Potential for strategic purchasing to promote person-centred provision of sexual and reproductive health services in low- and middle-income countries

This is one of a pair of evidence briefs that build on findings from a scoping review on family planning (FP) and comprehensive abortion care (CAC) services, which was conducted between 2019 and 2021 (1).

This brief examines the relevance of strategic purchasing in optimizing person-centred approaches to sexual and reproductive health (SRH) services and to illustrate how purchasing instruments may contribute to promote greater person-centred care, address access barriers and improve the provision of SRH services.
Key messages of this brief

- Of particular interest for the SRH community is that purchasing arrangements can greatly contribute to improving person-centred service provision, and therefore promote greater patient empowerment, improved privacy and confidentiality, and more equitable treatment, which are all critical for rights-based SRH service provision. Tailoring purchasing arrangements to promote person-centredness can therefore be instrumental to improve SRH service provision.

- Further research is needed to help us better understand the conditions under which purchasing arrangements can best be leveraged to promote person-centredness, therefore generating lessons and best practices for the SRH community and beyond, as person-centredness is a key dimension of integrated service delivery in every area of health care.

- Of particular interest for the SRH community is that purchasing arrangements can greatly contribute to improving person-centred service provision, and therefore promote greater patient empowerment, improved privacy and confidentiality, and more equitable treatment, which are all critical for rights-based SRH service provision. Tailoring purchasing arrangements to promote person-centredness can therefore be instrumental to improve SRH service provision.

- After a decade of global experience of purchasing reforms for SRH services, two key conclusions have emerged: (i) these interventions have had mixed impacts on SRH service provision; and (ii) the effects on the key features of SRH person-centred service provision have not been monitored systematically.

- Further tailoring of purchasing arrangements for SRH services – more strategic purchasing – should explicitly attempt to promote person-centredness in SRH service provision. The lack of consideration of important service quality and delivery features in the design of most health-care purchasing initiatives for SRH may explain the mixed results that have been observed so far.

Introduction

Access to SRH services can be constrained by a country’s policy and regulatory environment. In addition, social, economic and cultural factors also impact people’s access to SRH services. In 2020, approximately 800 women died every day from preventable causes related to pregnancy and childbirth. Current data also indicate that about 164 million women want to avoid pregnancy but are not using any contraceptive method and that more than 350 million men and women need treatment for at least one of the four curable sexually transmitted infections (STIs). In 2015–2019, some 61% of all unintended pregnancies ended in an induced abortion.

To address unmet needs and achieve universal access to SRH services, two important approaches to expand SRH service coverage, based on primary health care (PHC), are suggested:

- progressive integration of SRH services into primary care to improve the availability and affordability of SRH care; and

- person-centred SRH service provision to improve the quality (acceptability, accessibility, effectiveness, efficiency, equity, safety) of SRH care.

Definitions of key terms

- **Purchasing** is a critical component of health-care financing that enables the allocation and payment of pooled funds to health-service providers (e.g. health workers, health-care facilities and provider networks/organizations). Purchasing arrangements specify the services and interventions covered by pooled resources, provider selection criteria, contracting requirements, and provider payment methods and rates.

- **Strategic purchasing** refers to purchasing arrangements and reforms that promote equity, effectiveness, efficiency and quality in the delivery of health products and services for improved population health – including improved access to priority SRH services.

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- **Strategic purchasing** refers to purchasing arrangements and reforms that promote equity, effectiveness, efficiency and quality in the delivery of health products and services for improved population health – including improved access to priority SRH services.

1 WHO has compiled a list of services to be included in SRH programmes: antenatal care, labour and childbirth care, postnatal care, contraception and family planning, infertility care, sexual health, care for survivors of female genital mutilation (FGM) and intimate partner and sexual violence, comprehensive abortion care, ectopic pregnancy management, cervical cancer screening, prevention and treatment, comprehensive sexuality education.
Recent research on barriers that prevent people from accessing and using SRH services, and ways of overcoming these barriers, has highlighted the importance of key principles, including respect for privacy, confidentiality, autonomy and choice, as well as the provision of continuous care (5). While international guidelines addressing access to SRH services often focus on improving the technical quality of services, equipment and procedures, they often gloss over the importance of enhancing the quality of care and the service delivery processes, such as improving communication between health-service providers and service users, individual involvement in decision-making, respect for privacy and confidentiality, and follow-up care.

Quality of care is defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge”. Quality health services should be effective, safe, people-centred, timely, equitable, integrated and efficient (11).

The rights-based approach to SRH has long been recognized as a crucial framework for advancing the health and well-being of individuals and communities, emphasizing fundamental human rights linked to SRH, such as the right to health, privacy and confidentiality, the right to information and education, and the right to make decisions about one’s own body and reproductive health.2

Prioritizing person-centredness is crucial in a rights-based approach to SRH, recognizing individuals’ rights to access and use SRH services that are respectful, responsive and tailored to their specific needs (5), and evidence shows that this approach positively impacts patients’ pathways to seeking, accessing and using services over the long term (13).

