



Strategic Purchasers and Immunization

How to Leverage these Major Players for Public Program Improvements

November 2018

BREAKING NEW GROUND





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This report was prepared by Martha Coe and Yasmin Madan.

Recommended Citation:

Coe, Martha and Yasmin Madan. (2018). *Strategic Purchasers and Immunization: How to Leverage these Major Players for Program Improvements*. ThinkWell: Washington, DC.

This report was produced by ThinkWell, with support from the global policy team at Merck Sharp & Dohme Corp. (MSD), a subsidiary of Merck & Co., Inc., Kenilworth, New Jersey US.

ACRONYMS

CPAM Caisse Primaire d'Assurance Maladie
(French purchasing agency)

MoH Ministry of Health

MSD Merck Sharp & Dohme

NHSO National Health Security Office

NIP national immunization program

PPV pneumococcal polysaccharide vaccine

UHC universal health coverage

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INTRODUCTION

Public health insurance agencies play large roles in financing health systems across the globe, though what role they could, or should, play for preventive services is still to be understood. Though there are variations in the trends between regions and between mature and developing markets, in the context of the universal health coverage (UHC) agenda many countries are creating or expanding the role of public insurers as the purchasers within their systems. These are purchasing institutions outside of the Ministry of Health and sub-national governments. As more money flows into these mechanisms to deliver health care services, often so does their influence and their bearing on the public health system. However, as insurance agencies, the focus of purchasers is decreasing the risk of catastrophic expenditures. Their engagement then tends to be primarily in the treatment of disease, not in the prevention and promotion of health services. This can leave health systems unsure of what exactly a purchaser can offer to preventive service programs, like immunization. Many countries utilize rights-based language around access to immunization programs, leaving the impression that it is an activity for the Ministry of Health and public health departments alone to ensure. As the Sustainable Immunization Financing project¹ has engaged with a number of public health systems in Asia-Pacific and Latin America regions, it has become clear that, to ensure secured and increased financing for sustainable immunization programs, purchasers can, and often should, be engaged, though it is unclear as to what the scope and terms of the engagement should be.

Immunization programs across countries face challenges in resource mobilization and program performance that expanded and strategic engagement with purchasers can potentially address, given the right design and a fitting context. Immunization programs face a myriad of challenges across the scope of the program, ranging from access to coverage issues. These include inflexible budgets that prevent the addition of new technologies or the expansion of target cohorts; limited budgets to deliver current or expanded programs; limited accountability across actors in the system and poor performance. Engaging with public insurance purchasers holds the potential for increased financing of the program, improving lines of accountability, and the expansion of access to vaccines. In the regions of Asia Pacific, Latin America and the Caribbean, and Europe, 52 out of 80 countries utilize purchasers external to the Ministry of Health (MoH) to finance immunization in one form or another. Still, many of these countries utilize their purchasers in very limited ways, often just reimbursing providers for the delivery of vaccines. For many countries, the question of how to engage purchasers to increase sustainable financing for immunization is not where to begin, but how to strategically expand engagement. The recommendations provided are based on learnings from global contexts and are intended to be modified or adapted to countries based on their individual context. Considerations for how these recommendations can be applied include the flow of funds for immunization programs, the role of the purchaser in the larger health system and its relationship to the MoH, and the current role of the purchaser in immunization programs.

Objective

This paper will identify elements for countries to consider when exploring how best to leverage public health insurance agencies to address the challenges within immunization financing and program performance. The paper is informed by global experiences, including a global review of 113 country financing structures for immunization across three different regions, desk review of countries with purchasing mechanisms to learn from, and country landscaping and diagnosis done as part of previous phases of the Merck Sharp & Dohme (MSD)-funded sustainable immunization financing project in Asia Pacific and Latin America.² The objective of the review of these experiences is to raise potential ideas, learnings, and opportunities for the immunization program to consider in

¹ For more information on this project, visit the Sustainable Immunization Financing project overview, <https://thinkwell.global/projects/sustainable-financing-immunization/>

² The financing structures review considered countries in Asia Pacific, Europe, and Latin America. The subsequent countries of focus included Argentina, Czech Republic, France, and Turkey.

order to determine the level and type of engagement of the public health insurance purchaser in financing current and future immunization programming. This paper is designed to explore ways to answer the questions:

What aspects of immunization programs can a public health insurance purchaser cover, and how can these aspects be covered to maximize benefits for the sustainability of the immunization budget and absorptive capacity of the immunization program?

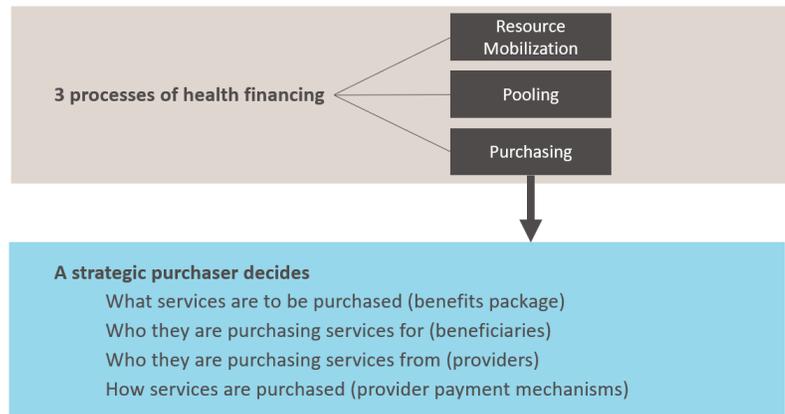
PURCHASERS AND THEIR PLACE IN HEALTH AND IMMUNIZATION FINANCING

Purchasing, one of three health financing activities, is done

strategically when deliberate actions are taken to achieve objectives.

Health financing is made up of three distinct activities: resource mobilization, pooling, and purchasing (Figure 1).³ (1) Resource mobilization simply refers to where finances are sourced from. In most public health systems this may consist of a mix of general taxes, local resources, and public insurance contributions, though many systems still rely on donor funding or may draw from earmarked taxes. (2) Pooling refers to where and how funds are held and who is responsible for managing those funds. Pools may include an insurance scheme or multiple insurance schemes, and government actors at national or sub-national level, among others. Finally, (3) purchasing is the act of paying for service delivery. Purchasing can simply be line-item or block transfers from a purchaser to an implementing partner. To be a strategic purchaser, these payments are made deliberately with outputs or outcomes in mind.⁴ By being strategic, purchasers can use resources more efficiently to achieve intended objectives.

Figure 1. Functions of Health Financing and Strategic Purchasing



A strategic purchaser can make strategic decisions to reach an objective by examining four questions:

1. What services are to be purchased (what will be in the benefits package)?
2. Who are services to be purchased for (who will be the beneficiaries)?
3. Who are services purchased from (which providers will be contracted)?
4. How are services to be purchased (what provider payment mechanisms will be utilized)?

³ World Health Organization. (2000).

⁴ Ibid.

Purchasers can be any actor within the system, but for the purposes of this paper, we are focused on public insurance purchasers that function external to the Ministry of Health. In many systems, the roles of purchaser and provider are split between two actors. This allows for the purchaser to operate more strategically by diminishing, or erasing, the conflict of interest that exists when a ministry purchases services from itself. This happens in systems when the MoH is both the purchaser and the provider of services through the public network that it oversees. A purchaser provider split can also create more opportunities for the payment of private facilities through pooled public resources. In other countries, the purchasing systems are further mixed, with sub-national governments also playing a role. Though in many country systems it will be important for stakeholders to engage with the MoH or sub-national governments in order to achieve coherency across the system and across specific programs, we will focus on potential engagements with public insurance mechanisms. Where we use the term “purchaser” for the purposes of this paper, we refer to institutions known as public health insurers, national health insurers, or social health insurers.

Immunization Program Fund Flow

Purchasers are often underutilized actors when it comes to financing immunization. In a desk review of 113 countries across Asia-Pacific, Europe, and Latin America, 80 countries had established purchasers outside of the Ministry of Health. Fifty-two of those 80 countries utilize their purchasers to cover the costs of their immunization program to some extent. Purchasers can engage in a myriad of ways, some of which we will explore below as we discuss opportunities. Engagement can result in increased financing for the program and/or new, or improved, performance incentives for providers and program managers. While many health systems already utilize purchasers to an extent, we find that there is often more that can be done. It is important to note that strategic purchasers are usually run like businesses. They are, after all, insurance companies, even if they are public institutions. These purchasers assess risk, cost things actuarially, make investments, and try to maintain the bottom line. This can offer some benefits when it comes to spending efficiency but can also create barriers to fully prioritizing and engaging with preventive programs.

