,12,16,23] Open-ended fee-for-service payment may be easy to set up, but it can quickly become burdensome, expensive, and difficult to move away from later on.[34,35]

All provider payment mechanisms—fee-for-service, capitation, line-item budgets, global budgets, per-day payments, diagnosis-related groups, and case-based payment—have pros and cons.[5–7] Using blended payment mechanisms to balance incentives within and between levels of care and types of services is often necessary to achieve service delivery objectives while managing costs.[36] The countries engaged with SPARC have made some progress in this area, but they have yet to make full use of blended payment systems.[12] Furthermore, the high degree of fragmentation in health financing in these countries means that many providers receive revenue from multiple financing streams with different payment methods and different, sometimes conflicting, incentives.[12] Consolidating and channeling payments through one allocation system, such as capitation for primary care, can mitigate fragmentation and thereby reduce the disparate and conflicting incentives to health providers due to multiple provider payment methods.[12,37,38]

Finally, for payment incentives to be effective, providers need managerial and financial autonomy to respond to them and to budget, plan, and use their resources to address local priorities.[12,17,18] This autonomy needs to be balanced with accountability as well as managerial capacity. Adapting public financial management (PFM) rules to allow funds to directly reach frontline providers and increase the financial autonomy of those providers can increase the effectiveness of health purchasing levers and improve budget execution.[39]

Focus on Collaborative Rather than Punitive Performance Monitoring

Defining benchmarks in contracts and linking them to performance monitoring of health providers can help

build a culture of improvement and accountability.[12,16] When designed well, performance monitoring systems can improve and strengthen all other purchasing functions. Rather than focus only on sanctions and penalties for poor performance, performance monitoring systems should support health providers' capacity development and inform human resource and infrastructure investment plans to improve the quality of care overall.[12,17,40]

"How-to"—Practical Steps Countries Can Take to Improving Strategic Purchasing

The lessons described in the previous section reveal the following insights on the steps to improving strategic purchasing.

Map the Journey

Strengthening health financing systems and embedding effective strategic purchasing measures to advance UHC is a long-term process that requires a path with incremental steps in the right direction as well as learning and adaptation along the way. Establishing a vision and a context-appropriate pathway to achieve that vision can help guide countries through the complex decisions and trade-offs along the way.

Ghana, one of only a handful of African countries that has achieved significant progress toward UHC through a national health insurance system,[41,42] has taken incremental steps to improve coverage and expand access to health services since 2003. Figure 2 provides a snapshot of the major milestones in the country's progress related to strategic purchasing. This progress has been made possible through a vision laid out in the National Health Insurance Scheme legislation of providing equitable access to comprehensive essential health care for the entire population with financial risk protection and step-by-step strategic purchasing improvements to enhance implementation of the scheme.[43–45]

The Strategic Health Purchasing Progress Tracking Framework is one tool that countries can use to inform a strategic purchasing roadmap.[4] By applying the framework, they can gain useful information for analysis, policy dialogue, and prioritizing actions and investments that advance progress on strategic purchasing.[1]

Use the Government Budget to Make Purchasing More Strategic

The government budget is the largest source of pooled funds for UHC in most African countries and can be a vehicle for improving equity and efficiency through strategic purchasing.[23,46] One misconception about strategic purchasing is that it can happen only in a health insurance model, where there is a purchaser-provider split, but all of the purchasing functions can be used for strategic purchasing in the government budget financing model. Health sector budget officials need a clear understanding of the flexibilities and constraints in the PFM system and where existing flexibilities can be exploited or new flexibilities negotiated to improve strategic purchasing.[47] Budget structures can be aligned with strategic purchasing objectives, as they have in Tanzania and Uganda, to make it easier to move funds across spending categories and reduce bottlenecks in funding flows to providers.[12,19,21,46] In many countries, including Tanzania and Uganda, stronger dialogue between the ministry of health and ministry of finance to align objectives has been a valuable first step, leading to necessary changes such as allocating flexible funds to frontline providers and giving those providers autonomy and flexibility in how they deliver the benefit package.[23,46]

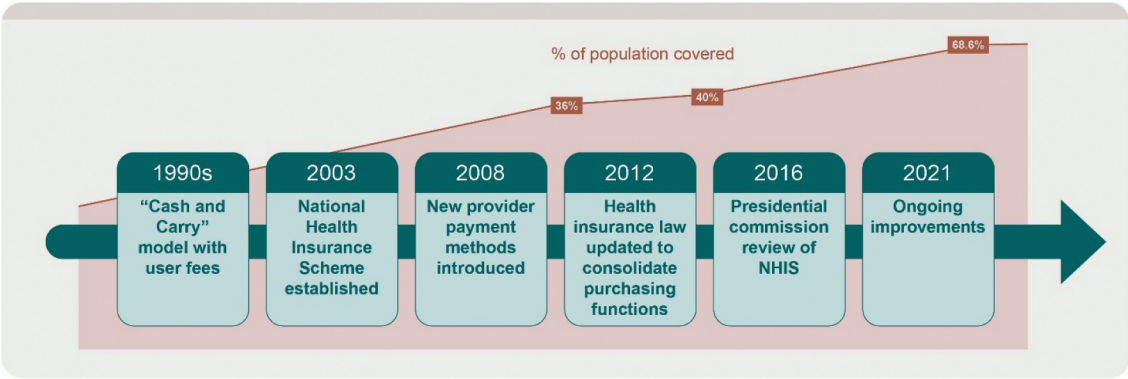

Figure 2. Ghana's journey toward UHC through the National Health Insurance Scheme.