Person-centred care emphasizes shared decision-making between patients and health workers, developing patients’ abilities to manage their own health-care needs. Advancing person-centred care in the context of SRH services requires focusing on the values and preferences of the individual, by adapting service provision around their needs, values and preferences3 – for example, relating to autonomy, dignity, equality, confidentiality, communication, social support, supportive care and trust. Hence, key features of these services include respecting service users’ agency and autonomy in decision-making, and providing services in a respectful manner, free from stigma or discrimination (14).

This approach acknowledges specific barriers that some groups face in accessing SRH services and encourages policy-makers to view health needs and services in a broader perspective. Person-centred models of care have the potential to be particularly beneficial for family planning (FP) and comprehensive abortion care (CAC) services, which often involve deeply personal and intimate decision-making processes shaped by individual and societal circumstances (12).

This policy brief presents an examination and discussion of the relevance and the potential role of strategic purchasing in optimizing person-centred approaches to SRH service delivery and illustrates how purchasing arrangements and instruments may contribute to promoting person-centred care, addressing access barriers and improving provision of SRH services (2). This brief focuses on a purposively selected set of strategic purchasing instruments, schemes and reforms for CAC and FP, indicating how similar efforts can benefit SRH services more broadly. The selection of purchasing instruments and schemes described in this brief is not aimed to provide a prescriptive or exhaustive list of strategic purchasing options available to improve SRH services. As argued in this brief, strategic purchasing arrangements cannot be applied as a one-size-fits-all approach: they require careful consideration through a context-specific lens jointly with tailored approaches to their implementation.

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2 The Programme of Action from the 1994 International Conference on Population and Development (ICPD) established that reproductive rights are founded upon the freedom of individuals and couples to make decisions regarding having children without facing discrimination, coercion or violence. This includes having access to the information and resources necessary to make these decisions. Additionally, these rights are linked to the right to achieve the highest possible level of sexual and reproductive health. The ICPD Programme of Action also established that reproductive rights are not a novel set of rights, but instead, they encompass a collection of freedoms and privileges that are already established in existing national laws, international human rights agreements, and other consensus documents (12).

3 Methodological tools such as Patient Reported Outcome & Experience Measures (PROMS & PREMS) are gaining recognition as important inputs promoting shared decision-making and capturing individual and societal preferences in design and delivery of services, and should therefore be important steps in defining patient preferences.
More specifically, this evidence brief will: (i) define strategic purchasing and person-centred care, and articulate the conceptual links between them in the context of SRH services; (ii) describe purchasing levers (or tools) that can be used to promote greater person-centredness in SRH service provision and present examples of the use of such levers, drawing on findings from a scoping review (1); and (iii) discuss the policy and programming implications.

How this brief was developed
This brief is one of two evidence briefs drawing upon an extensive scoping review on strategic purchasing for SRH services (1), conducted between 2019 and 2021. The scoping review examined more than 200 documents in total, and 15 documents on FP and 14 on CAC that met the inclusion criteria. Additionally, key informant interviews were conducted with 17 experts, predominantly from WHO, specializing in three focal interventions: FP, caesarean section, and safe abortion. Experts external to the organization, with dual expertise in SRH and health financing, were also consulted and included individuals from leading consulting firms and prominent nongovernmental organisations in the SRH sector, such as Population Health and ThinkWell.

The scoping review explored which service models should be incentivized through strategic purchasing to promote person-centred SRH service provision (the subject of this brief) and integration of SRH services into primary health care (PHC) (the subject of the other brief [15]) in low- and middle-income countries (LMICs). Findings derived from the scoping review were used to develop a conceptual framework for the purpose of this brief. This framework endeavours to elucidate the potential linkages between particular changes in purchasing arrangements and the central dimensions of person-centred care. Selected examples from purchasing instruments are included in this brief to illustrate these linkages within the context of the evidence reviewed.

Key concepts – person-centred care and strategic purchasing – and how they are linked

Person-centred care
The concept of person-centred care has gained traction in recent years, building upon the key principles of people-centred care outlined in the Integrated, People-Centred Health Services (IPCHS) framework adopted by WHO Member States (16).

Person-centred care focuses on addressing an individual’s unique needs and preferences by considering their personal history, social context, strengths and weaknesses. The goal of person-centred care is to improve health outcomes, patient satisfaction and efficiency in the use of health-care resources. This approach recognizes each person as a unique individual with subjective experiences and self-actualizing relationships with others (17), and it encompasses a broader and more comprehensive view of what constitutes a meaningful life. Key principles and characteristics of person-centred care include empathy, respect, engagement, relationship-building, effective communication, shared decision-making, a holistic focus, individualized attention and coordinated care (17).

Purchasing arrangements and strategic purchasing
Purchasing is a health financing function defined as the process by which pooled funds are paid to health-service providers to deliver a specified or unspecified set of health services on behalf of the population (18).

Purchasing arrangements pertain to decisions made in relation to the following.

- **Which health services to buy** – selecting services to be included in the benefit package based on the burden of disease and societal or policy priorities, and defining the conditions for entitlements, prepayments and copayments (also known as "co-pays", i.e. out-of-pocket payments made by the beneficiary in addition to payments made by an insurer).