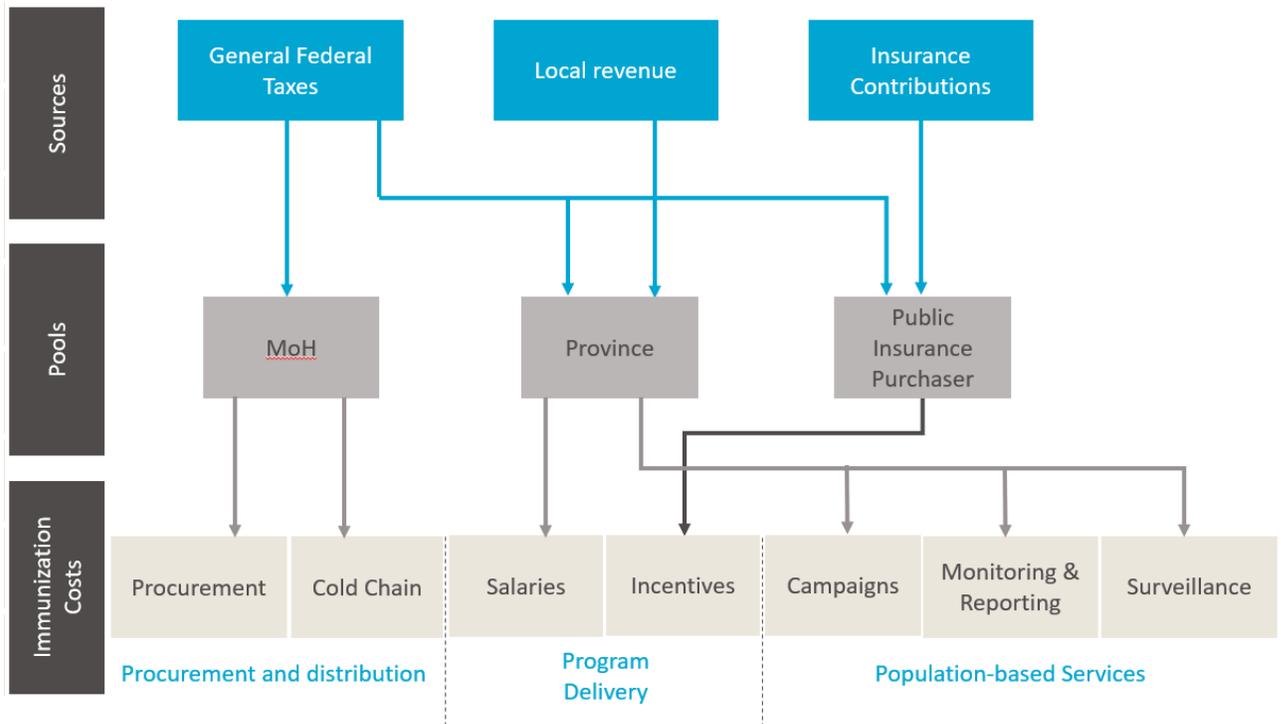
Box 1: Public Insurance Mechanisms:

Underneath the umbrella term of public health insurance, there are two types of health insurance: national and social.

National Health Insurer: A single entity that provides public insurance against healthcare costs for the entire population in a country. It can draw revenue from multiple sources, acting as a social health insurer or not, but usually receives funds from federal allocations.

Social Health Insurer: A public entity that utilizes individual contributions to cover premiums, at least in part. This is usually done through a salary tax. A social health insurance scheme can provide national coverage or can have a limited pool of beneficiaries.

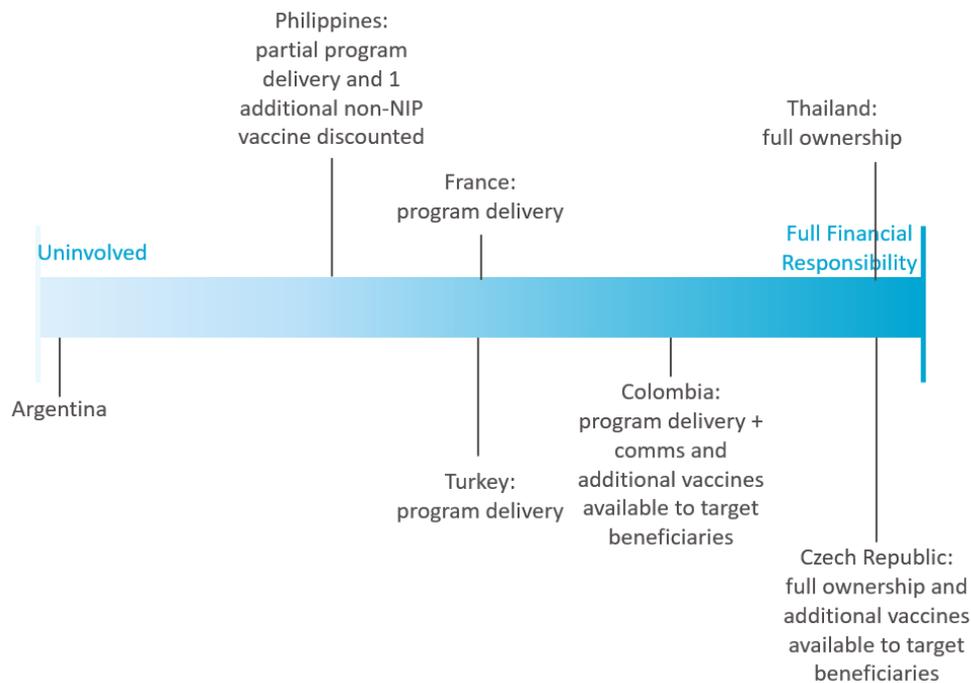
Figure 2. Example Fund Flow with Limited Purchaser Financing of Immunization



Before acknowledging whether a health system can catalyze a purchaser to engage on certain challenges, there must first be an understanding of what role the purchaser is currently playing within immunization financing. The foundation of knowing how to engage a strategic purchaser is to assess whether the issue is initiating engagement or exploring expanded engagement. Some challenges are easier for a strategic purchaser to engage on. In particular, program delivery on the spectrum above is the cost activity area where a purchaser is most likely to engage. A purchaser’s primary function is to pay for services, thus the reimbursement of immunization service delivery (whether through payments that contribute to salaries or are additional incentive payments) is often the first step for a purchaser to engage with the program (figure 2). Though this is the first step, many purchasers that finance vaccination do so through block payments or other forms of input financing that do not incentivize outputs or coverage outcomes. This means that providers are paid a set rate, regardless of their performance or reach. Of the 80 countries with purchasers that were found in the desk review, at least 65% of those countries pay for primary and preventive care services (including immunization) through input financing.⁵

⁵ Capitation: 28, Salary: 20, Global budget: 4, Fee-for-service: 15, Unknown: 13

Figure 3. There Are a Number of Levels at Which a Purchaser Can Engage with Immunization



Purchaser Context and Strategic Purchasing Decisions

Beyond the current role in immunization financing, to understand what role a strategic purchaser could potentially play in easing particular challenges in a given country, there must be a clear understanding of the strategic purchaser and how it functions within the country’s context. The context surrounding a strategic purchaser can influence their ability to act upon specific challenges within immunization financing, and the influence they will have on implementing potential solutions.

Context

- 1. How established is the purchaser?** What is the duration of the purchaser’s existence and its acceptance amongst the population as a health insurance provider? Have new public schemes affected this context? Understanding this context can illuminate how much weight a purchaser’s interests will carry.
- 2. What is the relationship of the purchaser to the Ministry of Health?** Do they have autonomy over their decisions and how their budget is spent or does the real power lie with the Ministry? Understanding this context will illuminate to what extent the purchaser is the right mechanism to go through. If the purchaser has limited autonomy from the Ministry of Health, working through the purchaser may produce minimal impact.
- 3. What are the sources of financing for the purchasing institution?** Referring to the fund flow of a given country’s immunization program, does the purchaser rely on Ministry of Finance budget allocations or does it bring in additional contributions from beneficiaries through a social health insurance scheme (Figure 4)? If a country is exploring what potential there is to expand budget headroom by expanding the role of the purchaser, access to additional revenue streams can provide opportunities.

Figure 4. Potential Sources of Funding for Immunization Programs



4. What role does the purchaser play in the national healthcare conversation? Is the purchaser’s purchasing power increasing or decreasing? Is the political and financial focus of the health system on the purchaser and the services they provide, or on other aspects? In some countries, from the Philippines to the United Kingdom, the push for UHC has placed the healthcare conversation almost exclusively on the agenda of the public insurance agency as the strategic purchaser. This political momentum can open opportunities for increasing the role of the purchaser in priority health services. It also often signals the increased flow of funds into the purchaser, a trend that could potentially be leveraged. If more and more health resources are being routed through a public insurance agency as the purchaser rather than the Ministry, it could be opportunistic to ensure some level of program funding through the purchaser.

Strategic Purchasing Decisions

5. Is immunization in the benefits package? Knowing what is included in the benefits package is the first step to understanding what role the purchaser can play. Is the engagement focused on expanding the role of the purchaser in immunization or is it simply to introduce a role for the purchaser? Strategic purchasers may be interested in including vaccination along a continuum of care (including prevention, diagnosis, and treatment) for diseases like cervical cancer, renal disease, etc. In Colombia, the purchasers add non-national immunization program (NIP) vaccines for treatment regimens, like HepB for renal disease and pneumococcal for chronic obstructive pulmonary disease.

6. Does the purchaser cover the entire population under one pool of funding, or a particular segment under multiple pools? If there are multiple purchasers within a system, there are implications to how they can engage with the immunization program. A national purchaser’s actions affect all. If the National Health Security Office in Thailand makes a decision for the immunization program, it will affect the entire Thai population. Working through a single purchaser within a system of multiple purchasers, on the other hand, has limited impact and could create equity issues. One purchaser within Mexico only reaches a limited segment of the population. If purchasers are competing for beneficiaries; however, improved quality or access to vaccines can be a business investment that attracts more beneficiaries.

