Quality of chronic care: the possible contribution of purchasing arrangements in LMICS

Round 2 Report

Participation rate
88.46 %

Completion rate
47.34 %

Statistics

Answers	1742
Questions	80
Respondents	52
Active respondents	46
Answers - Words count	11114 words
Q. EN - Words count	8085 words
Q. EN - Reading time	40 min

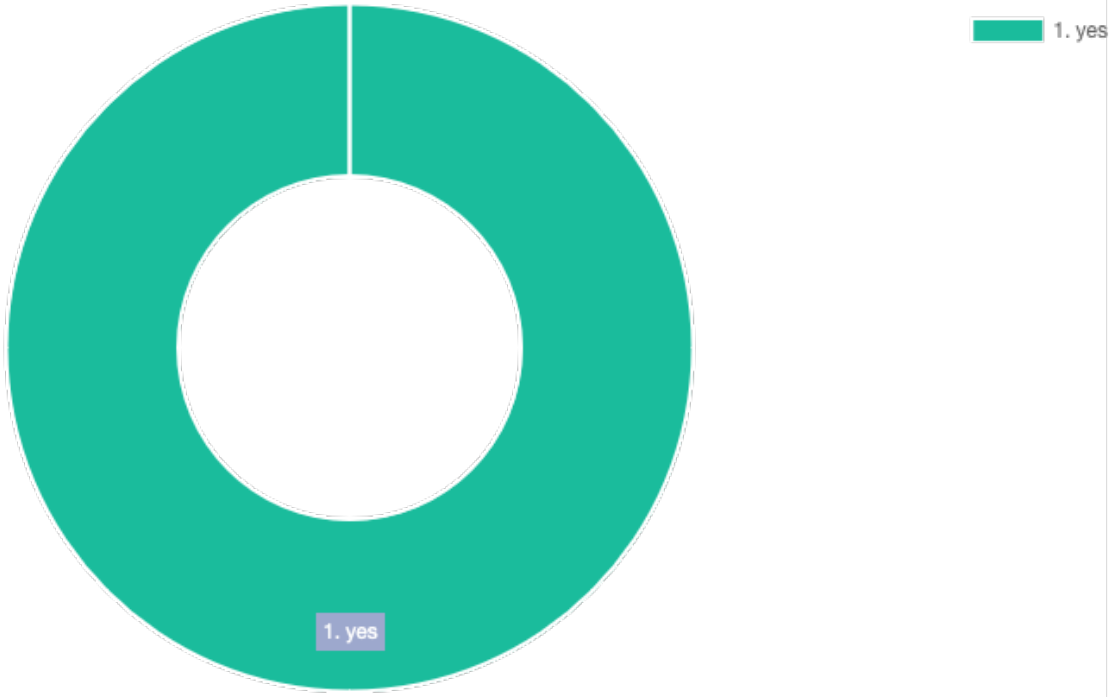
2.1.1 — Consent (Page 1)

EN

I consent to participate in this survey and the following has been explained to me: The survey may not be of direct benefit to me. My participation is completely voluntary. I have the right to withdraw from the survey at any time without any implications to me. My decision will not affect any relationships that I have or will have with the World Health Organization (WHO) or the Institute of Tropical Medicine, Antwerp. Only anonymized data will be used in the reports.

This research was reviewed and approved by the Institutional Review Board of the Institute of Tropical Medicine, Antwerp, Belgium. Should you have any questions on your rights as a study participant, please contact IRB@itg.be .

