



## The Strategic Health Purchasing Progress Tracking Framework: A Practical Approach to Describing, Assessing, and Improving Strategic Purchasing for Universal Health Coverage

Cheryl Cashin & Agnes Gatome-Munyua

To cite this article: Cheryl Cashin & Agnes Gatome-Munyua (2022) The Strategic Health Purchasing Progress Tracking Framework: A Practical Approach to Describing, Assessing, and Improving Strategic Purchasing for Universal Health Coverage, Health Systems & Reform, 8:2, e2051794, DOI: [10.1080/23288604.2022.2051794](https://doi.org/10.1080/23288604.2022.2051794)

To link to this article: <https://doi.org/10.1080/23288604.2022.2051794>



© 2022 The Author(s). Published with license by Taylor & Francis Group, LLC.



Published online: 21 Apr 2022.



Submit your article to this journal [↗](#)



Article views: 6020



View related articles [↗](#)



View Crossmark data [↗](#)



Citing articles: 12 View citing articles [↗](#)

# The Strategic Health Purchasing Progress Tracking Framework: A Practical Approach to Describing, Assessing, and Improving Strategic Purchasing for Universal Health Coverage

Cheryl Cashin<sup>a</sup> and Agnes Gatome-Munyua <sup>b</sup>

<sup>a</sup>Results for Development, Washington, DC, USA; <sup>b</sup>Results for Development, Kenya

## ABSTRACT

Strategic purchasing of high-priority services is a critical part of effective spending to advance UHC goals. Available conceptual frameworks for strategic purchasing have facilitated high-level advocacy and policy dialogue, and they have framed research and analytical work to describe and understand countries' purchasing arrangements. What has been missing is a framework and approach that combines the conceptual framing of strategic purchasing with practical guidance to describe and assess purchasing in sufficient detail to inform policy.

This paper presents a practical framework and approach to tracking progress in purchasing: the Strategic Health Purchasing Progress Tracking Framework. Co-created by a group of health financing researchers and academics through the Strategic Purchasing Africa Resource Center (SPARC), it builds on existing frameworks and focuses on the core purchasing functions of benefits specification, contracting arrangements, provider payment, and performance monitoring. It incorporates factors that can either strengthen or weaken the power of purchasers to directly influence resource allocation and provider behavior. The paper also proposes a set of evidence-based benchmarks that country stakeholders can use to assess where their health system is on the continuum from passive to strategic purchasing and to identify steps to make purchasing more strategic.

Application of the framework has shown the value of mapping purchasing functions across all health financing arrangements to identify where strategic purchasing progress is more advanced and where it may be lacking. It has helped countries identify challenges—such as fragmentation and duplication of purchasing functions across health financing arrangements—and prioritize policy actions.

## ARTICLE HISTORY

Received 1 October 2021

Revised 7 February 2022

Accepted 7 March 2022.

## KEYWORDS

Africa; health financing; purchasing framework; strategic health purchasing; UHC

## Introduction

In 2018, global spending on health reached \$8.3 trillion USD, or about 10% of the global economy. But progress on health sector objectives such as universal health coverage (UHC) has not kept pace.<sup>1</sup> Sustainable progress toward UHC requires that a country's health financing system routinely generate sufficient and largely domestic resources to expand and sustain access to high-quality health services with financial protection. Public resources are the most efficient and equitable way to fund health coverage,<sup>2,3</sup> so UHC requires significant fiscal commitment from governments. Increased health spending does not automatically translate into improved access to necessary health services without financial risk to households, however, without active policy measures that direct spending toward health priorities.<sup>4</sup> These policy measures—known collectively as *strategic health purchasing*—are essential to directing increased government health spending toward advancing UHC goals.<sup>5–9</sup>

Health purchasing is defined most generally as the allocation of pooled funds on behalf of the population to the providers of health services.<sup>10</sup> Purchasers can be more passive or more strategic in how they transfer these funds. With passive purchasing, information and evidence are not used to define benefit packages or to select providers to deliver the services. More passive purchasers also do not use contracting mechanisms to specify and enforce quality standards. They typically pay providers using historical input-based budgets, with no explicit link to the delivery of priority services, or, at the other extreme, they use open-ended fee-for-service payment with no mechanism for expenditure management.<sup>6,11</sup> More strategic purchasers use evidence and information about population health needs and health provider performance to make decisions about which health services should have priority for public funding (“what to buy”), which providers will provide these services (“from whom to buy”), and how and how much providers

will be paid to deliver those services (“how to buy”).<sup>5–9,11,12</sup> Strategic purchasers also allow funds to be used flexibly by frontline providers, while holding them accountable for service delivery results.<sup>8,9</sup>

While health purchasing can be carried out by either public or private purchasers, our focus is on public funds for UHC and the purchasers that manage them—typically public agencies. If a large share of health spending is channeled through public purchasing agencies (such as ministries of health and public health insurance agencies) or private purchasers acting on their behalf, these purchasers gain *purchasing power*. This means the purchaser can influence or dictate which services are prioritized, which providers deliver them, how much providers are paid, the quality standards providers must meet, and the many other levers that can be brought to bear to help achieve UHC objectives.<sup>13</sup>

There is general acceptance in the global health community that strategic purchasing is a necessary policy direction to continue making progress on UHC within funding constraints, or even as funding increases.<sup>5,9,11</sup> The conceptual underpinnings and policy levers included in strategic purchasing, however, continue to be debated.<sup>12,14</sup> This can create confusion in country-level policy dialogue and lead certain solutions to dominate, such as performance-based financing (PBF) and community-based health insurance, which are often driven by donor priorities.<sup>15,16</sup> Shifting the conversation to a more practical framing of health purchasing functions may help policy makers gain a clearer understanding of the options they have to better use strategic purchasing to advance UHC goals. This paper proposes a practical framework for describing, assessing, and improving health purchasing systems that can be applied across health financing arrangements at the country level to identify areas of progress that can be built on and areas of fragmentation or overlap that need to be addressed.