Figure 5. Pooling Funds for Immunization



Note: Funds for health are likely pooled under multiple actors, but we are concerned with the public insurer. A public insurer can be a single national pool or there can be multiple pools of revenue, thus multiple insurers.

7. Which providers are contracted and how? Knowing which type of providers that a purchaser contracts – whether public or private, midwives or hospital-affiliated practitioners, etc. – can illuminate where immunizations can be accessed and who can potentially be incentivized to implement program change.

8. How are payments to providers made? Are decisions around payments made to influence provider behavior? Changing provider behavior could be one option to improve immunization program performance. Understanding this context can provide some understanding of how financial incentives do play, or could play, a role in improving performance.

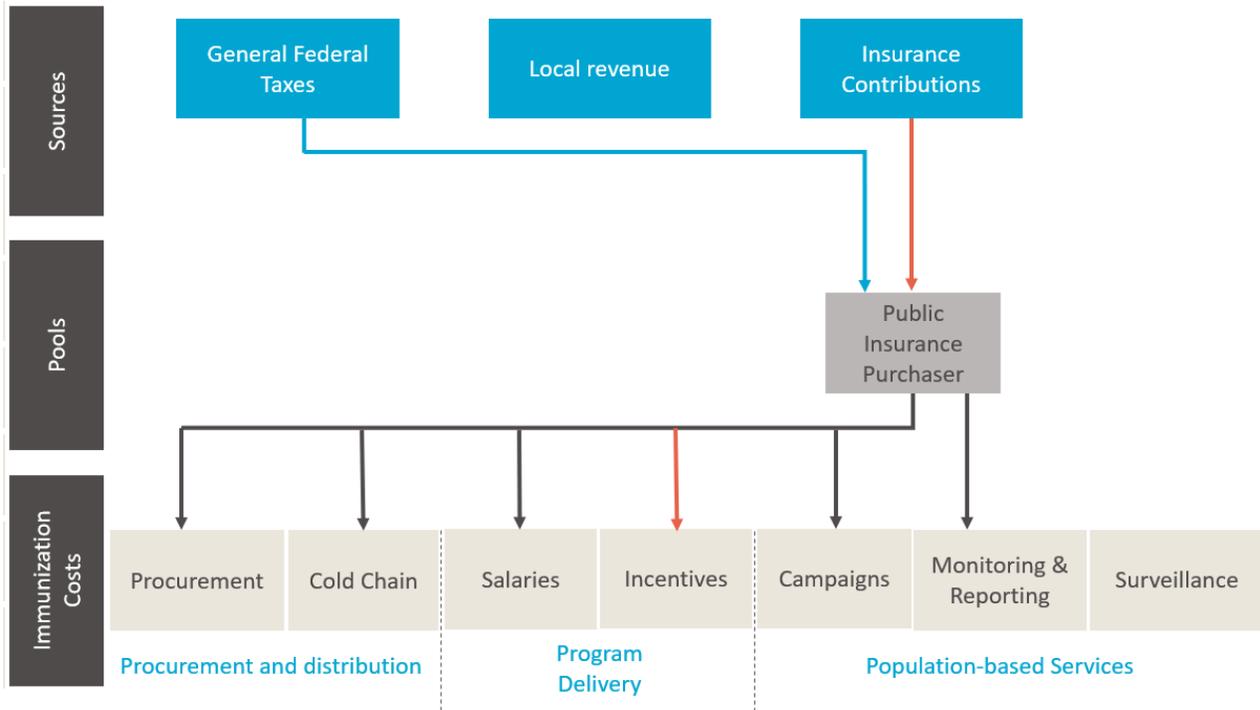
Immunization Challenges

Lastly, which immunization program challenges or potential opportunities can be addressed or exploited must be diagnosed before a strategic engagement involving a purchaser can be identified. Immunization program costs fall along a spectrum from procurement and distribution, to program delivery, to population-based services. The different challenges that an immunization program may face fall under one of these cost activities. Breaking down program challenges in this way creates a nice framework for understanding where a purchaser could potentially play a role. Though program delivery is where purchasers most comfortably play a role through service reimbursement, there are some opportunities for engagement in other cost activity areas as well. For example, the Czech Republic and Thailand's purchasers pay for procurement and distribution costs and Colombian purchasers offer vaccines outside of the NIP for their beneficiaries. Through the landscaping done in nine different countries in the Asia Pacific and Latin America regions, we have identified a number of challenges related to sustaining and increasing immunization financing as well as those related to system and program performance issues. Having a strong understanding of the challenges a particular country faces, and what the underlying causes are, will allow for proper diagnosis of performance issues and ultimately lead towards opportunities and tactical solutions that may, or may not, be addressed by including one or more aspects of immunization financing and programming under a strategic purchaser. Though strategic purchasers can engage in a variety of ways, most interventions boil down to either increased financing for the program and/or new/improved performance incentives for providers or program managers.

Immunization Program Cost Activities

1. Procurement and distribution
2. Program delivery
3. Population-based services

Figure 6. Finding a Role for the Purchaser



Much of how a purchaser can engage falls to 1. Expanding budget headroom by sourcing new funds through insurance contributions or finding efficiencies along the cost activities and 2. Performance improvement through incentivizing providers through payment mechanisms or engaging on additional cost activities.

IMMUNIZATION: WHAT ROLE CAN A STRATEGIC PURCHASER PLAY?

PROCUREMENT AND DISTRIBUTION

Procurement costs include vaccines, syringes, safety boxes, and costs associated with distribution, such as maintaining the cold chain. Procurement and distribution activities are focused on making vaccines available within the public system.

Procurement and Distribution Challenges:

1. Introduction or scale up of new / demonstration vaccination programs in the National Immunization Program (NIP)

Potential Engagement: Purchaser leveraged to add vaccines that are yet to be included or scaled up in the NIP

For this engagement, the purchaser must have the autonomy to make decisions around their benefits package and must have the mandate to procure vaccines outside of the national program. In any case, the purchaser does not have to take on the entire procurement budget but can add to it as needed. Often, the national program may not be able to receive the necessary funds from the Ministry of Finance to add a new vaccine into the national immunization program. Vaccines, which are excellent risk mitigators, can prove to be good investments for strategic purchasers. Particularly because expanded programs on immunization were initiated to provide pediatric vaccines, many national immunization programs continue to focus on pediatric vaccines. As a result, this tactic can be a particularly significant opportunity for vaccines further along the life-course.

Global Lessons: The Czech Republic has multiple purchasers which can provide additional vaccines at full or partial reimbursement to beneficiaries.⁶ This tactic can be applied anywhere where purchasers are mandated to finance procurement of additional non-NIP vaccines but must be applied carefully in countries with multiple purchasers. Vaccine additions under one of many purchasers can create concerns over equity, and therefore should be used to supplement access to needed cohorts in support of public health goals.

Potential Engagement: A purchaser can leverage available data to promote public preventive service investment and support vaccine program scale-up

Strategic purchasers, as insurance schemes, tend to have robust information systems. Payments are often based on outputs (though this is not always the case for primary care), so services and costs are tracked. An immunization program can thus utilize a purchaser for their information systems to generate the needed evidence to support public investments in immunization. If data on disease burden or costs are a limitation to vaccine introductions or scale-up in a country, a strategic purchaser can potentially be leveraged to fill this gap. The use of evidence in public decision-making requires capacity for local research and the resources to do so though. A strategic purchaser could potentially provide these resources, as a data resource or as a procurer of studies for evidence generation. This engagement would require lines of communication between the purchaser and the ministries of health and finance.

2. Government revenue generation or immunization budget allocation is inadequate for the costs of existing and prioritized new vaccines

Potential Engagement: Utilize insurance contributions (premium payments) to support vaccine procurement

Insurers rely on preventive services to keep treatment costs down. However, insurance mechanisms in developing countries are often used to limit the catastrophic expenditures that come with more complicated curative services rather than investing in preventive services themselves. It is a big shift to transform a public purchaser from a financial health coverage institution to a healthcare institution. For a purchaser to take on more public health services and preventive health services, such as immunization programs, can be a politically complicated task. To shift vaccine procurement away from the Ministry of Health and under the purview of a purchaser is a politically charged option and is not a common model across the globe. Ministries of health typically retain responsibility for public health programs, yet some examples have proven that putting more preventive service financing under a purchaser can have its benefits.

Global Lessons: Management of the vaccination program was shifted to purchasers in the Czech Republic since 2008. The purchasers are now responsible for about 90% of immunization program financing. They now contract a procurement agency to procure all vaccines in the national program. Though the Ministry of Health remains the steward of the program, determining the national schedule based on public health needs, the purchasers differentiate between vaccines and have the flexibility to add additional vaccines beyond the NIP for their beneficiaries. This shift has increased resources for immunization in the country by pooling government allocations with insurance contributions. Since the strategic purchasers took control of procurement, the national immunization schedule has increased, as multiple new vaccines have been added.

In the Philippines, the pneumococcal vaccine for adults was not on the NIP under the Department of Health. To increase access to the vaccine, pneumococcal vaccination for the elderly is provided at a discounted price in hospitals for PhilHealth beneficiaries, thanks to a partnership with the manufacturer.

⁶ To learn more about how the Czech Republic utilizes strategic purchasing for immunization, refer to Annex 3.