2.1.1 — Consent



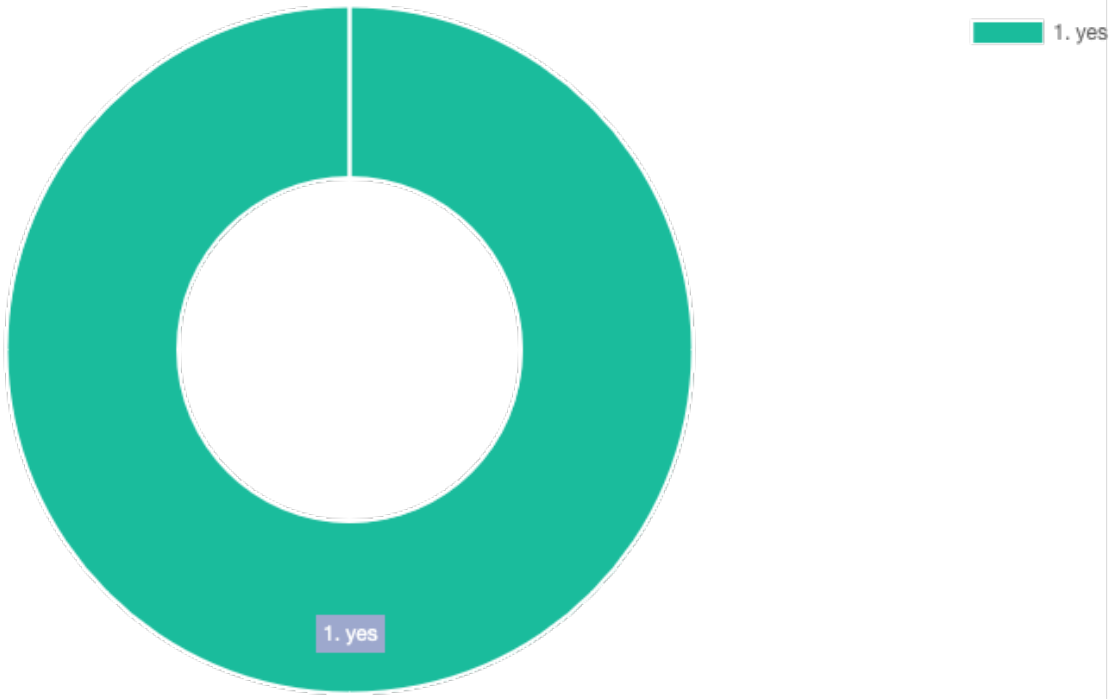
Choices	#
1. yes	46 (100 %)
Total	**46**

2.1.2 — Your name appearing in the acknowledgement section (Page 1)

EN

Your name appearing in the acknowledgement section.

2.1.2 — Your name appearing in the acknowledgement section



Choices	#
1. yes	46 (100 %)
Total	**46**

2.2.1 — seven dimensions: effectiveness, accessibility, sa (Page 2)

EN

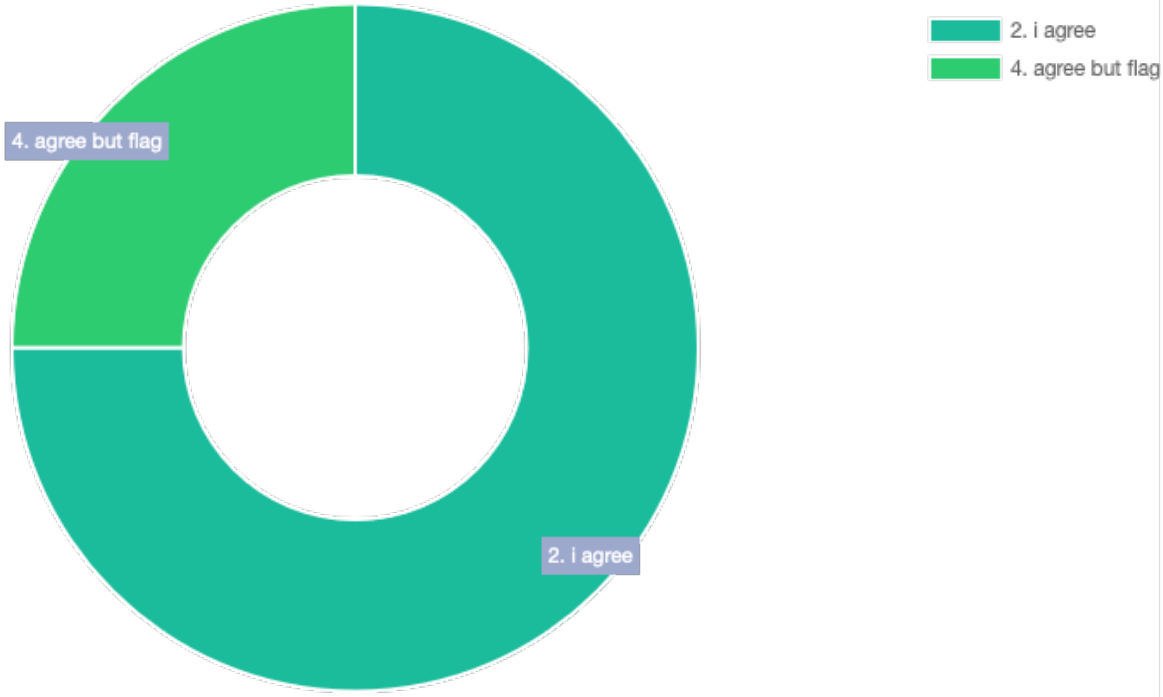
The next statement is part of the introduction to our report. It builds on the literature review and our conceptualization. We invite you to share your agreement with it.