- **From whom to buy these services** – selecting health-service providers through arrangements such as licensing, empanelling, accreditation and certification.
How to buy these services – deciding on which procedural and clinical requirements need to be met through contracting, what payment methods should be used to pay health-service providers, and what reporting obligations should be in place to allow payments. Adjustments in purchasing arrangements can trigger changes in the behaviour of health-service providers and health-service users. Strategic purchasing refers to the situation when these adjustments in purchasing arrangements are made strategically to trigger behaviour changes that will positively impact service provision and health outcomes, and promote equity. For example, strategic purchasing can help to overcome barriers for health-service users (demand-side barriers), such as the lack of ability to seek, reach and use health services (19), and it can give more flexibility and autonomy to health-service providers, facilitate integrated care to address access barriers in some settings, facilitate more efficient use of resources, and ensure the provision of safe and quality care for service users – thus promoting more person-centred care in many ways. It is important to note that adjustments in purchasing arrangements may also trigger undesirable behavioural responses from health-service providers, which can hinder the equitable and efficient delivery of quality SRH services. Therefore, it is crucial to monitor and evaluate the effects of any adjustments to ensure that they result in improved access, increased utilization and equitable delivery of quality SRH services.

Links between strategic purchasing and person-centred care

A conceptual framework was developed based on findings from the scoping review to summarize the links between strategic purchasing (changes in purchasing arrangements) and the key principles underpinning person-centred care (Fig. 1).

This conceptual framework (Fig. 1) shows the potential inter-connections between changes in purchasing arrangements and key dimensions of person-centred care. The box on the left summarizes the key policy areas (i.e. changes pertaining to the benefit design, selecting and contracting providers, or paying providers) that the health purchasing function covers, which can contribute to promoting the delivery of person-centred SRH services. The central box summarizes key service features of person-centred SRH services, which emphasize key service-provision dimensions such as empowerment, shared decision-making, coordinated care, greater empathy and respect, improving care-giving relationships and greater individualized focus. The framework illustrates that improving the dimensions of patient-centred care can directly contribute to address some of the demand- and supply-side barriers (which are listed in the box on the right), leading to improvements in SRH service provision and use.

Fig. 1. Conceptual link between strategic purchasing and person-centred care to improve the provision and use of SRH services

Sources: (a) Dimensions of person-centred care adapted from Håkansson Eklund et al., 2019 (17); (b) Access dimensions adapted from Levesque et al., 2013 (19)
Examples of how purchasing instruments can promote person-centred care in SRH

In the following three subsections, examples of purchasing schemes and instruments that were identified through the scoping review for their potential to be associated with improvements in person-centred services for SRH are grouped by the three types of changes in purchasing arrangements (as shown in the box on the left in Fig. 1).

1. Modifications in benefit design to improve person-centred care in SRH services

Modifications in benefit design pertain to adjustments made to entitlements (relating to both services and population groups), as well as the conditions for access to these entitlements (20). Such alterations can profoundly impact the availability of specific health services, potentially broadening the range of options that are provided to users and, in some cases, giving individuals the opportunity to select a health-service provider.

Benefit design refers to decisions about those health services and goods to be funded, either fully or partially, from public revenues. Benefit design also involves decisions about the conditions that must be met in order to access publicly funded benefits (20).

Various policy experiments have been undertaken involving the design of SRH benefits with interventions ranging from removing or reducing copayments, including for non-health services such as transportation, paying individuals through conditional or unconditional cash transfers to seek out SRH services for themselves, instead of paying the health-service providers; and promoting self-management (self-care) for some essential SRH services.

The objective of cash transfer initiatives is to incentivize specific behaviour changes in beneficiaries through the direct provision of limited financial support. Cash transfers or in-cash benefits have been used increasingly by purchasers to channel financial resources through users of health services, with the aim of incentivizing individuals to use health services, including SRH services. Cash transfers are usually considered demand-side financing interventions. However, when conditional, they can be seen as part of benefit design, providing specific groups with cash to cover the direct and indirect costs of access to specific SRH services. Meanwhile, SRH service-delivery models that are based on self-care (e.g. self-administered injectable contraception and over-the-counter oral contraceptive pills) have also become increasingly popular among purchasers as they have demonstrated cost-effectiveness by reducing visits to health-care facilities without negatively impacting health outcomes. Self-care models of care have the potential to promote greater equity in SRH service provision by reaching individuals who may otherwise face barriers to accessing care (18).