PROGRAM DELIVERY

Program delivery cost activities affect the actual process of vaccinating the population. These costs ensure that products are delivered by providers to individuals. Service delivery costs include any payments for human resources, including time reimbursement, through salaries or other mechanisms, or additional incentives for providers. Poor performance on delivery can affect political motivation to allocate expanded funding for all program needs. If coverage of the current immunization program is low, it may be less appealing for politicians to add new vaccines to the schedule. Because a strategic purchaser has direct lines of accountability to providers through service payments, this is an area where strategic purchasers can potentially play a large role.

Program Delivery Challenges:

1. Government revenue generation or immunization budget allocations do not provide the needed program financing to deliver procured vaccines

Potential Engagement: Utilize the additional budget headroom created through insurance contributions to social health insurance or financially prioritized mechanisms to release government health office budget pressures.

Social health insurance mechanisms pool government subsidies with individual contributions through premium payments. The contributions are a cost-sharing mechanism that bring in sector-specific resources to increase budgets for healthcare. In the analysis of financing structures, 80 of 113 countries tap into these resources to benefit immunization budgets in one way or another. In countries with growing purchasers, there is often a lot of political momentum behind the growth that is paired with increasing government investment in the mechanism. Purchasers can also provide budget headroom through this act of government-prioritized financial allocation. Engagement does not have to be expansive, but a purchaser can cover salaries or incentives for delivery in order to release budget pressure from government health offices, whether they be national or sub-national. This engagement can produce additional budget headroom only if funding through government health offices, like the MoH or sub-national governments, does not drop as a result of increased funding for the purchaser. Existing budgets must be protected before adding funding streams from a purchaser in order to see the benefits of additional budget.

Global Lessons: France provides immunization service delivery reimbursements to primary care providers through its purchaser, Caisse Primaire d'Assurance Maladie (CPAM). In the French healthcare system, individuals must receive a prescription for a vaccine from a doctor, usually a general practitioner. The patient is then responsible to obtain the vaccine from a pharmacy before returning to the doctor for the injection. CPAM pays reimbursement fees for both visits to the doctor.

Colombia runs their immunization program through the NIP office and local governments. These entities plan and manage the national program. In addition, the public insurance mechanisms purchase vaccination services from providers using a mixture of capitation and fee-for-service provider payments. This allows for individual premium payments or other lines of funding from the government to be tapped for immunization financing and releases the government from purchasing all costs related to vaccination services.

With the new UHC bill underway, the Philippines is currently expanding the role of its purchaser, PhilHealth. PhilHealth was established in 1995, but to this point has only covered inpatient care through secondary or tertiary facilities. With the election of President Duterte in 2016, expansion of health coverage has emerged as a top agenda item for the administration. The UHC bill has been working its way through congress and is expected to pass into law prior to the 2020 election cycle. As part of the bill, PhilHealth will become the single purchaser, pooling increasing funds from beneficiaries and the government, including general taxes and earmarked taxes. The expansion will include coverage of primary care services. How immunization will fit into this expansion is an ongoing conversation, but with an increasing prioritization of PhilHealth financing, it will likely offer additional

budget to what the Department of Health currently spends on the program if the Ministry of Finance protects the Department's budget through the shifting landscape.

2. Low vaccination coverage rates

Low vaccination coverage rates can be caused by several challenges, including stock outs, inequitable resource allocation due to poor systems or unavailable data, poor quality of service and a limited system of accountability to improve quality, limited access to the health system, or vaccine hesitancy. Leveraging a strategic purchaser's contracts with providers can potentially address many of these issues. Issues, like vaccine hesitancy, which involve communications strategies are larger efforts that require input financing and will be covered under population-based services. While poor performance is a major program challenge that can extend beyond reported outputs and outcomes and affect future program resourcing, understanding the root cause will allow for tactical solutions, whether they involve strategic purchasers or not.

Potential Engagement: Utilize financial incentives for improved performance

If motivation from providers to deliver on immunization targets is low, a strategic purchaser can utilize their payment mechanisms to providers as leverage for behavior change. The purchaser must have the ability to modify provider payment mechanisms as needed (there may be Ministry of Health oversight into this activity) and incentives must align to elicit the desired behavior.

Global Lessons: In the Czech Republic, providers are paid a set amount based on the population registered with them for primary care provision. To promote vaccination, an additional fee for service payment is made to providers for each vaccinated individual. This financial incentive utilizes the payment mechanisms already in place within the system but provides extra encouragement to achieve high program performance. Ten countries of the sample of 113 used an additional financial incentive to promote vaccination. If quality concerns are an issue, the country can add quality indicators to the payment calculation to incentivize increased quality as well.

Argentina utilizes a formal performance-based financing program that measures quantity as well as quality of service delivery for incentive payments. Plan Nacer, a World Bank backed program, was initiated in 2004 to improve maternal and child health. Though the program does not involve the country's purchasers external to the MoH, it offers some interesting lessons that could be adapted by other purchasers. The program enrolled a target population of uninsured pregnant women and children under 6. For each enrollee, a premium payment of \$5 was made. 60% of this was transferred from the Ministry of Health to provinces on a monthly basis. The remaining 40% was transferred quarterly based on performance. Performance was measured against 10 process and outcome indicators, including immunization coverage. The program was deemed a success, reducing neonatal mortality by 74%. It has since been brought to national scale, expanded to include additional populations, and re-branded as Plan SUMAR.

Potential Engagement: Increase access to the national program by contracting private providers

If access to the health system is limited, or if the existing access points that people have are not part of the public system, then vaccination rates can be lower than needed. Even if people are covered by the public insurance system, they might not access healthcare through the contracted providers. Many people interface with the healthcare system through private general practitioners, midwives, or pharmacies. Under the MOH, national immunization programs tend to limit service delivery to public sector facilities. Increased engagement of national insurance programs as purchasers of immunization programming allows for a wider range of providers across private sector to become part of immunization service delivery. If the strategic purchaser has autonomy over which providers can be contracted, and how, the purchaser can play a major role in increasing access to the national immunization program.

Global Lessons: It is not uncommon for a purchaser to contract in the private sector. In France, the majority of primary care is provided through private general practitioners.⁷ To ensure that the national immunization program is delivered, the national purchaser contracts private GPs. Many other countries, including Turkey, Indonesia, Korea, and Taiwan, have similar practices. The mechanisms to allow for public funds to be transferred to private providers must be in place for this set-up to function. For other private providers of health services, like pharmacies or midwives, it is often difficult to contract thousands of frontline workers. To bring in these providers to the national system, it may be necessary to set up systems that allow for midwives or all pharmacies to group themselves under a union or guild. This would allow for easier contracting that can tie in a guaranteed level of quality of care.

Potential Engagement: Increase access through a “vaccination without borders” program

In fragmented health systems where there are multiple purchasers with individual networks, accessing health services can be complicated. The nearest provider may not be part of the patient’s insurance network. To limit this barrier to accessing immunization services, some countries implement a “vaccination without borders” style program where any individual can access national immunization program services through any provider for free. Depending on the system, purchasers may or may not reconcile the costs to deliver services to another purchasing scheme’s beneficiaries.

Global Lessons: More so than in Asia Pacific, Latin America has fragmented health systems with multiple purchasers. In both Colombia and Mexico, the population has near universal coverage, but relies on multiple pools to deliver that coverage. To limit barriers to immunization, both countries have instituted “convenios” as a vaccination without borders program. All members of the population can access the national immunization program, free of charge, at any facility. This works quite well in Colombia, particularly in areas like Bogotá where it is well publicized. Data on delivery is collected and payments are reconciled between purchasers that delivered services for non-beneficiaries. The program works a little less sustainably in Mexico. Though it increases access, there is no reconciliation between purchasers. This results in some purchasers being short on vaccine supply and over spent on delivery while others underspend and have unutilized vaccines.

3. Inefficient spending at the national level

Potential Engagement: Utilize purchasing mechanism’s business foundation to find efficiencies in the system

Because strategic purchasers are often run more like businesses than governments – taking less risk, focusing on the bottom line, and often being more open to partnering with the private sector – putting more immunization costs under a purchaser can have potentially positive effects.

Global Lessons: Thailand shifted the management of the entire immunization program over to the National Health Security Office (NHSO) when it was founded in 2002. The NHSO is astute in its decision making and contracts out distribution processes to the private sector. The efficiencies found in the immunization program by the NHSO allowed for the addition of the Japanese Encephalitis vaccine to the national schedule without expanding the budget at all. The mechanism was able to make available money go further rather than sourcing more funds, thus still creating budget headroom. This example is an aspirational one, as most systems will struggle to find this level of efficiency gains. In addition, ministries of health may be reluctant to give up the entire immunization program. Thailand’s Ministry of Health and Welfare has struggled to regain management of the program since it was integrated into the insurance system.

4. Subnational governments not held accountable for delivery

⁷ To learn more about how France utilizes strategic purchasing for immunization, refer to Annex 4.

Potential Engagement: Through contracting mechanisms with local governments, purchasers can potentially gain leverage for improved accountability.