To steer better quality chronic care, it helps to adopt a conceptualization of quality of chronic care resting on seven dimensions: ***effectiveness, accessibility, safety, efficiency, equity, person-centeredness and continuity****.*

The last two dimensions (or aims) are probably the most specific to chronic conditions. Among other things, the person-centeredness dimension puts ***the persons with a chronic condition (PwCC) at the center of the action****. It acknowledges that the PwCC has agency and will be invited to progressively take the main role in the daily control of her/his disease.*
*The central importance of the continuity dimension stems from the chronic nature of the disease. Among other things, this dimension stresses that health system actors should develop what one may call 'j****ourney consciousness****': each health care provider should be aware that they participate in the patients' journey with their condition and with the health system in the past and into the future. The state of the patients in front of a provider is partly determined by the history of the disease, but also by how the health system has handled the PwCC and their disease(s) in the past.*

For interventions for improving quality chronic care, this entails that besides being concerned for effectiveness, efficiency, equity, etc. (as for any health problem), there is a need to put extra attention on the empowerment of the PwCC and the continuity of care. Effectiveness at individual level will often have to be assessed as the extent to which the level of care under scrutiny (e.g., community health worker; CHW) has managed to bring the PwCC (or at risk) to the next level of empowerment (e.g., awareness to be at risk).
As for health care purchasing arrangements, this suggests particular attention to barriers, including on the supply side, restraining the PwCC's (clinical) control over the disease and its daily impact.
We see these points of attention for chronic care as universal; these are not specific to any resource setting.

2.2.1 — seven dimensions: effectiveness, accessibility, sa



Choices	#
2. i agree	33 (75 %)
4. agree but flag	11 (25 %)
Total	**44**

2.2.2 — explanation (Page 2)

EN
Please specify below:

2.2.2 — explanation

I strongly agree with the statement. However, there is need to consider how purchasing arrangements may benefit embracing and strengthening "all of government" and "all of society" responses if not appropriate purchasing arrangements will benefit capacity to supply but patients will have to return to communities of poverty which are not conducive to desired health and developmental outcomes.

17b7b82a answered 1 month ago

In my view, you could give more emphasis to factors outside the traditional health care system, including the local community and family which can play a role in how well a PWCC can manage their condition. In addition, your statement does not clearly address the possibility that PWCCs may be *non-users* of the health care system, maybe because their expectations are so low or because they don't recognize their condition as impairment or health risk. Purchasing arrangements need to account for this group.

`edc53c5f` answered 1 month ago

I think equity considerations are of critical concern for PwCC as they operate at the level of fundamental causes (see Link and Phelan) at both individual and population level.

`edf03eea` answered 4 weeks ago

I agree with the 7 proposed dimensions for quality chronic care, but a choice to have 'quality care' that is available for a short run is not necessarily good. I am wondering if 'sustainability' should be mentioned somewhere, not as a dimension of quality but a necessary combination with quality, "...sustainable quality chronic care". Alternatively, add another dimension 'integrated' which somehow is a determinant of sustainability, if it is about integrated in health systems. Moreover, as reflected by the title, the focus is to "leverage purchasing arrangements (but not all possible strategies) to improve quality chronic care". So please, make this clear with more elaboration about purchasing arrangements and their potentials. Purchasing arrangements, to a larger extent, include prioritization of budget allocation to chronic care.