## Existing Health Purchasing Frameworks

Several frameworks have been developed to describe strategic purchasing systems, including the frameworks of the Resilient and Responsive Health Systems (RESYST) consortium,<sup>12</sup> the USAID Health Finance and Governance Project,<sup>17</sup> the World Health Organization (WHO) policy brief “Purchasing Health Services for Universal Health Coverage: How to Make It More Strategic?,”<sup>9</sup> and the WHO Health Financing Progress Matrix.<sup>18</sup> A number of tools also exist for countries to design and assess specific aspects of health purchasing systems, such as governance arrangements,<sup>19</sup> benefit packages,<sup>20,21</sup> provider payment systems,<sup>8,22,23</sup> and performance monitoring.<sup>24</sup> These frameworks and

tools have provided greater clarity in terms of the actors, roles, policy questions, and actions required to make more strategic health purchasing decisions. What has been missing, however, is a framework and approach that combines the conceptual framing of strategic purchasing with practical guidance on describing and assessing purchasing functions systematically and in sufficient detail to inform policy decisions.

## The Strategic Health Purchasing Progress Tracking Framework

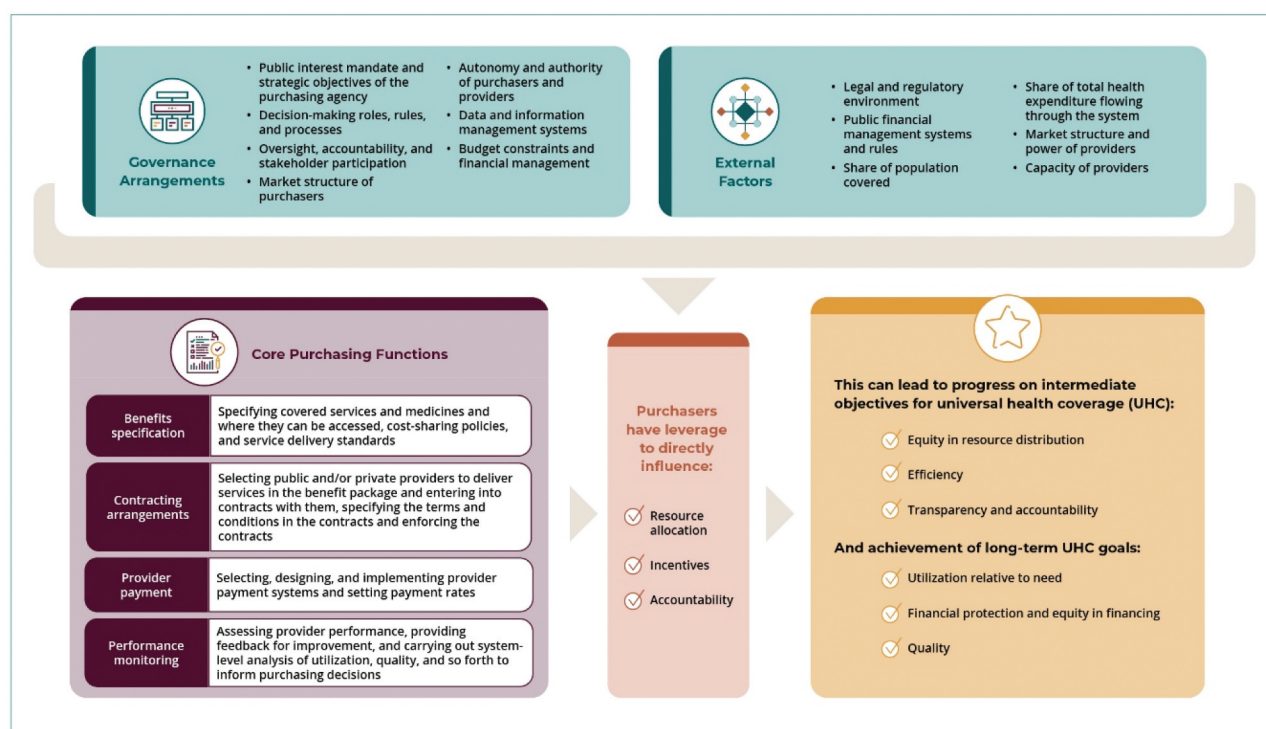
We propose a strategic health purchasing framework that consolidates and builds on existing frameworks, examining in greater depth and detail the core purchasing functions of benefits specification, contracting arrangements, provider payment, and performance monitoring (Figure 1). The framework considers these areas the core functions for making and implementing decisions on what to buy, from whom to buy, and how to buy priority health services.<sup>5,9</sup> The framework also goes further by incorporating factors that can either strengthen or weaken the power of purchasers to directly influence resource allocation and provider behavior, such as the share of total health funding managed by the purchaser, public financial management rules, and provider capacity.<sup>8,9,13,22</sup>

The framework was co-created by a group of health financing researchers and practitioners to fully capture and inform the policy questions that arise most frequently in country-level policy dialogue and reform.<sup>25</sup> It is accompanied by a Microsoft Excel-based spreadsheet to guide data collection and map health purchasing systems at the country level, as well as a set of benchmarks that indicate how strategically the functions are being carried out. The benchmarks are drawn from the published literature and the normative guidance in existing frameworks about what makes purchasing strategic.

