

Role of strategic purchasing in the integration of sexual and reproductive health services into primary health care

EVIDENCE BRIEF

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 illustrates how strategic purchasing can be used to integrate sexual and reproductive health (SRH) services into primary health care.



Key messages of this brief

- The government or health system purchaser can use strategic purchasing levers, including benefit design, selection and contracting, and provider payment methods (PPMs), to promote the integration of SRH services into primary care to improve access to these services.
- In the areas of family planning (FP) and comprehensive abortion care (CAC), there is currently a lack of robust evidence on the effectiveness of using these purchasing levers to improve access to these services.
- Careful examination of how SRH services have been purchased in different contexts and assessment of the purchasing levers used for SRH services are imperative to better understand the optimal purchasing arrangements for SRH services in different contexts.
- Provider payment levers (i.e. payment methods and rates) can result in both intended and unintended changes in SRH service delivery, including undersupply or oversupply of services. Consequently, a functioning information system is imperative to monitor SRH service delivery and ensure the strategic purchasing goals are being achieved.



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 (2).
- **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 (2).

Introduction

Access to SRH services¹ can be constrained by a country's policy and regulatory environment (4). In addition, social, economic and cultural factors also impact people's access to SRH services (5). In 2020, approximately 800 women died every day from preventable causes related to pregnancy and childbirth (6). Current data also indicate that about 164 million women want to avoid pregnancy but are not using any contraceptive method (7,8) and that more than 350 million men and women need treatment for at least one of the four curable sexually transmitted infections (STIs) (8,9). In 2015–2019, some 61% of all unintended pregnancies ended in an induced abortion (10).

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) (11) of SRH care.

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 (3).



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Integration of sexual and reproductive health into primary care

Integration of SRH services into primary care is an important health-system response to improve access to SRH services (5). As a starting point, SRH services themselves must be integrated, meaning that they are delivered so that people receive services addressing a continuum of SRH needs throughout their life course, with services coordinated between different health-care levels and sites of care within and beyond the health sector (14). Integration of SRH services is important because each component of SRH services is linked to other components. For example, services for the prevention and management of STIs can contribute to healthy pregnancy, safe delivery, and positive pregnancy outcomes (5).

Integration of SRH services is enhanced by ensuring that SRH programmes and interventions are integrated within and delivered through the primary care platform, rather than operating as stand-alone SRH programmes (e.g. STI clinics separate from maternal and child health clinics), to improve access and also coordination and continuity of care (15). The network of primary care facilities can support the provision of equitable, comprehensive, integrated health services to a defined population, with each facility acting as a service hub for a community.

Adapting the WHO models for integration of public health and primary care (15), SRH services can be integrated into primary care through:

1. inclusion of SRH staff at the primary care level;
2. cooperation between SRH staff and primary care providers;
3. creation of comprehensive and proactive health benefit packages (i.e. relevant to public health priorities) that include SRH services at different levels of service delivery;
4. use of incentives to ensure that SRH service priorities are addressed within primary care; and
5. provision of multidisciplinary SRH training for primary care staff to ensure provision of integrated services.

To achieve success, these models of care must be supported by the design and organization of services to align with public health priorities; the integration of primary, secondary and tertiary care (using referral systems); and the integration of relevant sectors, such as health and education.

When purchasing SRH services, active use of the health financing purchasing function, with a sustainable and adequate level of resources, can facilitate the implementation of an effective health service delivery model (12). However, conceptual links between health-care purchasing and SRH service delivery models are yet to be established, and evidence on the use of health-care purchasing levers to improve access to SRH services is limited.

This evidence brief illustrates how strategic purchasing can be used to integrate SRH services into primary care. Specifically, this brief will: (i) articulate the conceptual links between strategic purchasing and integration of SRH services into primary care; (ii) describe purchasing levers (or tools) that can be used to integrate SRH services into primary care; (iii) present experiences of the use of such levers, drawing on findings from a scoping review; and (iv) provide recommendations for future actions.