Strategies involving cash transfers and promotion of self-management have the potential to strengthen person-centred health services, emphasizing the significance of individual preferences and needs and giving people a more central role in decisions about their own care. These strategies could enable individuals to make informed decisions about their own health seeking and care trajectories, while cultivating a sense of ownership, responsibility and greater control over their health-care journey and outcomes. Both strategies can include, for instance, shared decision-making regarding preventive measures and therapeutic options. Cash transfer initiatives grant individuals increased choice and autonomy in selecting SRH services that may be better tailored to their needs, while self-care approaches strengthen access and encourage a person’s active engagement in managing their own health-care needs. Furthermore, integrating cash transfers and self-care into the larger health system may alleviate the strain on health workers, health-care facilities and other health-service providers, permitting them to allocate resources more efficiently and concentrate on delivering high-quality, personalized care.
However, to date, studies and reviews evaluating cash transfer programmes have yielded mixed results regarding contraceptive uptake and use, varying from positive impact on contraceptive use within households, to no effect among adolescents and young women (21–25). The available evidence indicates that there may be inequities in access to cash transfers and that the success of these programmes is strongly influenced by the sociodemographic characteristics of the beneficiaries (26), which raises concerns about the effects on equity in SRH service provision. Experience shows that purchasers frequently face challenges in accurately identifying recipients for cash transfers when they must perform this task independently, primarily due to a lack of institutional capacity for effective identification and targeting (27). Moreover, most evaluation frameworks that were used to evaluate these interventions have not measured their effects on person-centredness in SRH service provision.

It is worth noting that cash transfers may weaken the government’s capacity to regulate health-service providers’ practices. Individuals may be given the freedom to decide where and who to consult, but this can only be effective (i) if there are several health-service providers to choose from (otherwise there is no choice) and (ii) if users are not facing a very steep asymmetry of information (i.e. where health-service providers may be strongly influencing their “free” choice). If these conditions are not met, then cash transfers (and weakened government regulation) may lead to supply-induced service provision, which has adverse effects on the quality of SRH services such that individuals may have no choice but to use services that are of poor quality or not aligned with their needs. A summary of the relevant pros and cons of cash transfers is provided in Box 1.

Box 1. Cash transfers to increase person-centredness in SRH services – increasing choice and autonomy

Description:
Cash transfer initiatives, both conditional and unconditional, are intended to incentivize specific behaviour changes in beneficiaries, such as incentivizing them to use health-care services, including SRH services.

Pros:
- More individual choice and autonomy in selecting health services.
- Individuals have an enhanced sense of ownership, responsibility and control regarding their own health and care needs.
- A useful complementary initiative to demand- and supply-side health financing strategies.
- Alleviate strain on health-service providers and allow for more efficient use of resources.

Cons:
- Studies and reviews evaluating cash transfer programmes have yielded mixed results on contraceptive uptake and use.
- Evidence indicates that there may be inequities in access to cash transfers.
- The success of cash transfer programmes is strongly influenced by the sociodemographic characteristics of the beneficiaries.
- Effects of cash transfers on person-centredness of SRH service provision have not been measured.
- Cash transfers may weaken the government’s capacity to regulate health-service providers’ practices.
- More individual freedom to choose can only be effective if there is a range of providers and services to choose from and if users have access to accurate and balanced information.
- Purchasers frequently face challenges in accurately identifying recipients for cash transfers.
It is not yet clear whether self-care models of service delivery have improved access for those in vulnerable settings, or what their impact has been on the privacy and autonomy of patients; further research and evidence is needed before this can be assessed. It has been increasingly stressed that self-care models also create unique obstacles to access to and safe use of SRH essential services, which must be overcome before self-care interventions replace provider-based service provision (28).

The shift from provider-administered to self-managed care may be driven in some instances by concerns other than the best interests of the service users, e.g. cost containment, lowering the financial burden of providing SRH services by shifting most of the burden of costs to the patient (29). Self-management for SRH health care should, therefore, continue to be seen as a complementary rather than substitutive model of care. A summary is provided in Box 2.

### Box 2. Self-management models to increase person-centredness in SRH services – increasing empowerment and equity

**Description:**
SRH service-delivery models that are based on self-care involve the use of self-management interventions such as self-medication, self-treatment, self-examination, self-injection and self-administration.

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<th>Pros:</th>
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<tr>
<td>• Encourage active engagement in managing one’s own health-care needs.</td>
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<td>• Reduced number of visits to health-care facilities without negative impacts on health.</td>
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<td>• Access to services is strengthened by reaching individuals who may otherwise face barriers to accessing care.</td>
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<tr>
<td>• Individuals have an enhanced sense of ownership, responsibility and control regarding their own health and care needs.</td>
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<tr>
<td>• Alleviate strain on health-service providers and allow for more efficient use of resources.</td>
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<td>• A complementary (not substitutive) model of care.</td>
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<th>Cons:</th>
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<td>• Further research and clear evidence is still needed on whether or not self-care models of care have improved access for those in vulnerable settings, and on their impact on individuals’ privacy and autonomy.</td>
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<td>• Self-care models create unique obstacles to access to and safe use of SRH essential services, for which solutions must be sought.</td>
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<td>• The shift from provider-administered to self-managed care may be driven in some instances by the provider’s desire to contain costs by shifting most of the burden of costs to the patient.</td>
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Free health-care policies – where user charges or other forms of copayments at the point of care are removed – are commonly implemented in LMICs to improve access to essential health services. In theory, removing these financial barriers should boost equity in access to and use of SRH services, as there is compelling evidence that out-of-pocket payments significantly hinder access to and use of health services, with the greatest impact on people with lower incomes who are the least able to pay (30). However, evidence also suggests that in many instances policies establishing free health care have not been effective in addressing inequities in the use of SRH services (31,32). Such policies have faced several implementation challenges – such as shortages of inputs like contraceptive methods or skilled staff (33–36) – that have in turn undermined these efforts to make SRH health services more affordable and have also negatively impacted the quality of care (37,38). In many instances, these negative outcomes resulted from the absence of measures to compensate health-service providers for the loss of revenues that were previously generated through copayments. To recoup these losses, health-service providers have in some documented instances engaged in balance billing, unofficially reintroducing out-of-pocket payments at the point of care to cover the costs of some key inputs (e.g. medicines, devices), despite the official user fee exemption (39,40). These behaviours thus reverse any positive effects on SRH service use that may have initially been observed due to free health policies. These types of outcomes limit the effectiveness of interventions that were intended to improve financial protection, especially for the poor and vulnerable (41). A summary is provided in Box 3.