In a number of countries, due to financial and/or administrative decentralization, the management of the immunization program and the onus for delivering on targets is delegated to sub-national government entities. This system allows for more responsive healthcare provision, but also relies on a greater number of actors to deliver on national goals. It is important in this system to create accountability among actors to ensure performance at the local level, but many systems do not have these in place. Indonesia and the Philippines are both highly decentralized with sub-national governments responsible for creating budgets for immunization programming and delivering on national objectives. Though Indonesia has a mandated 10% local budget allocation to health and a national set of Minimum Service Standards which sets targets for immunization coverage, neither system has an accountability mechanism to ensure that the sub-national governments contribute their share of the financing and deliver on program objectives. There is a potential role for a strategic purchaser to instill the needed accountability system by contracting local government units for public healthcare services, like immunization. However, this may be a challenging option to implement. Purchasers tend to work directly with providers. Still, they have contracted local government units at times, particularly in less developed contexts where providers/facilities do not have their own bank accounts and rely on local governments for financial transfers from the purchaser.

Global Lessons: Systems can learn from Argentina where the Ministry of Health, rather than their strategic purchasers, the Obras Sociales, contracts provinces to deliver a number of maternal and child healthcare services. While 60% of the budget is transferred to provinces up front, the remaining 40% is transferred based on performance. An impact evaluation found that the program increased immunization coverage and resulted in a 72% drop in neonatal mortality.⁸

5. Unclear roles and responsibilities

While many programs might have challenges with understanding which actor in the system is responsible for which roles, this is not a system issue that a strategic purchaser can address. Ministries, as the traditional stewards of immunization programs, must regulate this space and make roles and responsibilities clear across the spectrum of stakeholders.

6. Unclear articulation of targets

As with roles and responsibilities, clear articulation of immunization program targets and expectations on performance is a role for the ministry as the traditional steward of the program. This is not a space in which a strategic purchaser fits easily, yet purchasers should explore leveraging their data systems and existing tools to help ensure targets are met.

POPULATION-BASED SERVICES

Population-based service costs are not associated with delivering a service to any one individual. These activity costs benefit all. They include investments like monitoring and surveillance, campaigns, training, infrastructure, and administration and management. While not likely to monitor the public health standing of a country or provide input financing for a health system, strategic purchasers make payments based on outputs, a method that is heavily reliant on the generation and utilization of data which can have wide-ranging applications.

Population-Based Services Challenges:

⁸ Center for Global Development (2015).

1. Poor data collection and utilization in budgeting, planning, and decision-making

Potential Engagement: Leverage the strategic purchaser's data cache for public health interventions.

As a purchaser becomes more strategic, switching from line-item input financing to output-based financing, the generation and utilization of evidence (patient visits, services rendered, outcomes, etc.) will increase and can be used throughout the system for various other things, including immunization program improvements. This engagement will require collaboration between purchasers and ministries and data systems for both actors that can communicate with each other.

2. Vaccine hesitancy

Potential Engagement: Collaborate with the government on communications strategies to increase demand for vaccination.

In addition to procurement of vaccines and service delivery, immunization budgets are must also cover a number of other input-financed activities. Activities like communications, surveillance, pharmacovigilance, outbreak response, and monitoring and reporting require set budget lines year to year. Strategic purchasers are not often an obvious player in this space. Their spending is usually based on outputs while governments can easily set budget lines for these activities. Still, certain activities, like communications campaigns are beneficial for strategic purchasers. The higher the vaccination coverage rate, the less likely people will contract the associated disease and require coverage for treatment, providing savings for the purchaser. It could be a beneficial investment for a strategic purchaser to add to certain population-based activities, like communications campaigns. Purchasers can leverage existing channels in place to communicate with their enrollees, such as reminders and assistance in scheduling appointments for age-based vaccinations. Particularly with the challenge of vaccine hesitancy, it is common for the government to combat such a trend, but a strategic purchaser could play a role by increasing the budget available.

CONCLUSION: WHAT ROLE SHOULD/COULD STRATEGIC PURCHASERS PLAY IN NATIONAL IMMUNIZATION PROGRAMS?

By understanding the country's context and drawing from global learning, any given country can begin to think through how exactly a strategic purchaser can combat immunization program challenges. Needed context includes specific challenges that a country is facing, how funds flow through the system, and what role the purchaser plays within the larger health system. Analysis based on these pieces will help a country decide if some level of integration is the right move, and to what extent different program costs could or should be integrated to help reach towards sustainable immunization financing. There is always a possibility that the program is, and should remain, vertical under the Ministry of Health. However, there are a number of options along the spectrum of engagement that could strategically tackle challenges and leverage opportunities to improve immunization programs. The spectrum includes reimbursement for vaccination, expanded schedules, incentivizing actors to create accountability, or even a fully integrated program so that all costs, from procurement, to program delivery, to population-based services are covered by the strategic purchaser. Drawing from the global learnings will be the next step towards matching challenges to strategic engagement opportunities. What is right for each individual country in regards to *What aspects of immunization programs can a public purchaser cover, and how can these aspects be covered to maximize benefits for the sustainability of the immunization budget and absorptive capacity of the immunization program?* will vary. Cross-country transferability is somewhat limited and the analysis of how a strategic purchaser should be utilized must be firmly rooted in country context.

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ANNEX 1. SUMMARY OF POTENTIAL ENGAGEMENTS AND GLOBAL LESSONS

| Challenge | Potential Engagement | Example | Considerations |
|--|--|---|--|
| Procurement and Distribution | | | |
| Introduction or scale-up of new/demonstration vaccination programs in the NIP | Purchaser can be leveraged to add vaccines not yet included in the NIP | The Czech Republic has 7 competing purchasers who can, and do, procure and offer vaccines outside of the NIP for their beneficiaries. This can be done with or without a co-pay. | The purchaser must have the autonomy to make decisions around their benefits package. In a system with multiple purchasers, adding non-NIP vaccines through fewer than all purchasers can create equity issues. |
| Government revenue generation or immunization budget allocation is inadequate to support vaccine procurement | Utilize insurance contributions (premium payments) to support vaccine procurement | <ul style="list-style-type: none"> The Czech Republic executes vaccine procurement through their purchasers, pooling government resources with insurance contributions to increase budget headroom. To increase access to the vaccine, pneumococcal vaccination for the elderly is provided at a discounted price in hospitals for PhilHealth beneficiaries, thanks to a partnership with the manufacturer. | Immunization as a preventive service needs to be a priority in health systems, but insurance mechanisms are often used to limit the catastrophic expenditures that come with more complicated curative services. Purchasers may find it difficult to increase expenditures on services that are not related to high-cost diseases. The connection between vaccination and risk-mitigation/cost-savings should be made. |
| Program Delivery | | | |
| Low vaccination coverage rates | <ul style="list-style-type: none"> Utilization of financial incentives for improved performance | <ul style="list-style-type: none"> We can learn from the Argentina example, though they do not utilize their purchasers for immunization. Argentina implemented an expansive performance-based financing program in 2004 covering maternal and child health, called Plan Nacer. The financial incentives increased maternal and child vaccination and resulted in a 74% drop in neonatal mortality. Beyond a formalized mechanism with qualitative indicators and an evaluative | <ul style="list-style-type: none"> The purchaser must have the ability to determine the provider payment mechanisms in order to put the right incentives in place to influence provider behavior as needed to improve coverage rates. A newly established public insurance system is likely to be focused on increased access and improved financial coverage for health services. Quality is often a secondary objective that comes with time. |

study, other countries have added financial incentives by paying a fee for service payment for each vaccinated individual in addition to provider's regular salary or capitation payment for primary care. The Czech Republic, Colombia, and a number of other countries utilize this model.

- Increase access through contracting private providers

- The French public healthcare system relies on mainly private sector general practitioners. To increase access to primary healthcare services, the national purchaser, CPAM, contracts private providers to increase access for its beneficiaries, reimbursing both the cost of the vaccine and the cost of service delivery. Many other systems, including Turkey, Indonesia, Taiwan and Korea also contract private providers for this reason, though they vary of what costs are reimbursed.

- Contracting private sector providers requires a set standard of care and an ability to vet potential private providers to ensure the level of quality. In countries where the purchaser is already contracting with private providers, this engagement with the purchaser can increase access greatly, but whether just service delivery will be reimbursed, or if vaccine procurement costs are to also be reimbursed must be considered.