How this brief was developed

This evidence brief draws on the findings of a scoping review on strategic purchasing for SRH services (1). The scoping review examined 15 documents on FP and 14 on CAC. The documents also included study of dimensions of health-care purchasing. As part of the scoping review, key informant interviews were undertaken with 17 experts in FP, CAC and health-care financing. The interviewees worked at WHO or non-governmental organizations specializing in SRH. The scoping review explored service models that could use strategic purchasing to incentivize the integration of SRH services into primary care (the subject of this brief) and person-centred SRH service provision (the subject of the other brief [13]) in low- and middle-income countries (LMICs). To conceptualize the links between strategic purchasing and the integration of SRH services into primary care, health service delivery models for achieving public health integration in primary care, identified by WHO in 2018 (14), were adapted to the delivery of SRH services into primary care and, drawing on the findings of the scoping review, the use of strategic purchasing levers to strengthen service delivery models was considered.

Access to health care involves several interacting dimensions (16,17). As SRH services are diverse, the above-mentioned approaches to SRH service integration into primary care can improve the availability of SRH services by including SRH professionals in primary care, increasing cooperation between SRH service providers and primary care providers, and providing primary care staff with multidisciplinary training, especially in SRH. The inclusion of comprehensive SRH services in publicly funded benefit packages can reduce out-of-pocket payments and, in doing so, improve the affordability of SRH services.

Role of strategic purchasing in the integration of SRH into primary care

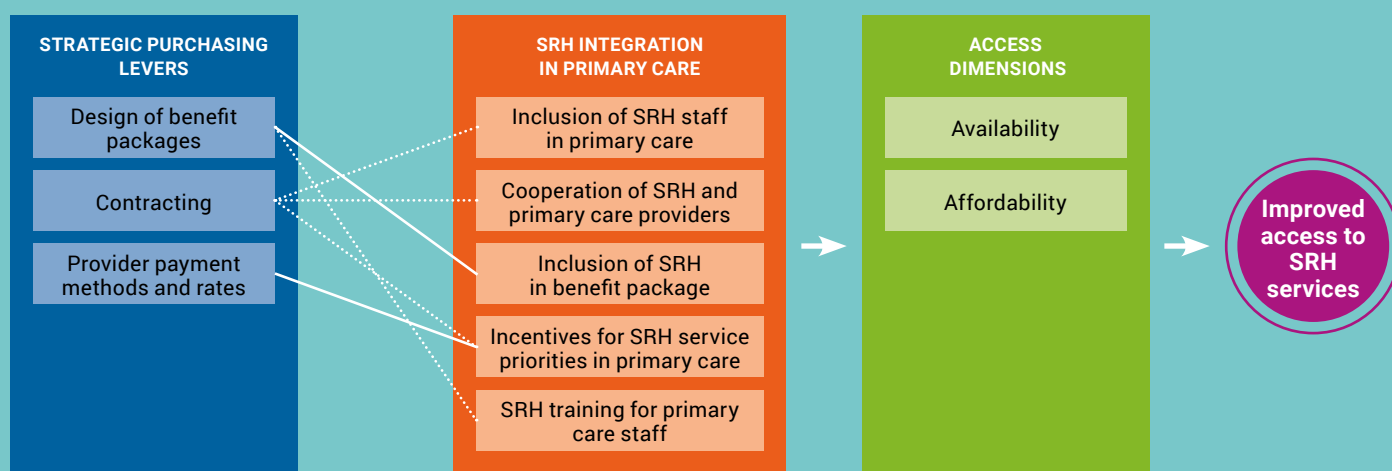
Adequate funding and sustainable financing can create an enabling environment for efficient, equitable and quality SRH service delivery (12). Health financing systems not only raise and pool resources but also “purchase” health services. Purchasing of health services refers to the transfer of pooled resources to health-service providers in exchange for the delivery of specified health services. Purchasing arrangements entail three broad decisions: what health services to buy (benefit package); from whom

to buy these services (selection and contracting of health-service providers); and how to buy these services (provider payment methods [PPMs]) (18). Strategic purchasing arrangements for health services are those that promote equity and improve efficiency and quality in service delivery, and contribute to improved health systems performance. Strategic purchasing requires the purchaser to actively engage in relationships with three main groups: government, health-service providers and people (19).