Box 3. Free health-care policies to increase person-centredness in SRH services – increasing access and equity

**Description:**
Free health-care policies are implemented to improve access to and use of essential health services, including SRH services.

**Pros:**
- The removal of financial barriers can greatly enhance equitable access to and use of SRH services, especially by improving access for those who are least able to pay.

**Cons:**
- The quality of care provided can be negatively impacted if no mechanism has been put in place to compensate health-service providers for the loss of revenues that were previously generated through copayments.
- Out-of-pocket payments may be unofficially reintroduced by health-service providers to recoup their loss of revenue.

2. Selecting and contracting health-service providers with a potential to promote more person-centred SRH services

Selection and contracting of health-service providers – the processes through which purchasers decide which providers to buy health services from – can be viewed as two major policy instruments in strategic purchasing that can influence provider behaviour and service utilization (2). In the field of SRH services, the prevailing strategy is still passive contracting4 of SRH service providers. However, a new strategy has emerged – often referred to as “selective contracting” – that can be used by purchasers of health services to decide which health-service providers are able to meet their quality requirements and then contract those providers for the delivery of specific services for a defined population/location.

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4 Passive contracting is when a payer reimburses all health-service providers without actively influencing the provision or quality of care.
The selection and contracting of SRH service providers has the potential to significantly enhance person-centred service delivery by ensuring that health-service providers are carefully selected based on their ability to deliver tailored, high-quality services that can effectively address the unique needs and preferences of each individual. This strategy helps to define quality requirements and performance expectations for health-service providers, and improve accountability for the quality of service provision. With careful design and monitoring, selection and contracting can also support improved equity in SRH service provision.

**Purchaser** or purchasing agent refers to the organization or organizational unit that transfers funds to health-service providers to pay them for their service provision and which takes explicit or implicit decisions on resource allocation and related conditions. Examples of purchasers include the ministry of health, the ministry of finance, a subnational health authority (e.g. at provincial or district level), a social health insurance scheme, a voluntary health insurance scheme (e.g. commercial or not-for-profit insurance company, community-based health insurance scheme), or an agency operating a results-based financing scheme (2).

**Social franchising** is a common model of selective contracting and it has grown the fastest in the last decade. This approach involves a network of local or national nongovernmental/non-profit and/or private/for-profit health-service providers (i.e. independent operators) that collaborate under a shared franchise brand to provide socially beneficial health services, with capacity-building/training and quality assurance provided by a coordinating organization, typically a nongovernmental organization (42). Social franchising has mostly been used to expand availability of services and improve quality of care, mostly for family planning services but also for quality abortion care and maternal health. In the field of family planning, it has often been coupled with social marketing interventions to get services even closer to the service users (especially young people) and break the geographical barrier, especially to get short-term contraceptives (e.g. pills and condoms) into pharmacies and drugs stores (shops) (43). In this way, social franchising can contribute to greater equity.

Although appealing, overall, unfortunately, reviews conducted between 2014 and 2018 found that the evidence on social franchising was primarily of low quality, and the findings regarding utilization, quality of care, efficiency and equity were mixed (44–47). In Ethiopia, for example, social franchising was found to be less efficient than other strategies, while in Pakistan, it was found to be just as efficient as strategies involving service delivery by nongovernmental organizations (44). In Kenya, although social franchising improved geographical coverage of family planning services, the presence of the franchise was not sufficient in itself to increase effective use of family planning methods in the country (48). There are also concerns that social franchising is benefitting people who are wealthier, rather than low-income service users. In three maternal health social franchises in India and Uganda, for example, it was found that people who attended antenatal care and gave birth in health-care facilities were concentrated in the richest quintiles of the population.
One reason for this could be the lack of suitable health-care facilities in poor areas and the inability of poorer women to afford fees applied by the individual operators (49). Regarding sustainability, it was found that social franchises were often dependent on significant start-up funds and ongoing technical support from donors (50). In addition, the designs may be too generous to the franchisees at the expense of the donor and ultimately at the expense of the franchise sustainability (50).