`7cd5dded` answered 4 weeks ago

Besides the essential need for uninterrupted availability of sufficient supply of medication and diagnostics, permitting different models of care and medication delivery modes, it is also important to continue improving the quality (efficacy, safety and delivery mode/dosage needs) of treatment. Having better drugs to avoid having to take combinations or several intakes per day will improve adherence and continuity.

`db7d89a4` answered 2 weeks ago

I would draw your attention to considering a broader framing/view on the idea of person centeredness. The Delphi team might want to consider (if you already havent) using the health systems responsiveness framing in addition, or instead. Responsiveness was agreed as one of the goals of health systems in the WHR 2000, and enables one to draw upon a well elaborated and well established concept.

`560d961f` answered 2 weeks ago

Regarding the dimension of quality chronic care, I suggest adding "comprehensive care". it points out that the health systems must ensure not only quality chronic care but also health promotion, preventive measures, and rehabilitation. On the other hand, it is important not only to focus on the individual dimension of care (which is instrumental for chronic diseases) but also to emphasize local health systems´ performance. Both former statements are strongly related to the training of human resources in health. For this Report, the WHO should

consider recommending a special task force for the training in chronic care in all the WHO regions.

c8b8aeb4 answered 2 weeks ago

One needs to consider the capacity of the health system (public to address chronic care concerns of the population). Also one needs to consider the health literacy of individuals (and populations) with regards chronic conditions.

69938cd2 answered 1 week ago

My comments relate to the last two dimensions (people-centredness and continuity): - In addition to 'empowerment', the definition of people-centredness should also consider the 'engagement' of people in their own care planning as well as the actions taken by health workers to 'engage' people in this process of care (eg. active listening, communication, etc.). By including the voice of the person in care planning, health and social services will ultimately be more responsive to their needs and support the process of 'empowerment' mentioned above as well. - The definition of 'continuity' used here heavily focuses on the patient's past history with the health system, and not enough on the present and future. You may wish to also consider the following definition of 'continuity' from WHO: "the degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences". From a health worker perspective, this definition supports the actions that need to be taken to coordinate the care of the person within and outside the health system (eg. with social services, community-based resources, etc.).

98e18de7 answered 1 week ago

Timeliness is another key dimension relevant to chronicle conditions. Indeed the evolution of many chronicle conditions involves acute complications that require timely interventions. Thus timeliness is a relevant dimension we may stress out or ensure it gets captured properly in one of the existing dimensions. But I encourage us to make it a dimension on its own. Indeed, designing the care providing system to ensure timeliness require so many specific measures.

9a5c49a2 answered 1 week ago

I agree with this statement, but I want to flag this extra point for your consideration for your report. The care givers also need to be taken into consideration besides the PwCC.

5e94bb18 answered 1 day ago

2.2.3 — good management of chronic conditions is integrati (Page 2)