We suggest applying the framework in a way that describes how the purchasing functions are carried out across all health financing arrangements in the country (e.g., budget financing, national health insurance schemes, PBF, etc.), rather than examining one scheme in isolation. When the framework is applied in this way, it can provide a more complete picture of purchasing functions across health financing arrangements to identify areas of progress that can be built on and areas of fragmentation or overlap that need to be addressed.<sup>26–32</sup>

## Conceptual Underpinnings of the Framework

The premise underlying this framework is that any purchasing system carries out a set of core functions that are supported by governance and institutional



**Figure 1.** The strategic health purchasing progress tracking framework.

arrangements that allocate the responsibility for carrying out the functions, and it includes governance structures that provide oversight, accountability, and reporting lines and ensure effective stakeholder participation. When purchasing functions and governance arrangements are in place, the purchaser can directly influence (positively or negatively) the allocation of resources (to priority services and population groups, geographic regions, types of providers, etc.), the incentives that drive individual provider behavior, and accountability through contract enforcement and performance monitoring.<sup>6,8,9,12</sup> Resource allocation, incentives, and accountability can in turn affect overall progress on intermediate UHC objectives (equity in resource distribution, efficiency, transparency, and accountability) and long-term UHC goals (utilization of services relative to need, financial protection and equity in finance, and quality).<sup>18</sup>

However, the purchaser's influence on resource allocation, incentives, and accountability, and in turn on higher-level UHC objectives, can be enhanced or mitigated by factors outside the purchaser's control ("external factors"). Some of these factors include the share of funds under the control of the purchaser (i.e., how effectively funds are pooled), public financial management rules, and the clinical and management capacity of providers. Furthermore, purchasing reforms change

how funds flow through the system and to whom, so they often involve political trade-offs and negotiations that can weaken or stall their implementation.<sup>33,34</sup>

Together, these factors affect how much power purchasers have to influence overall resource allocation in the system, their ability to create financial and nonfinancial incentives to influence provider behavior, and the ability of providers to respond to those incentives.<sup>6,8,13,35,36</sup> The assumption is that more consolidated purchasing power within a purchasing agency that has a legal mandate to serve the public interest, or well-harmonized funding flows across multiple agencies, can lead to more positive outcomes when public funds are limited.<sup>13,36</sup>

### **Governance and Institutional Arrangements**

Purchasing is carried out by an institutional home that transfers the funds (the main "purchasing agency"), although other institutions may be responsible for supporting or carrying out some of the functions.<sup>19</sup> Governance of health purchasing includes the systems and structures that are in place for stewardship of the system to provide strategic direction and ensure coherence, oversight of the various actors, definition of their roles and responsibilities, and ways to hold them accountable for carrying out their responsibilities.<sup>19</sup> The institutional arrangements for health purchasing encompass how responsibilities and decision-making



authority to carry out health purchasing functions are distributed across different institutions and how those institutions relate to each other.

Governance and institutional arrangements also define how much autonomy purchasers and providers have in decision making, how financial management is carried out, and how information is generated and used. Purchasers require information on population health needs and system capacity to prioritize the use of funds within the constraints of the current system. They also need financial management systems to track the budget and use purchasing instruments to keep expenditures within the budget.<sup>9</sup> Health care providers need a degree of financial and management autonomy so they can receive funds directly and respond to the incentives in provider payment systems.<sup>8,22,35</sup>

### Purchasing Functions

The core functions that any purchaser needs to be able to carry out include:

- **Benefits specification.** This includes selecting the services and interventions to be included in the benefit package, the service delivery standards, where and how the services can be accessed (including gatekeeping policies), how much of the cost of services will be covered by the purchaser (and accompanying cost-sharing policies), and which medicines will be covered.
- **Contracting arrangements.** This includes systems and policies for selecting public and/or private providers to deliver services in the benefit package, entering into contracts with them that specify terms and conditions (e.g., at which level specific services can be delivered and data reporting requirements), and enforcing the contracts.
- **Provider payment.** This includes systems and policies for selecting, designing, and implementing provider payment systems and setting payment rates.
- **Performance monitoring.** This includes systems and processes for assessing provider performance, providing feedback for improvement, and carrying out system-level analysis of utilization, quality, and so forth to inform purchasing decisions.

### What Makes Purchasing Strategic?

Purchasing functions exist in all health financing systems, and purchasing arrangements fall along a continuum from more passive to more strategic.<sup>9</sup> Evidence is building on what is required to make purchasing more strategic—that is, to get more value from existing funds, be more

responsive to population health needs, and advance other health system objectives.<sup>9,11,12,37,38</sup> The main purchasing agency should have a public interest mandate and clear objectives.<sup>19</sup> The core purchasing functions should be carried out through strategic, objectives-driven policies<sup>8,9,18</sup> and supported by strong, preferably information technology-based, operating systems.<sup>17,39</sup> Some key features of purchasing functions that make them more strategic are described in the following sections.

### Benefits Specification

Strategic purchasing decisions start with an understanding of the health needs of the covered population and specifying a benefit package—covered services that will be paid, in part or in full, by the purchaser from pooled funds<sup>9</sup> to meet those needs. Benefits specification is strategic when a package is well defined and periodically revised through a transparent process, reflects health priorities, and is a commitment to the entitled population.<sup>9,18</sup> When the benefit package is a commitment, it means that access to all of the services in the package is assured at a reasonable level of quality. For example, in Chile's national health insurance system, which includes both public and private purchasers, the benefit package takes the form of explicit and enforceable service guarantees for a list of 85 conditions. The list of conditions, known as *Acceso Universal con Garantías Explícitas* (AUGE), is reviewed every three years by an advisory committee. Care for these conditions is guaranteed within a defined waiting time and must be provided according to national service delivery standards.<sup>40,41</sup>

Benefits should also be specified in a way that is aligned with purchasing mechanisms—that is, the payment to providers should be directly linked to services in the benefit package.<sup>18,20</sup> The purchasing agency should further specify the benefits through service delivery standards in line with national service delivery policies and clinical protocols when contracting with providers.<sup>9,17</sup> For example, the benefit package may include “antenatal care,” but the purchaser can further specify the number of antenatal visits and the diagnostic tests and procedures that individuals are entitled to receive and providers are obligated to provide.