Another model of selective contracting that has been increasingly explored and used is the contracting of private pharmacies for the delivery of family planning services (51,52) and, to some extent, medical abortion services (53,54). Some organizational characteristics of pharmacies as health-service providers – proximity, longer working hours, improved privacy – have the potential to help address some key roadblocks that hinder access to SRH services, especially among adolescents and young adults. However, to date, there is limited evidence about the effectiveness of these contracts. Moreover, contracting private pharmacies is not an easy task for purchasers, especially in LMICs (55). Managing contracts to regulate private pharmacies – heterogeneous institutions, with diverse conditions of practice and used in different ways in different contexts (56,57) – and to respond to any inappropriate dispensing behaviours requires organizational capacity that most purchasers do not currently have in most LMICs (58), especially in terms of the capacity for monitoring.

A summary of the pros and cons of selective contracting is provided in Box 4.

**Box 4. Selective contracting to increase person-centredness in SRH services – increasing quality, equity and accountability**

**Description:**
Selective contracting is a new strategy that can be used by purchasers of health services to select suitable health-service providers that meet their quality requirements, and contract them for the delivery of specific services for a defined population/location.

**Pros:**
- Can ensure that the selected health-service providers are able to deliver tailored, high-quality and effective services for individuals.
- Can support improved equity in SRH service provision, with careful design and monitoring.
- Helps to define quality requirements and performance expectations for health-service providers and improve accountability.
- Social franchising (a common and fast-growing model of selective contracting) can expand availability of and access to SRH services and improve quality of care, mostly for family planning services, and especially for young people.
- Contracting private pharmacies (another model of selective contracting) can help to improve access to and use of SRH services, especially for family planning services and especially among young people, due to the proximity, long opening hours and improved privacy at pharmacies.

**Cons:**
- The available evidence on social franchising is mostly of low quality. Findings regarding utilization, quality of care, efficiency and equity have been mixed, and there is evidence of poor sustainability.
- Contracting private pharmacies – and managing/monitoring these contracts – is not easy, and there is limited evidence about the effectiveness of this strategy.
3. Changing the methods of paying health-service providers to incentivize fair provision of person-centred care

Provider payment methods (PPMs) are policy instruments that define when, how and under what conditions health-service providers are remunerated for service provision (59). Types of PPMs include traditional line-item budgeting and fees for service, global budget transfers (or capitation payments), pay-for-performance (P4P) add-ons, and bundling payments for services. Changes in PPMs – or even modification of key parameters of the existing ones (e.g. regularity, rate of payment) – will create incentives or signals that significantly influence health-service provider behaviour and activities. Over recent years, PPMs have been progressively reformed to promote more value-based health care. In the field of SRH services, three main shifts in PPMs have moved in this direction over the past decade: the transition from input-based to output-based allocation; the blending of traditional PPMs with P4P add-ons; and the bundling of payments for various services and service providers.

Line-item budgets have historically been used – and are still largely used – to buy SRH services that are commonly delivered through the network of government-owned health-service providers, including family planning and maternal health services. However, evidence suggests that this PPM can limit the provision of contraceptive services due to the time needed to serve each client; for example, clients may not be offered a full range of methods, in particular they may not be offered long-acting reversible contraceptives (LARCs, i.e. injectables, intrauterine devices and implants) or permanent methods, all of which require greater skill and more time (60).

To overcome the issues related to line-itemized allocation, purchasers have been exploring the opportunity to transfer global budgets to health-service providers. With global budget transfers, providers receive a fixed amount for a specified period to cover aggregate expenditure associated with providing a defined set of services for the registered participants. Global budget transfers have the potential to promote person-centred care when cost containment is not the primary objective, because they give health-service providers greater autonomy in clinical decision-making and the flexibility to tailor service provision to the specific needs and expectations of individuals or local communities, which can enhance quality of care.

With capitation payments, where providers receive a fixed amount in advance to provide a defined set of services for a specified number of individuals (per capita) for a fixed period of time, payments may vary across administrative units based on key public health priorities and income levels, and may include a flexible component or may be weighted to account for individual or subpopulation-specific vulnerabilities or to re-balance unjustified differences in use of health services across population groups. Capitation payments are often used to pay primary care health-service providers (e.g. community health centres), and usually include family planning services, either for the full range of services or for specific methods. Capitation should lead to fairer distribution of resources, especially if it applies some equity/vulnerability-oriented weights to adjust the capitated amount transferred to health-service providers. Fairer allocation is a key condition to fairer service use.

However, if providers prioritize profit over patient care, these changes in PPMs can also generate perverse incentives and lead to negative outcomes. With capitation payments, health-service providers’ revenue will be greater if the registered population is healthier. Therefore, they may select which patients they can register for their services, favouring healthier patients and discriminating against those most at risk as a cost-containment strategy, leading to greater inequity. In addition, if the allocation per capita is too low, or is not paid in a timely manner, health-service providers are likely to select the services or inputs they provide with a view to keeping costs down. For instance, if the capitated amount is the same regardless of the contraceptive method provided, then the provider may disregard LARCs in favour of offering short-term or less effective methods. Another common issue lies in the lack of coordination of PPMs used by the various health-service purchasers for different types of providers (at different levels of care or from different sectors) and, more specifically, the interaction – at times conflicting – between capitation and other payment methods. This can inadvertently encourage
providers to engage in gaming tactics, such as shifting patients to higher levels of care where services are billed per contact, since capitation payments are typically used for primary care services. Using capitation to pay for contraception was briefly tested in Indonesia’s national health insurance programme. Provision of intrauterine devices (IUDs) was paid for using capitation at the primary care level and under fee-for-service at the secondary and tertiary levels. Such arrangements incentivized primary care providers to refer women for IUD insertions to a higher-level facility, to reduce costs – an unjustified referral that was welcomed by secondary and tertiary hospitals who were paid for each IUD insertion (60,61). Global budget transfers and capitation payment models need to counterbalance these risks, otherwise they may trigger supply-induced demand and patient selection – phenomena which go against the concept of patient-centred service delivery.