- Increase access through a "vaccination without borders" program

- In a fragmented system like Colombia or Mexico where multiple purchasers compete for beneficiaries, access to health services for an individual is usually limited to the network of providers contracted by their purchaser. To decrease the fragmentation for priority services, like immunization, these two countries utilize "convenios". This system allows for individuals to access immunization at any facility free of charge. Payments for service delivery are later

- A Vaccination without Borders mechanism is most useful in a system with multiple purchasers. It requires sound data collection systems and the ability for purchasers to transfer funds amongst each other if the design includes payment reconciliation.

| | | | |
|---|--|---|---|
| | | sorted by the purchasers in Colombia, though in Mexico there is no reconciliation between purchasers. | |
| Government revenue generation or immunization budget allocations do not provide the needed program financing to deliver procured vaccines | Rather than relying on the government to pay for the financing of program delivery, purchasers can pay what is needed depending on program outputs | For many countries, from Colombia to Korea, the extent of their purchaser's engagement with immunization is to reimburse service delivery, or the program output of a vaccinated individual. Other countries, like the Czech Republic, or Mexico may cover additional aspects of the program, but the typical crux of a purchaser's engagement with immunization is for service reimbursement. | Some countries have historically preferred to keep their immunization programs vertically funded through input-financing due to its public health implications. However, this is no longer the norm globally and many examples on how to use output-financing for immunization can be drawn on. |
| Inefficient spending at the national level | Utilize purchasing mechanism's business foundation to find efficiencies in the system | Thailand transferred the management of the immunization program's procurement, distribution, and delivery to one of their purchasers, the NHSO, in 2002. By paying providers based on outputs and outsourcing distribution contracts to the private sector, the NHSO made the available budget go further. The efficiency gains they found saved Thailand enough money to add a whole new vaccine, Japanese Encephalitis, to their national schedule. | By purchasing outputs (example: fee-for-service) rather than allocating budget through estimation (example: capitation), resources are likely to be more efficiently utilized. A purchaser should have a sound data system and a robust decision-making process based on that data in order to find efficiencies. |
| Subnational governments not held accountable for delivery | Through contracting mechanisms with local governments, purchasers can potentially gain leverage for improved accountability. | Argentina utilizes a performance-based financing program between government entities. The national government has contracts with provinces and for the program, makes 60% of capitated payments monthly and performance-based payments quarterly. Though the purchasers external to the MoH are not involved in the program, the mechanism design could potentially be adapted for a purchaser. | Purchasers tend to work directly with providers but can contract local government units to instill local ownership of health programming. This option may be of particular use in less developed contexts where providers/facilities do not have their own accounts and rely on local governments for financial transfers from a purchaser. |

Population-Based Services

| | | | |
|---|---|--|--|
| <p>Poor data collection and utilization in budgeting, planning, and decision-making</p> | <p>Leverage strategic purchaser's data cache for public health interventions</p> | | <p>If a purchaser utilizes output-based financing, the generation and utilization of evidence (patient visits, services rendered, outcomes, etc.) will increase and can be used throughout the system for better needs-targeting, including immunization program improvements.</p> |
| <p>Vaccine hesitancy</p> | <p>Purchasers can collaborate with the government on communications strategies to increase demand for vaccination</p> | | <p>Many purchasers do not yet see their role in this space. Public health communications are often seen as the role of the Ministry. However, the positive outcomes of such campaigns can be beneficial for strategic purchasers who look to offset treatment costs with prevention. Investments in communications could be a simple and positive engagement if the budget is available.</p> |

ANNEX 2: ARGENTINA SNAPSHOT

BACKGROUND:

The health system in Argentina was restructured in the 1990s to expand financial coverage and move towards universal health coverage. The result has been a complicated and fragmented system with overlapping insurance schemes and multiple benefits packages that offers some level of healthcare to all.

The system is broken into two basic schemes: Ministerio de Salud, or the Ministry of Health scheme (MS) and Obras Sociales (OS). - -

- The MS is a tax-funded public insurance that provides basic benefits for all. Each province manages its own MS scheme and can set the benefits for its population. This puts the management of the majority of health services in the hands of the provinces.
- OS is a social-health insurance mechanism that is actually broken up into nearly 300 national purchasers, mainly managed by trade unions, as well as one provincial OS for each province for civil servants. Again, the province-based schemes set their own benefits. The national OS, however, are beholden to a basic benefits package set by the Ministry of Health. The National Health Insurance Administration oversees compliance to the basic benefits by the OS.

In 2015, social health insurance was 58% of total health expenditure, a stark increase from 4% in 2000. For the OS, the purchasers receive government subsidies and individual contributions through premium payments (8% of salary – 3% employee, 5% employer). Provincial OS may also draw from local resources. Provincial MS, are completely tax funded and each province receives a capitation payment to deliver the basic benefits to its population.

ARGENTINE NATIONAL IMMUNIZATION PROGRAM



Vaccines in NIP: 26

Pediatric: 17

Adolescent: 2

Lifespan: 9

NIP provides protection against 28 vaccine-preventable diseases

People



- Overlaps between schemes and utilized networks



63%
Formally covered by OS



36%
Reliant on MS

Package

- Provinces, through MS, cover immunization for all, though individuals can also access services through their OS.
- Provinces set their own packages and are not held to the basic benefits package set for national OS, though the immunization schedule is nationally required.

Providers

- MS purchasers (provinces) contract public providers
- OS purchasers contract private providers



DTP3 Coverage:
86%

Measles Coverage:
89%

WHO/UNICEF 2017

National Immunization Program Financing Responsibilities

| Procurement | Cold Chain | Salaries | Incentives | Campaigns | Monitoring and Reporting | Surveillance |
|-------------|-----------------|-----------|---|-----------|--------------------------------|--------------|
| MoH | MoH + Provinces | Provinces | Provinces (through World Bank loan to central government) | Provinces | Provinces/ Municipalities/ MoH | Provinces |

PLAN NACER/SUMAR

Despite efforts towards coverage for all, during the recession in the early 2000s Argentina saw its health investments and some major outcomes worsening. Such a decentralized system with limited accountability attached to capitation payments proved addressing inefficiencies and quality concerns difficult. Working with the World Bank, Argentina introduced a new strategic purchasing program, called Plan Nacer, that would greatly affect the health system.

Beginning in 2004 with a US\$107 million loan that would cover nine provinces for 3 years, Plan Nacer was introduced to increase enrollment, access, and quality in maternal and newborn MS services. The program functioned by paying an additional \$5 premium to health facilities for enrollees, targeting poor pregnant women and children. Funds were held at the Ministry of Health, transferred to provinces, and then transferred to facilities. Monthly payments of 60% of the total premiums were made. The additional 40% was paid every 3 months based on performance on a set of indicators.

These payments were in addition to normal salary transfers and could be used by facilities as they pleased. Indicators included “Effectiveness of Prenatal Care”, which included the delivery of the tetanus vaccine for pregnant women, and “Immunization Coverage” for infants. Though enrollment in the program was completely voluntary, the financial incentive was designed to motivate providers to enroll individuals and provide them with quality care. By the end of 2008, 82% of the eligible population was enrolled in priority provinces. By the close of the loan in 2012 when the program reached national coverage, over 2 million women and children were enrolled in the program.

Results from the program have been positive. High enrollment in the Plan Nacer increased the number of people accessing the health system. An impact evaluation showed improved birth outcomes and decreased neonatal mortality. Plan Nacer beneficiaries in large hospitals saw a 74% drop in neonatal mortality. The World Bank attributes these outcomes, in part, to improved vaccination for mother and child.

In 2012, with a US\$400 million loan from the World Bank, the government started a new expanded program: Plan SUMAR. The new scheme expands coverage to children ages 6 – 19 and women ages 20 – 64. In mid-2015, coverage expanded to uninsured men ages 20 – 64. Plan SUMAR includes performance indicators on immunization coverage at 24 months and 7 years. The new program had reached a total of 16 million children and adolescents, pregnant women, and adult women and men as of July 2015.

Payment

- OS often use FFS, though it depends on which OS scheme.
- MS use capitation for primary care, transferred to provincial governments and on to public providers.
- Plan Nacer/Plan SUMAR introduced a performance-based payment for certain primary care services, including immunization. Provinces are paid 60% of an additional capitation monthly and the remaining payment, depending on performance indicators, is made every 3 months.

TAKE-AWAYS FOR USING STRATEGIC PURCHASERS FOR IMMUNIZATION:

Though the strategic purchasing mechanism that is utilized in Argentina runs through their Ministry of Health, rather than a separate public purchaser (like the OS system that exists in-country), the model and the strategies utilized are possible because of the financial relationship that exists between one actor to another. In this manner, purchasers in other contexts can learn from this model as much of the lessons are adaptable to other purchasing institutions.

- 1. Output-based financing creates lines of accountability.** Plan Nacer established contractual relationships between central and provincial health ministries and between provincial health ministries and public providers. Under normal MS primary care payments, purchasing is not done strategically. Supply-side input financing is transferred to provinces with no accountability on how transfers are spent. Outputs on a number of priority services were poor and falling with economic decline at the turn of the century. By introducing payments based on outputs (vaccinations, neonatal check-ups, etc.) providers were accountable to provinces to perform for their payments. Similarly, provinces had to ensure that their providers were delivering services in order to receive the payments from the national Ministry.
- 2. Incentives do not have to cost large portions of the health budget.** Argentina has relied, in part, on the World Bank to bolster its financing for its performance-based payment programs. Still, under Plan Nacer, funding for incentives totaled less than 1% of total public health spending at the provincial level. It is important to ensure that the level of financial incentives used is aligned with eliciting the desired behavior change but adding a positive incentive program does not have to break the bank.
- 3. Performance indicators can be tailored to the particular challenges of a given system.** Argentina had identified access to the health system and quality of maternal health care services as particular challenges that they wished to address. The program was thus designed to respond to these challenges. Payment for the performance-based program in Argentina requires both enrollment (to set the payment base line) and quality service delivery (to receive bonuses). Any performance-based program can be adjusted to respond to local challenges.
- 4. Payment mechanisms based on outputs increase the data culture.** In order to make payments based on outputs, providers must deliver proof of services rendered. The requirement of reporting in order to receive payment can increase the collection of data, which can often increase the utilization of data in planning and decision-making. Plan Nacer has helped implement a stronger data culture, improving the system of collection across provinces. During the impact evaluation, the World Bank found that two provinces had to be excluded because prior to their involvement in Plan Nacer, data was not systematically collected. Still, changing the way that data is collected and used is not simple, and ongoing supervision and training need to be tailored to local capacity.