### Contracting Arrangements

Once the service package is defined, the purchaser contracts with providers to deliver the services to the covered population. Contracting can take many forms, from highly structured and competitive to more implicit and relational, and the most appropriate approach is likely to

be context specific.<sup>42</sup> In Ghana, for example, the purchasing agency for the National Health Insurance Scheme (NHIS) enters into formal contracts with both public and private providers that specify the terms in detail.<sup>28</sup> In Burkina Faso, the *Gratuité* scheme does not use explicit contracts between the purchaser (the Ministry of Health's UHC unit) and public providers; instead, the terms that the purchaser and providers agree to are specified in the *Gratuité* operating manual.<sup>31</sup>

Certain general principles govern what makes contracting more strategic and more supportive of health system goals. Contracting is considered to be strategic when formal agreements are in place between the purchaser and public and private providers that specify obligations on both sides. The purchaser can use contracts to achieve explicit objectives (such as improved prescribing of medicines or better data reporting), and the purchaser contracts selectively with public and private providers based on uniformly applied quality standards.<sup>6,8,42,43</sup> All of these conditions may rarely be met in low- and middle-income countries, however, and selective contracting is often impractical or works against the goal of ensuring access to care.<sup>6,42</sup> Nonetheless, contracts are an important tool for communicating expectations and, even if not intended to stoke competition, for introducing a credible threat of being excluded from financing if a provider does not meet minimum quality and performance standards.<sup>6</sup>

### Provider Payment

The purchaser pays contracted providers to deliver the services in the benefit package through a set of provider payment systems. Provider payment is strategic when payment incentives and rate-setting are used to achieve health system objectives—that is, when payment is linked to services in the package (“output-based payment”) and specific service delivery objectives, creates incentives for efficient and high-quality service delivery, promotes effective allocation of resources across levels of care, and enables management of the purchaser's budget (that is, payments are not open-ended but capped at some level of the system).<sup>8,17,18,22</sup>

There is no gold standard or perfect payment method, and every method has strengths and weaknesses and can produce unintended consequences.<sup>8</sup> Different payment methods may be useful in different contexts to address the most pressing health system priorities and service delivery objectives. For example, fee-for-service payment will lead to cost escalation in many contexts, but the method can be useful if a priority objective is to increase productivity or service utilization.<sup>22</sup> Output-based payment requires that providers have some autonomy to

make decisions to respond to payment incentives—they can decide to shift their staff or use a different mix of inputs to improve the delivery of the service package.<sup>8,9,34</sup>

Payment rate-setting is strategic when it is based on a combination of cost information, available resources, policy priorities, and negotiation.<sup>23</sup> Provider payment rates should reflect the average cost to efficient providers of delivering the services in the benefit package. Cost estimates are just a starting point for rate-setting, however, because they often reflect distortions in the current system (such as inefficiencies or chronic underfunding).<sup>44</sup> The purchaser should take other factors into consideration, including the available budget and what the providers consider adequate and acceptable. Payment rate-setting is also another opportunity for the purchaser to direct funding toward objectives, such as paying relatively higher rates for primary care providers or for higher-priority services.<sup>45</sup>

### Performance Monitoring

Purchasers need access to both service delivery and financial information so they can assess how purchasing policies are affecting the performance of individual providers and the system as a whole, so they can address provider performance issues or adjust purchasing policies.<sup>9,22</sup> Performance monitoring is strategic when information is generated routinely through integrated health information systems and used for monitoring at both the provider level and the system level to inform purchasing policies.<sup>9,17,18,24</sup>

Information systems in many low- and middle-income countries are far from being able to provide the detailed and interlinked information necessary for routine monitoring that can inform purchasing decisions. Many countries do not fully use routine information, such as claims data, to its fullest potential.<sup>9,22</sup> Nonetheless, all purchasers carry out some monitoring functions and can gradually improve their capacity to generate, analyze, and use data for purchasing decisions even before large-scale improvements toward integrated health information systems are possible. In some cases, they can start by simplifying reporting requirements and reducing the number of indicators reported through the system.<sup>24</sup> Rwanda began its multi-year journey of improving and integrating its health information systems by paring down the list of indicators reported by health providers, standardizing reporting, and making analyzable data available to providers. This facilitated the move toward more interoperability of information systems and built a culture of data use.<sup>46</sup>

## Benchmarks for Tracking Strategic Purchasing Progress

We propose a set of benchmarks to be used along with the purchasing framework that provides a more granular description of the typical movement along the continuum from passive to strategic purchasing. We have consolidated the normative guidance from existing purchasing frameworks and assessment guides to establish the ideal way to carry out each function most strategically. We have added steps along the continuum toward the ideal based on earlier progress frameworks<sup>17</sup> and implementation experience<sup>39</sup> so countries can assess whether their purchasing functions and policies are moving in a more strategic direction. The benchmarks were validated for practical relevance through a series of stakeholder consultations by the Strategic Purchasing Africa Resource Center (SPARC)<sup>25</sup> and the application of the benchmarks in nine countries (Benin, Burkina Faso, Cameroon, Ghana, Kenya, Nigeria, Rwanda, Tanzania and Uganda).<sup>47</sup>

### Governance and Institutional Arrangements

The “ideal state” for well-functioning governance and institutional arrangements to support strategic purchasing can be summarized as follows:

- **Institutional roles and capacity.** An agency or agencies have responsibility for carrying out all purchasing functions with a legal mandate to serve the public interest. Which agencies have the authority to make which purchasing decisions is clearly defined to avoid overlaps, inconsistencies, and conflicting policies.<sup>19</sup> A strategic purchaser should have sufficient flexibility and autonomy, as well as institutional capacity, to effectively design and carry out purchasing functions to achieve its objectives.<sup>19,26</sup>

- **Expenditure management.** A transparent process is used to set the purchaser’s budget, and mechanisms are in place to track and manage budget execution/spending. For example, total expenditure may be capped at the level of the entire system (as in Japan’s social health insurance system)<sup>45</sup> or for subsectors such as hospitals, ambulatory care, and pharmaceutical products (as in France’s social health insurance system or Thailand’s Universal Coverage Scheme).<sup>37,48</sup> Expenditure caps can also be applied at other levels, such as subnational administrative levels or individual providers. If purchasing is strategic, these mechanisms are enforced and budget overruns rarely occur.<sup>9,19</sup>
- **Health provider autonomy.** Health care providers can directly receive funds and flexibly manage them to respond to the financial incentives of the provider payment systems, while being held accountable for appropriate spending and service delivery results.<sup>19,22,35</sup>

Benchmarks that can be used to indicate incremental progress on governance and institutional arrangements are shown in [Table 1](#).