Blending traditional PPMs (i.e. line-item budgets and fee-for-service models) with various P4P add-ons creates a range of PPMs that use financial incentives/disincentives to improve provider performance, translated into both quantity and quality targets. This approach usually draws the attention of health-service providers to a broad array of process, quality and efficiency measures, encouraging them to pay more attention to patient experience. Ideally, a P4P mechanism can reward better results on more patient-centred metrics that better represent the complex needs of different patient populations and can therefore be a powerful policy instrument to encourage more personalized care, foster stronger patient–provider relationships, and focus on long-term health outcomes. P4P programmes have also progressively integrated the reduction of disparities in access to and use of health services either as a target or as a payment adjustor (62). As many countries are introducing or are considering introducing a P4P approach, it is key for SRH service objectives – especially targets that are central to more person-centred SRH care – to be reflected in the P4P performance framework as health-service providers would be financially incentivized to achieve them, and this would contribute significantly to promoting greater equity in SRH service provision. In LMICs, most P4P models – usually promoted through performance-based financing (PBF) schemes – include family planning services in their performance framework, and often link financial incentives to family planning service-use metrics such as numbers of new and returning users and/or coverage rates (63,64). Several PBF programmes have been shown to encourage equity and increase coverage by providing supplementary incentives to providers to reach underprivileged and marginalized communities, or to enhance service delivery at remote health-care facilities.

However, P4P add-ons are not a magic bullet: they tend to push health-service providers to prioritize some services over others – i.e. those that guarantee the highest rewards. These add-ons may lead health-service providers to game the P4P system by prioritizing activities that maximize profits, limiting access to services that are not attached to any reward, or influencing users to choose services (e.g. particular contraceptive methods) that are more profitable for the providers by spreading inadequate information. A systematic review exploring the impact of PBF on family planning services in LMICs suggests mixed results, including potential undesired effects: (a) the P4P performance framework still highly incentivizes output while paying less attention to quality and outcome metrics, which are harder to implement in data-poor settings; (b) PBF schemes lack incentives for key SRH service delivery principles (e.g. greater patient-centredness) that are crucial to improving coverage and equity in SRH service delivery – for example, certain groups, such as adolescents, are systematically excluded from priority target populations (for which providers are eligible for performance-related pay), while they are underserved and disadvantaged in relation to their needs for family planning services; and (c) services for comprehensive abortion care are often excluded from PBF programmes, further exacerbating existing inequities in access to SRH services (64). In the United Republic of Tanzania, for example, health-service providers have developed strategies to increase the number of babies delivered at their health-care facility – a key financially rewarded target. These strategies ranged from spreading inadequate information to pregnant women to influence their choices (e.g. about contraceptive methods to adopt) to issuing sanctions in case of home delivery (e.g. refusing to vaccinate babies born at home) (65). These profit-maximizing behaviours may do more harm than good and should therefore be monitored and addressed as soon as they emerge.
Bundling payments for services – that is, making a single payment for a range of services provided by different health-service providers – is a promising PPM that enhances coordination across different providers, and therefore improves efficiency, quality and outcomes – all at lower cost. Greater coordination across health-service providers may greatly improve patients’ experiences and allow for more individualized care. However, there is limited evidence on the implementation of bundled payments for SRH services, and the effects on service provision. The available evidence suggests that a key dimension that needs attention is the range of services bundled under the same payment. In the United States of America, some states have adopted reimbursement approaches that bundle pregnancy services in a way that acts as a barrier to care, particularly in the provision of LARCs postpartum. When the state pays for prenatal and obstetrics care with a global fee or bundled payment, hospitals have little incentive to provide expensive LARC devices to Medicaid beneficiaries if the plan does not pay them for the devices separately (66).

A summary of the pros and cons of making changes to PPMs is provided in Box 5.

**Box 5. Shifts in provider payment methods (PPMs) to increase person-centredness in SRH services – increasing equity and acceptability**

**Description:** Provider payment methods (PPMs) are policy instruments that define when, how and under what conditions health-service providers are remunerated for service provision. Types of PPMs include:
- traditional line-item budgeting and fees for service
- global budget transfers
- capitation payments
- pay-for-performance (P4P) add-ons (often promoted through performance-based financing [PBF] schemes)
- bundling payments for services.