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ANNEX 3: CZECH REPUBLIC SNAPSHOT

BACKGROUND:

The public social insurance system of the Czech Republic was founded in 1992 with one purchaser (VZP) that is backed by the state and designed to be open to other competing purchasers. Purchasers besides VZP may come and go, depending on the market. VZP remains the largest purchaser within the system (around 60% population coverage), partly due to its traditional role as the purchaser for pensioners. VZP also controls the redistribution fund that provides some cross-subsidization among the 7 existing competing purchasers.⁹

The Ministry of Health (MoH) oversees and has authority over the entire system. Though purchasers are only quasi-public and self-governed, the MoH and Ministry of Finance (MoF) must approve the annual operational and financial plans of the purchasers and the MoH manages the operating license that purchasers need to function. Additionally, both ministries play a large role on the boards of each purchaser. Each purchaser has a board with 1/3 of the representatives assigned to the government (MoH, MoF, and Ministry of Labor and Social Affairs). Other seats are filled with top contributors to their pool of funds (businesses) and elected union representatives. A final check on the system includes regional health authorities, decentralized MoH offices, which register the providers that can be contracted by purchasers.

FINANCING:

Social health insurance made up 70% of total health expenditure in the Czech Republic in 2015. SHI is funded by a combination of government allocation and insurance contributions. This level of contribution is lower than previous years. In 2005, social health insurance made up 81% of total health expenditure. This decline has been accompanied by a doubling in government expenditure and a slight increase in out of pocket expenditures.

Each purchaser is funded by a mix of government allocations and contributions from premium payments. Individuals contribute 13.5% of their monthly wages (4.5% employee, 9% employer) to their selected scheme. Because of the varying capacity of individuals to contribute, and the different levels of care needed by individuals, collected funds are then re-distributed by VZP, based on a risk-adjustment formula. VZP

People



Package

- Immunization is in the benefits package
- Additional vaccines can be offered by purchasers
- Cohorts can also be expanded beyond the national program (flu).

Providers

- Public and private sector providers are contracted by purchasers.
- About 95% of primary care services are provided by the private sector.

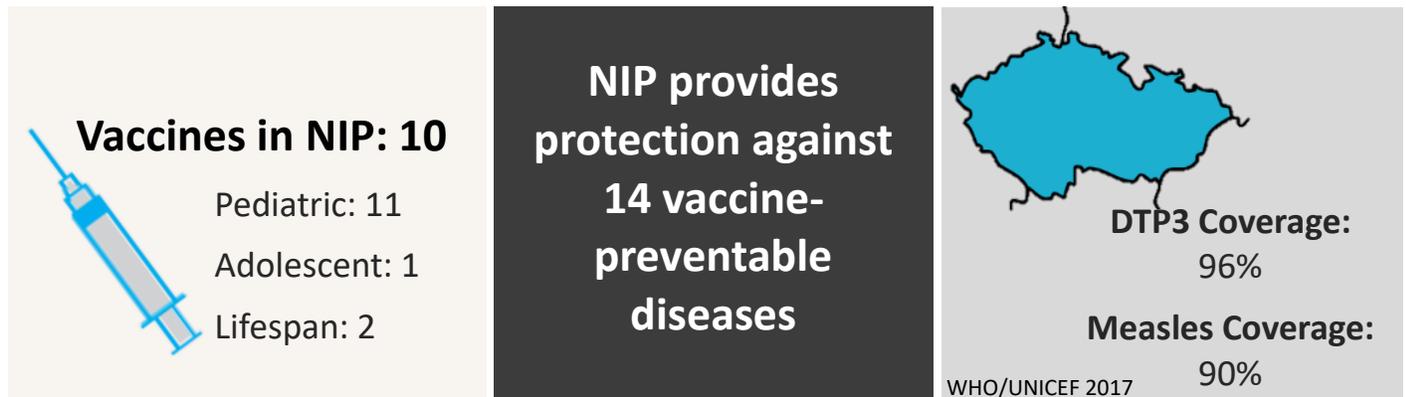
Payment

- General practitioners receive capitation payments for primary care with an additional fee-for-service payment for some public health services, like immunization. These additional payments accounted for approximately 10-15% of physicians' income in 2012.
- Negotiations on reimbursements are done between purchasers and providers but supervised by the MoH.

⁹ VZP CR, VoZP CR, CPZP, OZP, ZPS, ZPMV CR, RBP [https://www.mzcr.cz/Cizinci/obsah/health-insurance-companies_2652_23.html]

remains the only purchaser backed by the government and protected from bankruptcy.

CZECH NATIONAL IMMUNIZATION PROGRAM



National Immunization Program Financing Responsibilities

| Procurement | Cold Chain | Salaries | Incentives | Campaigns | Monitoring and Reporting | Surveillance |
|----------------------------|------------|----------|------------|-----------|--------------------------|--------------|
| SPs (through a contractor) | SP + RHAs | SP | SP | RHAs | RHAs | RHAs |

Note: Strategic Purchaser (SP), Regional Health Authorities (RHAs), Ministry of Health (MoH)

TAKE-AWAYS FOR USING STRATEGIC PURCHASERS FOR IMMUNIZATION:

Management of the vaccination program was shifted to the purchasers in 2008. The purchasers are now responsible for about 90% of immunization program financing. Some important learning can be taken from the Czech experience in how a strategic purchaser can affect an immunization program's performance.

- 1. By pulling in a social health insurance mechanism, the immunization program now draws from individual contributions to the schemes, thus saving the government money.** Estimates suggest the shift saves over US\$38 million annually in the ministry's budget, though this cost has just been transferred to the insurance budgets. Delivery of a national immunization program (NIP) does come with a cost and is likely to be associated with a premium increase to support quality implementation. However, in this case, the shift to managing the program under the purchasers was not associated with a premium hike, causing some stress on the purchaser's finances.
- 2. Prioritization of the program is shown through additional incentives via fee-for-service payments.** General practitioners in the Czech Republic are paid based on the number of patients registered with them. This is a set payment that is not reliant on delivering services or quality services. For immunization, a preventive program that often requires some level of demand generation, this form of payment does not signal the program as a priority or encourage general practitioners to take initiative on vaccinating the population. In this example adding an additional fee-for-service payment that rewards vaccination outputs, signals the government's priorities to providers.
- 3. An option for partial reimbursement provides increased access to vaccinations.** All purchasers within the Czech system must fully reimburse for vaccines on the national schedule. However, there is a lot of opportunity to expand upon this schedule within individual mechanisms. This provides multiple options for the population. Partial reimbursement is often provided for vaccines not in the

NIP or for brands that have not been procured through the national tender. The number of reimbursed vaccines, full and partial, continues to grow since 2008. This system could potentially function in a landscape where the NIP is still run vertically through the Ministry as well. Purchasers that have the legal ability to procure vaccines can provide additional options to the national schedule, at full or partial reimbursement.

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ANNEX 4: FRANCE SNAPSHOT

BACKGROUND:

Financial health coverage is available to all in France under the 2016 Protection Universelle Maladie (PUMA) law. However, the national social health insurance scheme, the Regime General, is much older. At a local level the Regime General is administered by a health authority, called the Caisse Primaire d'Assurance Maladie (CPAM). CPAM acts as the single purchaser of health services.

CPAM is an influential body in French healthcare, sharing power with the Ministry of Health and its local Regional Health Authority branches. Though CPAM sits on the price negotiating committees for health technologies and negotiates reimbursement rates with providers, the Ministry is the overarching authority and must approve all decisions.

FINANCING:

Social health insurance contributes 75% of total health spending in France. This has been a steady rate over time, with both strong contributions from individuals as well as robust investment from the government. The Regime General is financed by individuals through an employer and employee payroll taxes (50%), federal funds through a national earmarked income tax (35%), taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies (13%), as well as state subsidies (2%).

Immunizations are fully reimbursed by CPAM though the vaccination process is quite labored. Vaccines are given via prescription from a GP at a pharmacy level and then delivered by GPs or nurses. Each step is reimbursed by national purchaser. All in all, it is a 3-step process to receive a vaccination. Understanding the toll this process may take on individual motivation, the purchaser has recently experimented with delivering letters to individuals that served as a prescription for the flu vaccine, thus cutting out the first step in the usual process. To what extent this solved the problem is unclear.

CPAM has also tried a pay-for-performance scheme, first piloted in 2009 and available nationally for self-employed GPs to enroll into since 2014. Though the program includes indicators across a range of health programs and some indicators showed improvement, immunization outcomes show mixed results. An evaluation from the spring of 2018 found limited impact on immunization.

People



Package

- Immunization is in the benefits package
- Patients are reimbursed for two visits to the doctor: 1) for the vaccine prescription and 2) for delivery and additionally for the cost of the vaccine at the pharmacy.