Strategic purchasing, using levers such as making modifications to the design of benefit packages and PPMs and using selective contracting, can be used to facilitate the integration of SRH services into primary care, for example by coordinating funding flows from multiple purchasers and sending incentive signals that align health service delivery with public health priorities, including SRH needs.

A conceptual framework was developed (Fig. 1) based on findings from the scoping review to illustrate the links between the three types of purchasing levers (shown in the box on the left) and the integration of SRH services into primary care (central section of the figure), which contributes to improving the accessibility of SRH services, including the availability, affordability and timeliness of service access (shown on the right of the figure).

Fig. 1: Conceptual links between strategic purchasing and integration of SRH services into primary care



Note: The section of this figure on “SRH integration in primary care” has been adapted from WHO, 2018 (14).

Three strategic purchasing levers

Design of benefit packages

Benefit packages are the services, products and population entitlements that are fully or partially funded by health-care financing mechanisms (20). Inclusion of SRH services in the benefit packages of publicly funded health-care financing mechanisms (e.g. mandatory health insurance, tax-funded systems) can reduce out-of-pocket payments for SRH services, which reduces financial barriers to accessing SRH services. Furthermore, the efficient allocation of resources and improved integration of SRH services can be achieved if benefit packages are designed to include a comprehensive range of SRH services available to beneficiaries throughout their life course, and if they assign clear roles to health-service providers, and describe how coordination should occur between different levels of care (3,21). Benefit design should also consider the target population, cost-sharing arrangements with service users and rules of referral (2). Engagement with service users during the design of benefit packages is imperative so that user needs and preferences can be taken into account and improve the acceptability of SRH services. It is also important for purchasers (and government) to clearly communicate with providers and beneficiaries about which SRH services are included in the benefit packages and define the conditions for access to ensure services are used when necessary (12).

Contracting

Financing mechanisms can use contracting to specify the roles and responsibilities of purchasers and health-service providers. Contracting terms can be designed to link payments to the provider's successful achievement of public health priorities, including defined SRH outcomes, thus generating health-service provider accountability to SRH goals and objectives. Contracting can also facilitate engagement with the private sector in the provision of SRH services, support the creation of integrated health-service provider networks that are based on community needs, and contribute to increasing the availability of SRH services (21).

Provider payment methods and rates

The PPMs and rates used with health-service providers send incentive signals that shape the delivery of services. Various types of incentive signals can impact the case numbers, number of services provided per case, expenditure control (i.e. controlling the cost of delivering services) and technical efficiency in delivering services (i.e. the service is delivered using minimal inputs and produces minimum waste) (Table 1). Building incentives into PPMs can encourage health-service providers to focus on SRH priority areas and/or to endeavour to reach people in need to increase the availability of SRH services and reduce the level of unmet need for SRH services. The incentive signals inherent in certain PPMs can also influence service quality. It is important to ensure that health-service providers, including public sector providers, have sufficient autonomy to allow them respond to the incentive signals and align their service delivery with public health priorities.

Table 1. Health service provider payment methods (PPMs)

PPMs	DEFINITION	INCENTIVE FOR HEALTH-SERVICE PROVIDERS			
		Cases or enrolled members	Services per case	Expenditure control	Technical efficiency
Global budget transfers	Providers receive a fixed amount for a specified period to cover aggregate expenditure associated with providing a defined set of services	↓	↓	↑	0
Case-based payment (e.g. diagnosis-related groups)	Providers receive a fixed amount per case or full episode of care, often classified by the patient's demographic and clinical characteristics, which may involve likely medical procedures	↑	↓	0	↑
Fee-for-service	Providers receive a fee for each individual service provided	↑	↑	↓	0
Capitation payments (per capita) ^a	Providers receive a fixed amount in advance to provide a defined set of services for a specified number of individuals for a fixed period of time	↑	↓	↑	↑

^a Capitation payments are paid to health-service providers based on the number of registered participants/enrolled members multiplied by the capitation payment rate. Consequently, capitation payments encourage providers to increase the number of enrolled members while reducing the number of services provided to each of them.

Note: ↑ indicates "increase", ↓ "decrease", and 0 "neutral" or "unclear".