### Core Purchasing Functions

The “ideal state” for the core purchasing functions in order for them to be strategic can be summarized as follows:

- Benefits specification
  - A benefit package is well specified and periodically revised through a transparent process, reflects health priorities, and is a commitment

**Table 1.** Benchmarks for progress on governance and institutional arrangements.

Institutional arrangements and capacity	○	The main purchasing agency does not have a legal public interest mandate, the allocation of purchasing functions is not well defined, and capacity is weak.
	●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain.
	●●●	An agency or agencies have responsibility for carrying out all purchasing functions with a public interest mandate, appropriate autonomy, and effective accountability, and there is meaningful stakeholder participation; there are no overlaps or gaps in responsibilities; and the institutional and technical capacity of the purchasing agency is strong.
Expenditure management	○	The process used to set the purchaser’s budget is not transparent; mechanisms are in place to track budget execution/spending, but these mechanisms are not enforced and overruns routinely occur.
	●●	A transparent process is used to set the purchaser’s budget; mechanisms are in place to track and manage budget execution/spending, but these mechanisms are weakly enforced and budget overruns occur.
	●●●	A transparent process is used to set the purchaser’s budget, and mechanisms are in place to track and manage budget execution/spending; these mechanisms are enforced, and budget overruns rarely occur.
Health provider autonomy	○	Public providers have very limited or no autonomy to receive funds and carry out managerial and financial functions; they are unable to respond to the financial incentives of the provider payment systems.
	●●	Public providers are given a larger degree of managerial and financial autonomy, but the ability to respond to the financial incentives of the provider payment systems is still limited and accountability mechanisms are weak.
	●●●	Health care providers can directly receive funds and flexibly manage them to respond to the financial incentives of the provider payment systems, and they are held accountable for appropriate spending and service delivery results.

to the covered population, and provider payment is linked to the delivery of the services in the package.

- The purchaser further specifies service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
- Contracting arrangements
  - Explicit agreements are in place between the purchaser and both public and private providers that specify obligations on both sides, and contracts are used to achieve specific objectives.
  - The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
- Provider payment
  - Output-based payment is used to pay providers to deliver services in the benefit package, and payment systems are linked to specific service delivery objectives, effective allocation across levels of care, and purchaser budget management.
  - Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
- Performance monitoring
  - Provider-level information is automated, fed back to providers, and used for purchasing decisions.
  - Information and analysis are used for system-level monitoring and purchasing decisions.

Benchmarks that can be used to indicate incremental progress on making purchasing functions more strategic are shown in [Table 2](#).

### Application of the Framework for Policy Dialogue and Learning

The framework described here has been adapted and applied in 11 countries—Benin, Burkina Faso, Cameroon, Ghana, India, Indonesia, Kenya, Nigeria, Rwanda, Tanzania, and Uganda. In Indonesia, the framework was applied to inform improvements in institutional arrangements for more strategic purchasing under the national health insurance scheme, *Jaminan Kesehatan Nasional* (JKN). The analysis identified a lack of clarity in the institutional responsibility for purchasing functions in JKN, which was weakening the purchasing power of the main purchasing agency, *Badan Penyelenggara Jaminan Sosial Kesehatan* (BPJS-K). The analysis revealed that the original 2004 JKN law

allocated most of the purchasing functions to BPJS-K, but a series of regulations enacted over time brought the provider payment function at least partially back under the control of the Ministry of Health. The result was that BPJS-K was serving as a passive intermediary to transfer payments to health providers and carry out some other largely administrative functions, rather than as a strategic purchaser. Based on the results of the mapping analysis, new regulatory changes have been initiated to shift more authority for provider payment policy back to BPJS-K.<sup>26</sup>

In India, the analysis based on the framework is being used as a foundation for collaborative learning and problem-solving among technical partners that are supporting the implementation of India's national health insurance scheme, *Ayushman Bharat Pradhan Mantri Jan Arogya Yojana* (PM-JAY).<sup>49</sup> In the nine African countries, the analysis was implemented through a partnership with SPARC. The findings show that all of the countries have made some progress on purchasing functions within individual financing schemes, but the low level of pooling and highly fragmented financing arrangements greatly limit the power of strategic purchasing to bring about large-scale health system improvements.<sup>47</sup>

The results are being used to support collaborative learning among technical partners, who are taking back findings to policymakers to prioritize policy actions and investments in several of the countries.<sup>25,27–32,50</sup> In Burkina Faso, for example, the application of the framework led to a multi-stakeholder dialogue to harmonize the government *Gratuité* scheme and the PBF pilot.<sup>31</sup> In Rwanda, the application of the framework has supported efforts to better harmonize PBF with provider payment systems in the Community Based Health Insurance scheme.<sup>32</sup>

### Conclusions

Progress toward UHC requires not only significant fiscal commitment from governments, but also spending that is actively directed to health priorities. Greater strategic purchasing of high priority services is a critical part of effective spending, to advance UHC goals. Available conceptual frameworks for strategic purchasing have helped facilitate high-level advocacy and policy dialogue as well as frame research and analytical work to describe and understand purchasing arrangements in many countries.