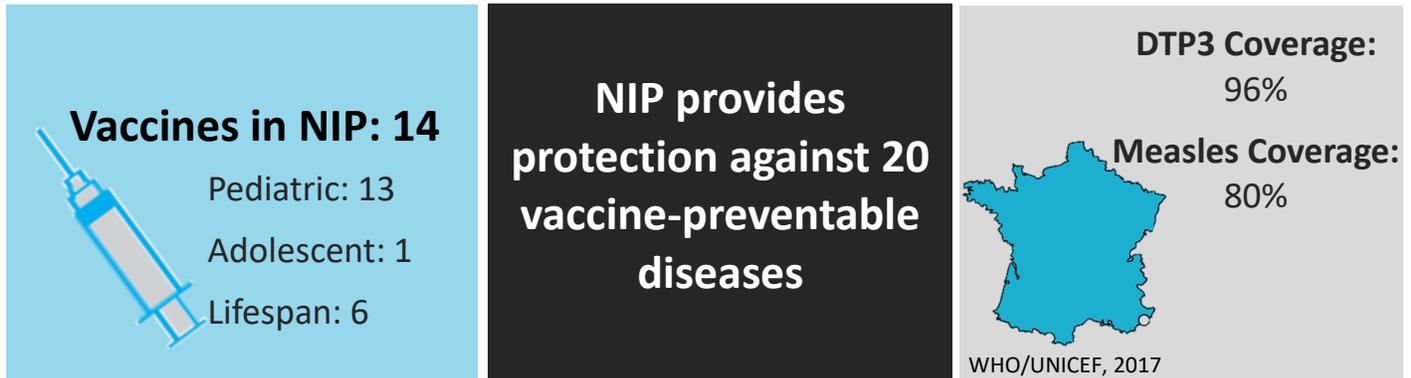
Providers

- Public and private sector providers are contracted by CPAM.
- Primary care services are provided by private general practitioners.

Payment

- The purchaser makes fee-for-service payments for vaccination outputs
- Fees, set by the health ministry and SHI, have been frozen since 2011.

FRENCH NATIONAL IMMUNIZATION PROGRAM



National Immunization Program Financing Responsibilities

| Procurement | Cold Chain | Salaries | Incentives | Campaigns | Monitoring and Reporting | Surveillance |
|-------------|------------|--|------------|-----------|--------------------------|--------------|
| SHI | | RHAs for public sector / SHI for private | SHI | RHAs | RHAs | RHAs |

Note: Strategic Health Insurer (SHI), Regional Health Authorities (RHAs), Ministry of Health (MoH)

TAKE-AWAYS FOR USING STRATEGIC PURCHASERS FOR IMMUNIZATION:

Tapping into social health insurance contributions opens up fiscal space. France shares immunization program costs between the government and CPAM. However, by utilizing CPAM for program delivery the government has been able to tap into a lucrative line of funding. SHI makes up 75% of total health expenditure, 50% of which is premium payments (employee/employer contributions). That means nearly 38% of health expenditure is sourced from premium payments. Utilizing this line of funding releases a lot of pressure from the government to cover all program delivery fees.

Contracting private providers is a way to increase access. Though France has no real general practitioners in the public sector and must utilize private practitioners, many other countries have a large number of private practitioners functioning in the primary care space despite a robust public system. By contracting private providers into the system through set reimbursement fees, France ensures that access to a provider is not a barrier to receiving a vaccine. Other countries can adopt this practice if access is a persistent issue.

An incentive program has to align incentives with desired behavior change in order to achieve outcomes. Two of the country snapshots (France and Argentina) utilize pay-for-performance bonus mechanisms to improve immunization outcomes. Though Argentina's program has been quite successful in increasing coverage rates, France's program has been unsuccessful. This reinforces the basic tenant that incentives must be attractive to the recipient in order to work. Bonus rates or other available incentives need to be tailored appropriately to have any effect and require much context and collaboration.

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ANNEX 5: TURKEY SNAPSHOT

BACKGROUND:

Turkey's General Health Insurance Scheme (GHIS) was passed into law in 2007 and began implementation in 2008. Previously, five separate insurance schemes existed, fragmenting the population into formal and informal workers, civil servants, pensioners, and the subsidized poor and providing multiple public benefits packages. Slowly, all existing pools were combined under the new general scheme which offers a universal benefits package and is managed by the Social Security Institution (SSI).

Though Turkey has 81 provinces, it is a highly centralized country. Despite this, efforts have been made to decentralize health service management to an extent. In the Turkish system, the central government appoints provincial governors. The Ministry of Health (MoH) has local offices in each province, but these local offices are accountable to the governors, not the central MoH. This could potentially create tension between national and provincial priorities, but both governors and MoH offices within provinces are centrally appointed, limiting the existence of such tension.

The MoH and SSI work within a system with a purchaser/provider split. SSI purchases services while the MoH delivers services. What services are included within the benefits package is negotiated between the two actors. For immunization in particular, the MoH takes ownership of the program, undertaking the planning, target-setting, and outcome management. Still, the SSI plays a role in the delivery of the program.

FINANCING:

Social health insurance through the GHIS constituted 56% of total health expenditure in Turkey in 2015. This proportion is on the rise. Just ten years earlier, in 2005, social health insurance was 40% of total health expenditure. This financial source has been beneficial for the immunization program which is funded through social health insurance contributions as well as general taxation.

General taxation is the major funding source, subsidizing SSI premiums and funding the Ministry of Health which covers all procurement, distribution, and population-based service costs for the immunization program. In addition to the salaries paid to public family doctors through provincial MoH capitation payments, SSI reimburses vaccination service delivery. SSI payments are also made to contracted private facilities for vaccines on the national schedule, though not for service delivery.

People



Package

- Immunization is included under the GHIS and vaccination is free for all in public facilities.

Providers

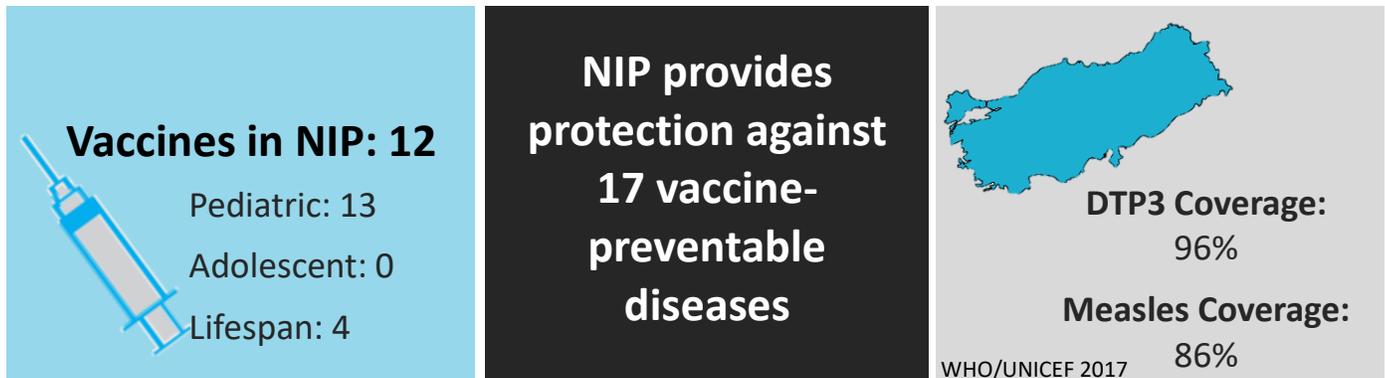
- 85 - 90% of doctors are public
- Private sector can be contracted by SSI and about 10% of newborns are vaccinated in the private sector

Payment

- Public providers receive a salary from their provincial MoH through capitation payments.
- P4P scheme has repercussions for poor performance on immunization coverage
- The GHIS also provides service fees to facilities which are kept in a revolving fund and utilized as needed.
- The private sector is reimbursed for vaccines, but not service delivery under the immunization program.

Though service delivery payments in addition to salaries is an incentive in itself to deliver the program, Turkey also has a performance-based financing (PBF) scheme for public family doctors based on 3 indicators, one of which is immunization coverage. Poor performance results in detracted salary payments.

TURKISH NATIONAL IMMUNIZATION PROGRAM



National Immunization Program Financing Responsibilities

| Procurement | Cold Chain | Salaries | Incentives | Campaigns | Monitoring and Reporting | Surveillance |
|-------------|------------|----------|------------|-----------|--------------------------|--------------|
| MoH | MoH | MoH | SSI | MoH | MoH | MoH |

TAKE-AWAYS FOR USING STRATEGIC PURCHASERS FOR IMMUNIZATION:

Contracting-in private sector providers increases access to vaccination services. Although around 90% of the national immunization program is delivered through public facilities, 10% of newborn vaccinations are accessed in the private sector. By contracting in these private providers, the purchaser creates a comprehensive system for program delivery that can improve data tracking and program implementation.

The utilization of the GHIS to pay for immunization delivery opens budget headroom. Turkey utilizes their purchaser, more or less, as an incentive mechanism for the delivery of the national immunization program. The majority of the costs within the program are financed by the Ministry of Health through general taxation. Where such an incentive mechanism could be a burdensome addition within a program’s budget, the utilization of the GHIS which has additional capital through premium payments opens up the needed budget to implement the fee-for-service program.

Incentives for service delivery (fee-for-service and PBF) offer a mechanism through which to control a system. Turkey offers additional motivational mechanisms for providers to deliver vaccinations through financing incentives. With many providers across a large country that have competing priorities, and sometimes limited incentive to promote public healthcare and ensure the delivery of preventive services, such financing mechanisms can bring cohesion and a shared priority across actors. Financing mechanisms can promote certain behaviors and stimulate action. Though there is no clear research for the Turkish context, financial incentives have had mixed outcomes in other cases. Argentina has seen strong improvements through its PBF program while France has experienced no real change in outcomes. Any

financing mechanism must fit the context and offer a reward that aligns with the motivation to change behavior.

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