Resist Fragmentation

The most persistent obstacle to improving how resources are used to advance UHC goals through strategic purchasing is fragmentation in health financing. The main reason for this fragmentation is very low per capita spending by governments on health, which leads to high out-of-pocket costs and a heavy reliance on donor funding, which often flows outside of government budget structures and has separate priorities and requirements.[23] But much of the fragmentation in financing for health in Africa is also caused by new health financing "solutions"—such as community-based health insurance, performance-based financing schemes, and voucher systems, many of which are also driven by donor investments. These new financing schemes often have their own service packages, contracting and payment mechanisms for providers, and reporting and monitoring systems.[12,48] Most recently, interest in creating new contributory national health insurance schemes has increased all across Africa, despite limited evidence of their success in low- and middle-income countries.[36,49] Despite some successes in Gabon, Ghana, and Rwanda, national health insurance has not led to significant increases in government spending on health, greater population coverage, or improvements in equity.[36,37]

The lesson for health sector leaders in Africa is to avoid so-called solutions that fragment health financing, which can weaken strategic purchasing and be difficult to remedy later. Countries might find more benefit in first building on the government budget or improving purchasing functions within and across existing schemes before undertaking major institutional reforms. Countries that are firmly on the path to setting up contributory national health insurance or other new schemes should ensure that those schemes have an equity focus so the most vulnerable groups gain access to health care and that institutional arrangements support the core purchasing functions and enable those functions to evolve and be consolidated over time.[37]

Another level of fragmentation results from government decentralization, where subnational levels receive resources for delivering public services to their populations.[50,51] When managed well, this decentralization can facilitate resource flows and create a more responsive health system and better accountability for resources. But if poorly implemented, decentralization can cause further fragmentation, compromise coordination and planning, increase bottlenecks and administrative costs, and lead to waste of resources.[51–58] For decentralization to work well, countries should first ensure that the fundamentals are in place, including mechanisms to allocate resources equitably across administrative and geographic areas according to need, and the political will to make necessary legislative and administrative changes and ensure adequate technical skills at the subnational level.[55–58] In the meantime, more research is needed to inform decentralization agendas.[55–59]

Learn Together with Peer Countries

Making progress on strategic purchasing for UHC is both a technical and a political endeavor. There is no universal blueprint or "one-size-fits-all" solution. Many countries are grappling with similar issues and can benefit from learning together about how to build system capacity and make progress incrementally.[13] Peer learning networks such as SPARC and the Joint Learning Network for Universal Health Coverage[60] provide opportunities for learning on both technical and nontechnical aspects of strategic purchasing, bringing practical insights and innovations from similar country contexts that can be adapted for implementation in Africa.

Conclusion

Governments that commit to UHC are committing to a long road, and they will need to use all available tools, networks, evidence, and practical lessons to be successful. The tremendous expertise and experience with strategic purchasing efforts on the African continent can be tapped and shared to accelerate the journey for all. SPARC is one resource that supports country actors by providing lessons from strategic purchasing efforts across the continent that other countries can apply to advance UHC in their own way, prioritize actions, and avoid pitfalls. The key is to start with and build on existing systems, tap domestic resources, trust local expertise, and resist new solutions today that may become the problems of tomorrow.

Notes

a. Amref Health Africa (Amref) is an international nongovernmental organization based in Nairobi, Kenya. Amref's mission is to increase sustainable access to health care in communities in Africa through solutions in human resources for health, health services delivery, and investments in health.

b. The Africa-based institutions include Center de Recherche en Reproduction Humaine et en Démographie in Benin, Recherche pour la Santé et le Développement in Burkina Faso, Research for Development International in Cameroon, Kwame Nkrumah University of Science and Technology in Ghana, KEMRI Wellcome Trust Research Programme in Kenya, Health Policy Research Group in Nigeria, University of Rwanda School of Public Health, Ifakara

Health Institute and University of Dar es Salaam in Tanzania, and Makerere University School of Public Health in Uganda.

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Author Contributions

CC, DB, and AG-M led the drafting of the manuscript; GK and NO reviewed the drafts and provided critical input.

Data Availability Statement

The authors confirm that the data supporting the findings of this study are available within the article and/or its supplementary materials.

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