Source: Adapted from OECD, 2016 (22) and Langenbrunner et al., 2009 (23).

Experiences of strategic purchasing arrangements with potential to support the integration of FP and CAC into primary care

In the following three subsections, examples are presented of the active use of the purchasing function in health-care financing to facilitate the integration of SRH services into primary care, with specific reference to FP and CAC, based on the results of the scoping review. The examples are grouped by the three types of strategic purchasing levers that purchasers can use to create an enabling environment for improving SRH services, as in the previous section.

1. Designing benefit packages to improve access to SRH services

To reduce out-of-pocket payments and remove financial barriers for individuals to access the SRH services they need, some countries reduce or remove user fees from SRH services that align with public health priorities by including SRH services in the benefit packages covered by publicly funded financing schemes (24). For example, the results of the scoping review indicate that in some sub-Saharan African countries, contraceptives are provided free of charge to the population in need, with costs covered by government (25). The National Health Insurance Fund in Kenya includes family planning services in its benefit package (26). Similarly, in Nicaragua, the social health insurance scheme includes family planning services and counselling in the benefit package (27). The benefit package for the Thai Universal Health Coverage scheme includes both family planning and post-abortion care (28). While information on the inclusion of CAC in publicly funded benefit packages is limited (28) in countries where abortion is highly restricted and not covered by public schemes, CAC services are generally only available to women who can afford to pay and are able to access the necessary health-service providers (29,30).

The inclusion of SRH services in benefit packages does not remove all constraints to accessing SRH services. To address demand-side constraints that may be undermining public health priorities (i.e. underutilization of services due to a lack of patient demand, including for reasons of financial burden, lack of information, people's preferences), benefit design also defines conditions for

access to services (20). For example, several countries have introduced conditional cash transfers (CCT) or voucher schemes to facilitate the use of prioritized SRH services. In Ecuador, the *Bono de Desarrollo Humano* programme provides a cash transfer to women from low-income households, which is tied to health and education co-responsibilities including household members of reproductive age attending at least one annual talk on family planning (31). While many CCT programmes in LMICs aim to improve access to both maternal and child health services and further educational opportunities, a number of studies found that some programmes have indirect positive impacts on contraceptive use (32).

2. Selecting and contracting health-service providers to improve access to SRH services

Some countries have used contracts to engage with unconventional health-service providers, such as private pharmacies, to improve the availability of target services by increasing the number of service providers operating in the health system. For example, in the Philippines, where suppliers of family planning services are limited, PhilHealth, the purchaser for the mandatory health insurance scheme, contracted private health-care providers to deliver family planning services alongside the services delivered by public sector providers (33). In the United Republic of Tanzania, due to scarce public sector health-care facilities and limited human resources for health, drug suppliers and pharmacies are contracted to provide contraceptives and information on family planning to meet people's needs, particularly in remote areas (34). In Cambodia, as part of the social marketing programme for medical abortion, private pharmacies and clinics were contracted to improve service availability (35). While experience indicates that significant benefits can be gained when the publicly funded system contracts non-state health-care facilities and pharmacies to deliver services, assessment of this type of policy intervention emphasizes the importance of carefully designing the mechanisms to ensure service quality (34,36,37). In Cambodia, a voucher scheme was piloted to improve access to and quality of select SRH services, including family planning. This involved selling subsidized, affordable vouchers to the target population that could be exchanged for specific SRH services from contracted providers. Accreditation was regularly used to confirm whether the health-care facilities participating in the scheme were adequately resourced to provide the defined services (38).