The framework described in this paper is not intended to add to the debate on the conceptual framing of strategic purchasing; rather, it is meant to build on existing frameworks and focus in on the core purchasing functions of benefits specification, contracting arrangements, provider payment, and performance monitoring. The framework



**Table 2.** Benchmarks for progress on purchasing functions.

Benefits specification		
A benefit package is specified and aligned with purchasing arrangements.		A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with provider payment systems.
		A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with provider payment systems.
		A benefit or service package is well specified and periodically revised through a transparent process, reflects health priorities, is a commitment to the covered population, and is aligned with provider payment systems, and a transparent process for revision is specified.
The purchasing agency further defines service delivery standards when contracting with providers.		The purchaser defines some general service delivery standards (e.g., for gatekeeping), but enforcement through contracts is weak.
		The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are at least partially enforced through contracts.
		The purchaser specifies service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting arrangements		
Contracts are in place and are used to achieve objectives.		Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements are in place with some private providers.
		Explicit agreements are in place between the purchaser and public and private providers that specify obligations on both sides, and contracts are used to achieve specific objectives.
Selective contracting specifies service quality standards.		The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider payment		
Provider payment systems are linked to health system objectives.		Some output-based payment is used to pay providers to deliver services in the benefit package.
		Output-based payment is used to pay providers to deliver services in the benefit package, and payment systems are linked to specific service delivery objectives.
		Output-based payment is used to pay providers to deliver services in the benefit package, and payment systems are linked to specific service delivery objectives, effective allocation across levels of care, and purchaser budget management ("closed-ended" payment).
Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.		Provider payment rates are determined based only on the purchaser's available budget.
		Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance monitoring		
Monitoring information is generated and used at the provider level.		Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		Provider-level information is automated, fed back to providers, and used for purchasing decisions.
Information and analysis are used for system-level monitoring and purchasing decisions.		Some form of analysis is carried out at the system level (e.g., budget and revenue tracking, claims ratio, expenditure ratio, renewal ratio, claims ratio).
		System-level analysis is automated and carried out routinely.
		Information and analysis are used for system-level monitoring and purchasing decisions.

also incorporates factors that can either strengthen or weaken the power of purchasers to directly influence resource allocation and provider behavior. Because it was co-created by a group of health financing researchers and academics, it directly targets the practical policy questions that arise in country processes to improve health financing systems, and purchasing functions in particular. The addition of a set of benchmarks allows country stakeholders to assess where they are on the continuum from passive to strategic purchasing and whether current policies are moving the system in a more strategic direction. The application of the framework and benchmarks can help countries prioritize steps they can take to make better use of strategic purchasing to advance UHC goals.

Application of the framework in 11 countries shows the value of producing a systemwide view of where strategic purchasing progress is more advanced and where it may be lacking. This has helped a number of countries to identify challenges, such as fragmentation and duplication of purchasing functions across health financing arrangements, and to prioritize policy actions.

## Acknowledgments

The authors are grateful to SPARC and the consortium of Africa-based Anglophone and Francophone partners that co-created the Strategic Health Purchasing Progress Tracking

Framework. The authors also appreciate the individuals who provided insights, comments, and reviews that improved the quality of the manuscript.

## Author Contributions

CC led the co-creation process to develop the Strategic Health Purchasing Progress Tracking Framework and the benchmarks and led the drafting of the manuscript. AG-M collaborated closely on the drafting of the manuscript.

## Disclosure of Potential Conflicts of Interest

No potential conflict of interest was reported by the author(s).

## Funding

This work was supported, in whole or in part, by the Bill & Melinda Gates Foundation [Grant number: OPP1179622].

## ORCID

Agnes Gatome-Munyua  <http://orcid.org/0000-0001-8910-4989>

## References

- GBD 2019 Universal Health Coverage Collaborators. Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet*. 2020;396(10258):1250–84. doi:10.1016/S0140-6736(20)30750-9.
- Fuchs VR. What every philosopher should know about health economics. *Proc Am Philos Soc*. 1996;140:186–96.
- Kutzin J. Anything goes on the path to universal coverage? No. *Bull World Health Organ*. 2012;90(11):867–68. doi:10.2471/BLT.12.113654.
- Cashin C Health financing policy: the macroeconomic, fiscal, and public finance context. Washington (DC): The World Bank; 2016. [accessed 2021 Sep 29]. <https://openknowledge.worldbank.org/bitstream/handle/10986/23734/9781464807961.pdf?sequence=3&isAllowed=y>.
- World Health Organization. The world health report 2010. Health systems financing: the path to universal coverage. Geneva (Switzerland): World Health Organization; 2010. [accessed 2021 Sep 29]. <https://www.who.int/publications/i/item/9789241564021>.
- Figueras J, Robinson R, Jakubowsky E. Purchasing to improve health systems performance: drawing the lessons. In: Figueras J, Robinson R, editors. *Jakubowsky, Purchasing to improve health systems performance*. Maidenhead (UK): Open University Press; 2005; 44–80.
- Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. *Bull World Health Organ*. 2013;91(8):602–11. doi:10.2471/BLT.12.113985.
- John L, Cashin C, O'Dougherty S Designing and implementing health care provider payment systems: how-to manuals. Washington (DC): World Bank; 2009. [accessed 2022 Feb 1]. <https://openknowledge.worldbank.org/handle/10986/13806>.
- Mathauer I, Dale E, Jowett M, Kutzin J Purchasing health services for universal health coverage: how to make it more strategic? Geneva (Switzerland): World Health Organization; 2019. [accessed 2022 Feb 1]. <https://apps.who.int/iris/handle/10665/311387>.
- Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy (New York)*. 2001;56(3):171–204. doi:10.1016/S0168-8510(00)00149-4.
- Hanson K, Barasa E, Honda A, Panichkriangkrai W, Patcharanarumol W. Strategic purchasing: the neglected health financing function for pursuing universal health coverage in low-and middle-income countries. Comment on “What’s needed to develop strategic purchasing in healthcare? Policy lessons from a realist review.” *International Journal of Health Policy and Management*. 2019;8(8):501–04. doi:10.15171/ijhpm.2019.34.
- Hanson K Researching purchasing to achieve the promise of universal health coverage. London (UK): Resilient and Responsive Health Systems, London School of Hygiene and Tropical Medicine; 2014. [accessed 2021 Sep 29]. <https://resyst.lshtm.ac.uk/resources/researching-purchasing-to-achieve-the-promise-of-universal-health-coverage>.
- Hussey P, Anderson GF. A comparison of single- and multi-payer health insurance systems and options for reform. *Health Policy (New York)*. 2003;66(3):215–28. doi:10.1016/S0168-8510(03)00050-2.
- Sanderson J, Lonsdale C, Mannion R. What’s needed to develop strategic purchasing in healthcare? Policy lessons from a realist review. *International Journal of Health Policy and Management*. 2018;8(1):4–17. doi:10.15171/ijhpm.2018.93.
- Paul E, Brown GW, Ridde V. Misunderstandings and ambiguities in strategic purchasing in low- and middle-income countries. *The International Journal of Health Planning and Management*. 2020;35(5):1001–08. doi:10.1002/hpm.3019.
- Gautier L, De Allegri M, Ridde V. How is the discourse of performance-based financing shaped at the global level? A poststructural analysis. *Glob Health*. 2019;15(1):6. doi:10.1186/s12992-018-0443-9.
- Cashin C, Nakhimovsky S, Laird K, Strizrep T, Cico A, Radakrishnan S, Lauer A, Connor C, O'Dougherty S, White J, et al. Strategic health purchasing progress: a framework for policymakers and practitioners. Bethesda ((MD)): Health Finance & Governance Project, Abt Associates; 2018. [accessed 2021 Sep 29]. <https://www.hfgproject.org/strategic-health-purchasing-progress-a-framework-for-policymakers-and-practitioners/>.

18. Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG. Assessing country health financing systems: the health financing progress matrix. Geneva (Switzerland): World Health Organization; 2020. Report No: Health financing guidance, no. 8. [accessed 2021 Sep 29]. [https://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/98428/E86300.pdf](https://www.euro.who.int/__data/assets/pdf_file/0004/98428/E86300.pdf).
19. Governance for strategic purchasing: an analytical framework to guide a country assessment. Geneva (Switzerland): World Health Organization; 2019. Report No: Health financing guidance, no. 6. [accessed 2022 Feb 1]. <https://www.who.int/publications/i/item/9789240000025>.
20. Glassman A, Giedion U, Smith P, editors. What's in, what's out: designing benefits for universal health coverage. Washington (DC): Center for Global Development; 2017.
21. Designing health benefits policies: a country assessment guide. Washington (DC): Joint Learning Network for Universal Health Coverage; 2018. [accessed 2022 Feb 1]. <https://www.jointlearningnetwork.org/resources/designing-health-benefits-policies-a-country-assessment-guide/>.
22. Cashin C editor, Assessing health provider payment systems: a practical guide for countries working toward universal health coverage. Arlington (VA): Joint Learning Network for Universal Health Coverage; 2015. [accessed 2021 Sep 29]. <https://www.jointlearningnetwork.org/resources/assessing-health-provider-payment-systems-a-practical-guide-for-countries-w/>.
23. Özaltın A, Cashin C editors., Costing of health services for provider payment: a practical manual based on country costing challenges, trade-offs, and solutions. Arlington (VA): Joint Learning Network for Universal Health Coverage; 2014. [accessed 2021 Sep 29]. [https://www.jointlearningnetwork.org/wp-content/uploads/2019/11/JLN\\_Costing\\_Manual.pdf](https://www.jointlearningnetwork.org/wp-content/uploads/2019/11/JLN_Costing_Manual.pdf).
24. Using data analytics to monitor health provider payment systems: a toolkit for countries working toward universal health coverage. Arlington (VA): Joint Learning Network for Universal Health Coverage, Results for Development (R4D), PATH, PharmAccess Foundation; 2017. [accessed 2021 Sep 29]. [https://path.azureedge.net/media/documents/DHS\\_jln\\_full\\_toolkit.pdf](https://path.azureedge.net/media/documents/DHS_jln_full_toolkit.pdf).
25. Gatome-Munyua A, Tapsoba C, Cashin C. Collaborative learning to advance knowledge and practice of strategic health purchasing in sub-Saharan Africa. *Health Syst Reform*. **Forthcoming**.
26. Ministry of Health of Indonesia. Overview of strategic purchasing functions of JKN: policy note. Jakarta (Indonesia): Ministry of Health of Indonesia; 2018. [accessed 2021 Sep 29]. <http://documents1.worldbank.org/curated/en/328701534744931433/pdf/129507-REVISED-PurchasingOverview-PolicyNotes1.pdf>.
27. Sieleunou I, Tamga DDM, Tankwa JM, Munteh PA, Tchatchouang EVL. Strategic health purchasing progress mapping in Cameroon: a scoping review. *Health Syst Reform*. 2021;7(1). doi:10.1080/23288604.2021.1909311.
28. Amporfu E, Agyei-Baffour P, Edusei A, Novignon J, Addo-Cobbah V. Strategic health purchasing progress mapping: a spotlight on Ghana's National Health Insurance Scheme. *Health Syst Reform*. **Forthcoming**.
29. Ekirapa-Kiracho E, Ssenyonjo A, Cashin C, Gatome-Munyua A, Olalere N, Ssempala R, Mayora C, Ssegooba F. Strategic purchasing arrangements in Uganda and their implications for universal health coverage. *Health Syst Reform*. **Forthcoming**.
30. Ezenwaka U, Gatome-Munyua A, Nwankwor C, Olalere N, Orji N, Ewelike U, Uzochukwu BSC, Onwujekwe O. Strategic health purchasing in Nigeria: investigating governance and institutional capacities within the formal sector social health insurance programme and tax-funded health services. *Health Syst Reform*. **Forthcoming**.
31. Kiendrébéogo J, Tapsoba C, Kafando Y, Kaboré I, Sory O, Yaméogo SP. Strengths and weaknesses of strategic health purchasing for universal health coverage in Burkina Faso: a bird's-eye view. *Health Syst Reform*. **Forthcoming**.
32. Umuhzoa SM, Musange S, Nyandwi A, Gatome-Munyua A, Mumararungu A, Hitimana R, Rulisa A, Uwaliraye P. Strengths and weaknesses of strategic health purchasing for universal health coverage in Rwanda: a functional mapping. *Health Syst Reform*. **Forthcoming**.
33. Greer SL, Klasa K, van Ginneken E. Power and purchasing: why strategic purchasing fails. *Milbank Q*. 2020;98(3):975–1020. doi:10.1111/1468-0009.12471.
34. Reich M, Harris J, Ikegami N, Maeda A, Cashin C, Araujo E, Takemi K, Evans TG. Moving towards universal health coverage: lessons from 11 country studies. *The Lancet*. 2016;387(10020):811–16. doi:10.1016/S0140-6736(15)60002-2.
35. Cashin C, Bloom D, Sparkes S, Barroy H, Kutzin J, O'Dougherty S. Aligning public financial management and health financing: sustaining progress toward universal health coverage. Geneva (Switzerland): World Health Organization; 2017. Report No: Health financing working paper no. 4. [accessed 2021 Sep 29]. <https://r4d.org/resources/aligning-public-financial-management-health-financing/>.
36. Barasa E, Mathauer I, Kabia E, Ezumah N, Mbau R, Honda A, Dkhimi F, Onwujekwe O, Phuong H, Hanson K. How do healthcare providers respond to multiple funding flows? A conceptual framework and options to align them. *Health Policy Plan*. 2021;36(6):861–68. doi:10.1093/heapol/czab003.
37. Tangcharoensathien V, Limwattananon S, Patcha-ranarumol W, Thammatacharee J, Jongudomsuk P, Sirilak S. Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy Plan*. 2015;30(9):1152–61. doi:10.1093/heapol/czu120.
38. Habicht T, Habicht J, van Ginneken E. Strategic purchasing reform in Estonia: reducing inequalities in access while improving care concentration and quality. *Health Policy (New York)*. 2015;119(8):1011–16. doi:10.1016/j.healthpol.2015.06.002.