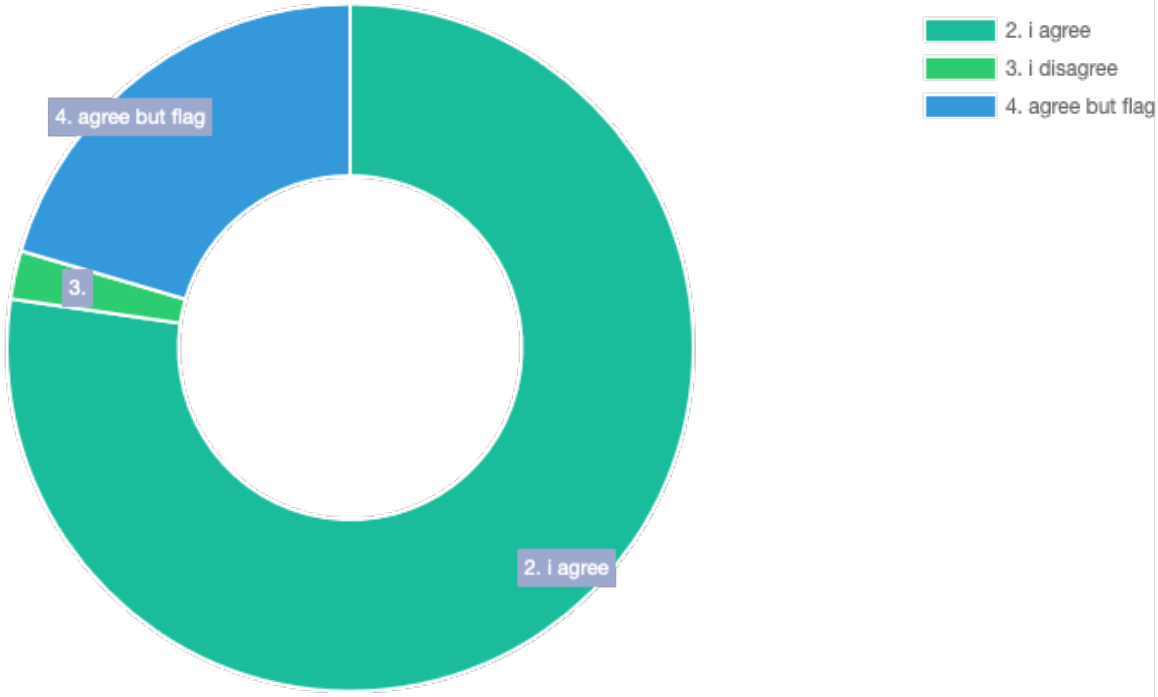
EN

The literature stresses the view that a crucial requirement for good management of chronic conditions is **integration**.

'Integration' can be seen as a crucial 'organizing principle' to apply across service delivery providers in order to organize them into performing systems. It aims at countering the negative side-effects of specialization and its subsequent fragmentation of services. It is instrumental to progress on several dimensions of quality of chronic care, and more particularly to secure attention to the comprehensive needs of the patient (person-centeredness), to organize a seamless journey (e.g., ensuring fluid flow of information between providers) and to seize efficiency gains (e.g., not missing a screening opportunity). The more complex the health system, the more attention should go to integration. The need for integration is not a challenge specific to low- and middle-income countries (LMICs).

Integration also applies beyond service delivery. It raises important questions about various efforts and interventions to improve quality of care. It reminds that the latter should never be thought of or assessed in isolation. The contribution of purchasing arrangements to improve quality of chronic care should be contemplated within the broader role of purchasing arrangements (to finance health services, whatever the condition) and the broader set of interventions to improve quality of care in general (e.g., training, quality assurance program).

2.2.3 — good management of chronic conditions is integrati



Choices	#
2. i agree	34 (77.27 %)
3. i disagree	1 (2.27 %)
4. agree but flag	9 (20.45 %)
Total	**44**

2.2.4 — explanation (Page 2)

EN
Please specify below:

2.2.4 — explanation

I had already started typinc above

6a456bee answered 1 month ago

I strongly agree that the arrangement finances health services, whatever the condition. Perhaps flag integration

between health programs to respond to escalating co and multi-morbidities which are often constrained by existing funding models, in the introductory paragraph.

17b7b82a answered 1 month ago

I would highlight the need for both horizontal and vertical integration. "This includes vertical integration and the role of the health system at each level of care, as well as horizontal integration in having different healthcare teams, tools and the community present at each of these echelons of service delivery. Finally at the individual level integration needs to take into account the individual with all their needs, their family situation and ensure that the health system as well as the community supports them."

9ec4643f answered 1 month ago

Similar to my above comment, this statement is focused on service delivery and formal care systems. That seems like a limited view, especially for chronic care, and even with regards to purchasing arrangements.

edc53c5f answered 1 month ago

See my comment above. I agree that integration is beyond service delivery. Integration for service delivery is perhaps 'vertical integration' to ensure 'continuum of care' where as horizontal integration entails an integration in a broader health system and beyond.