**Pros:**
- Changes in PPMs can incentivize better behaviours among health-service providers and promote value-based health care.
- Transferring global budgets to health-service providers can give more clinical autonomy to providers, and the flexibility to provide more patient-centred care.
- Capitation payments should lead to fairer distribution of resources, especially if the amount transferred to health-service providers is adjusted to account for levels of vulnerability in the population.
- Blending traditional PPMs with P4P add-ons can encourage improved health-service provider performance and improved patient experience.
- Incorporating SRH objectives into the set of rewarded P4P targets can promote greater equity in service provision.
- PBF programmes can use incentives for providers to increase coverage in underprivileged and marginalized communities, or to enhance service delivery at remote health-care facilities.
- Bundling payments for services provided by various health-service providers into a single payment enhances coordination across providers and improves efficiency in service provision, as well as quality, experience of care and outcomes, all at lower cost.

**Cons:**
- Global budget transfers and capitation payment models – if badly designed or poorly coordinated with other PPMs used in the system – may lead health-service providers to make clinical choices to contain costs instead of prioritizing patient care.
- P4P add-ons are not a magic bullet: they tend to push health-service providers to game the system, prioritizing or promoting services that guarantee the highest rewards.
- PBF schemes often focus on output over quality or outcomes, may lack incentives relevant to SRH service delivery, and may exclude certain groups (e.g. adolescents) or particular SRH services (e.g. abortion care).
- Evidence is limited, but the decision to bundle payments for some services (or not to bundle some with others) can significantly influence the behaviour of the health-service provider at the expense of some key SRH services, e.g. long-acting reversible contraceptives.
Policy and programming implications

The way pooled funds are allocated to health-service providers has great potential to improve SRH service provision. This brief has highlighted several strategic purchasing strategies that have been implemented in LMICs and that have the potential to promote more person-centred SRH services, particularly for FP and CAC. This potential is yet to be fully exploited, and therefore we offer several key considerations and lessons that policy-makers and decision-makers involved in purchasing arrangements and SRH service providers can draw upon.

1. Pay attention to purchasing arrangements appropriate to specific contexts and use them as policy levers to improve SRH service provision.

Purchasing arrangements exert substantial influence on the behaviour of health-service providers in health systems worldwide. Defining the conditions under which an entitlement listed in the benefit package is to be operationalized, selecting health-service providers eligible to receive pooled funds, and specifying the contractual terms including procedures for remuneration are all key policy levers that can be used to influence health-service provider behaviour. The SRH community should therefore use these arrangements wisely to promote desirable attributes in service provision that can boost access to and use of key SRH services (e.g. to promote task sharing when desirable) or conversely use them to reduce the negative effects of some health worker behaviour (e.g. to disincentivize and reduce conscientious objection among health workers).

2. Explore the potential of purchasing instruments to promote person-centredness as part of a rights-based approach.

The focus of this brief has been on the potential for purchasing arrangements to promote more person-centredness in the provision of quality SRH services, which can be a game changer for service users and providers. To bring about these positive changes, purchasing arrangements should be used strategically to foster improved confidentiality, privacy, and support for patient autonomy, decision-making and choice, which are central to more person-centred and equitable SRH service provision.

How exactly strategic purchasing can help promote person-centredness in SRH service provision remains widely unstudied. There is a need for further research and guidance on how to facilitate this positive transition. Decision-makers, purchasers and expert groups involved in strategic purchasing reforms for SRH services should ensure that operational guidance is readily available and that it offers relevant technical support in complex and diverse service-provision arrangements. Methodological tools such as Patient Reported Outcome & Experience Measures (PROMS & PREMS) are gaining recognition as important inputs promoting shared decision-making and capturing individual and societal preferences in design and delivery of services, and could be therefore important steps towards defining patient preferences.

This topic is of great interest for both the health-financing and the SRH communities. Enhanced collaboration on this issue would be beneficial to both and will also surely benefit other communities for whom patient-centredness is key to improved service provision.

3. Review and adjust purchasing arrangements regularly, based on regular reviews of the effect of purchasing arrangements on SRH service provision.

Modifications to purchasing arrangements will modify the signal sent to health-service providers, which are likely to adapt their behaviour and procedures in response – in a wide range of expected and unexpected ways that will need close monitoring (67). These effects should be reviewed and analysed to assess whether the attempt at strategic purchasing has brought about the expected positive impact (68). Any plan to modify SRH purchasing arrangements should be explicitly grounded in a theory of change and it should (a) be built upon a situational analysis that not only identifies the current SRH service-delivery challenges in a given context, but also describes how purchasing arrangements for SRH services are designed and implemented in that context, and (b) describe the intended effects and identify any potential unintended effects of the proposed adjustments in the SRH purchasing arrangements on SRH service delivery. The theory of change used for this purpose should be regularly reviewed.

4. Embrace a systems perspective to capture the effects of purchasing arrangements on SRH service provision.

SRH service provision is likely to be affected by adjustments to purchasing arrangements that were intended to target other health services. As explained above, the introduction of a P4P scheme can lead health-service providers to pay more attention to other activities at the expense of SRH service provision. The lens of monitoring and analysis should therefore be broader than just the purchasing arrangements for SRH services. Attention should also be given to the coherence of different payment methods, especially when there is a mix of different purchasers and providers. In that perspective, robust information systems are central to generate necessary evidence to inform decisions regarding purchasing arrangements for SRH services.
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