39. Cashin C, Eichler R, Hartel L. Unleashing the potential of strategic purchasing: beyond provider payment mechanisms to the institutional roles, systems, and capacities required to implement them. Bethesda (MD): Health Finance & Governance Project, Abt Associates; 2018. [accessed 2021 Sep 29]. <https://www.hfgproject.org/unleashing-potential-strategic-purchasing/>.
40. Organisation for Economic Cooperation and Development. OECD reviews of public health: Chile: a healthier tomorrow. Paris (France): OECD Publishing; 2019. [accessed 2022 Feb 1]. [https://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-public-health-chile\\_9789264309593-en](https://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-public-health-chile_9789264309593-en).
41. Ministry of Health of Chile. Plan AUGÉ-GES. Santiago (Chile): Ministry of Health; 2021. [accessed 2022 Jan 27]. <https://www.chileatiende.gob.cl/fichas/2464-plan-augé-ges>.
42. Perrot J, Roodenbeke E, editors. Strategic contracting for health systems and services. New York (NY): Taylor&Francis Group; 2012.
43. Howden-Chapman P, Ashton T. Shopping for health: purchasing health services through contracts. Health Policy (New York). 1994;29(1-2):61-83. doi:10.1016/0168-8510(94)90007-8.
44. Barber SL, O'Dougherty S, Vinyals Torres L, Tsilaajav T, Ong P. Other considerations than: how much will universal health coverage cost? Bull World Health Organ. 2020;98(2):95-99. doi:10.2471/BLT.19.238915.
45. Ikegami N. Japan: achieving UHC by regulating payment. Global Health. 2019;15(Suppl 1). doi:10.1186/s12992-019-0524-4.
46. Management Sciences for Health. The Rwandan health management information system: improving collection and management of health service data to support informed decision making. Medford (MA): Management Sciences for Health; 2014. [accessed 2022 Feb 1]. [https://msh.org/wp-content/uploads/2014/12/ihssp\\_techbr2\\_final\\_webv.pdf](https://msh.org/wp-content/uploads/2014/12/ihssp_techbr2_final_webv.pdf).
47. Strategic Purchasing Africa Resource Center 2021. Policy briefs. Nairobi (Kenya): Strategic Purchasing Africa Resource Center. no date. [accessed October 2021] <https://sparc.africa/changing-the-conversation/a-theory-of-change-and-practical-steps/policy-briefs>.
48. Barber SL, Lorenzoni L, Ong P. Price setting and price regulation in health care: lessons for advancing universal health coverage. Geneva (Switzerland): World Health Organization, Organisation for Economic Co-operation and Development; 2019. [accessed 2022 Feb 1]. <https://apps.who.int/iris/handle/10665/325547>.
49. Results for Development. Strategic Purchasing India Resource Center (SPIRC) activity summary report. Washington (DC): Results for Development; 2021.
50. Gatome-Munyua A, Sieleunou I, Barasa E, Ssengooba F, Issa K, Musange S, Osoro O, Makawia S, Boyi-Hounsou C, Amporfu E, et al. Lessons from sub-Saharan Africa on the application of the Strategic Health Purchasing Progress Tracking Framework. Health Syst Reform. Forthcoming.