3. Using different provider payment methods to build incentives for inclusion of SRH services in primary care

In many of the countries where SRH services are included in health benefit packages, PPMs are used to control the volume of services by using the incentive signals inherent in the payment methods. For example, in Kenya and the Philippines, where unmet needs for family planning services are high, the mandatory health insurance schemes use activity-based payments (i.e. fee-for-service payments and case-based payments wherein payments are based on the number and type of health services delivered) for certain types of family planning services in order to send incentive signals to health-service providers to increase delivery of those services (26,33). However, in the Philippines, low fee-for-service payment rates and high commodity prices in the private health-care market discourage private providers from delivering family planning services as a result of concerns about cost recovery (33). In Indonesia, mandatory health insurance used to pay capitation payments for family planning services delivered by primary care providers, while fee-for-service payments were made to secondary and tertiary providers for the same services, thus unintentionally incentivizing primary care providers to refer patients to higher-level health-care facilities. Consequently, the government switched the PPM to case-based payments for family planning services at the primary care level, to motivate primary care providers to deliver family planning services and only refer patients to higher-level facilities when necessary. However, the effect of the change in PPM has yet to be assessed (39). Many pay-for-performance (P4P) programmes that target maternal and child health in LMICs include family planning related performance indicators (e.g. number of contraceptive supply visits) to address unmet need for family planning services, although the effectiveness of P4P on family planning outcome measures (e.g. improved use of modern family planning methods) was mixed (40).

Policy and programme implications

For the integration of SRH services into primary care, strategic purchasing can directly facilitate the inclusion of comprehensive SRH services in the benefit packages of financial protection mechanisms (or prepayment mechanisms) and improve the affordability and availability of SRH services that align with public health priorities. Furthermore, incorporating integrated models of SRH service delivery into primary care – using the design of benefit packages, contracting and PPMs, and rates – can advance the integration of SRH staff/professionals (i.e. SRH health workers, including specialist SRH doctors) into primary care teams, promote cooperation between SRH service providers and primary care providers, and encourage multidisciplinary SRH training for primary care staff to further improve the accessibility of SRH services.

As discussed above, three categories of strategic purchasing levers – benefit design, contracting and PPMs – can be used by government or health-system purchasers to contribute to building an enabling environment for integrating SRH services into primary care. It is important to note that the use of purchasing levers requires a robust information system to understand how the purchasing levers are impacting on health service delivery.

The scoping review on FP and CAC literature provided evidence on the use of strategic purchasing levers for SRH services, but the effectiveness of the various strategic purchasing tools on access to SRH services is yet to be established. For FP services, studies have been undertaken on the use of P4P and demand-side financing, such as conditional cash transfers (CCT) and voucher schemes; however, many of the interventions were undertaken as part of externally funded programmes in LMICs and have produced mixed outcomes depending on the context and implementation methods. In relation to CAC, while some issues associated with the affordability of these services have been reported, when the services are not included in publicly funded benefit packages, there is a dearth of literature on how abortion care is financed in various settings.

The existing literature on the experience of using strategic purchasing levers supports the following approaches.

1. Include priority SRH services in the benefit packages of publicly funded health-care financing schemes to reduce or remove user fees.

Doing this will mitigate financial constraints to service access (24). Also, to address other demand-side constraints



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and ensure the uptake of underutilized priority services, several countries have introduced CCT and/or voucher schemes (20).

2. Contract non-State health-service providers (i.e. both for-profit and not-for-profit organizations) and non-clinical actor groups, such as pharmacies, under publicly funded health-care financing mechanisms to expand access to SRH services.

Inclusion of training and accreditation in the process of selecting and contracting has also been used to ensure quality in the operation of health-care facilities, including the availability of trained SRH staff and equipment (36,37,38).

3. Use provider payment levers to send incentive signals that shape the delivery of health services.

Activity-based payment methods, with adequate payment rates, can be used to increase the availability of underutilized priority SRH services so that the supply of services expands to meet societal needs (26,33). The literature indicates that changes in health service delivery in response to changes in PPMs can produce both expected/desired and unexpected/unwanted results (41). For instance, activity-based payments can create incentive signals that promote the over-provision of services. Consequently, it is imperative to incorporate a functioning information system to monitor health service delivery, including the number of cases, the number of services provided per case, expenditure on targeted services, and documentation of the components involved in the services, to ensure the strategic purchasing goals are being achieved.

4. Design appropriate strategic purchasing interventions that narrow gaps in unmet needs for SRH services.

To do this, it is important to be clear about the country's public health priorities for SRH services (12) and understand what needs to be achieved to benefit the population using the strategic purchasing levers of benefit package design, selection and contracting, and PPMs. It is also imperative to build stronger evidence on the use of purchasing levers for efficiency, equity and quality in SRH service delivery.

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