7cd5dded answered 4 weeks ago

It would be helpful if the link between working towards integration and achieving Universal Health Coverage could be touched upon in this definition.

a77d36f9 answered 3 weeks ago

Integration should also include any activity related to influencing health determinants and prevention interventions

db7d89a4 answered 2 weeks ago

There are many dimensions to integration. For example, within the context of the Law on Universal Health Care in the Philippines there is: 1) structural integration -- which means bringing together of various structural units involved in health care delivery; this could means provinces and municipalities; 2) managerial integration -- which means the strengthening of policy-making instruments which underpin the delivery of health services; 3) financial integration -- which means the pooling of funds from various sources, national, local, grants etc. to finance chronic care.

69938cd2 answered 1 week ago

You may wish to consider adding to this definition on 'integration': - Something on the continuum of health care: promotion, prevention, diagnosis, treatment, management, rehab and palliative care. - The coordination needed between health and other sectors and between different levels and facilities (eg. social services, community-based groups, hospitals and health centres, etc.) - Also: the distinction between 'coordination' and 'integration' (the former being what care professionals and providers do for patients)

98e18de7 answered 1 week ago

I agree with this statement, but I want to flag this extra point for your consideration for your report: I don't feel there is sufficient explanation about who should be purchasers. It should perhaps be mentioned that a purchaser does not have to be a separate organisation than the one administering health services.

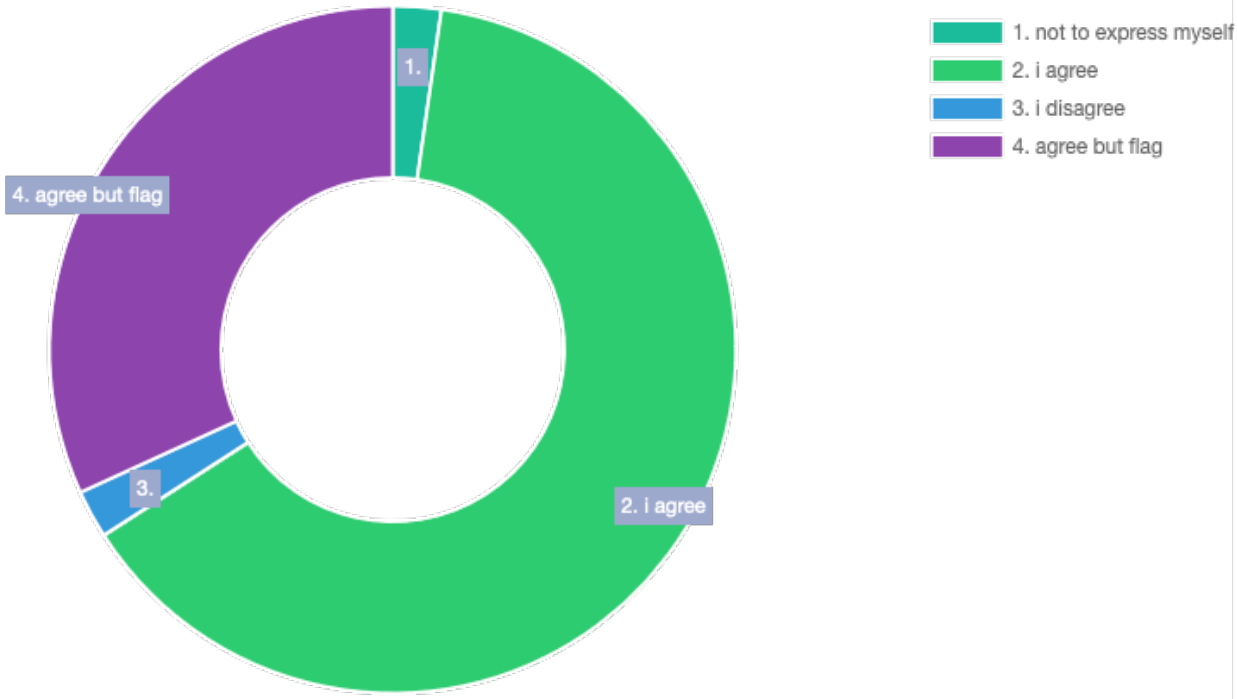
5e94bb18 answered 1 day ago

2.3.1 — Equity is a cross-cutting issue in many countries (Page 3)

EN

Equity is a cross-cutting issue in many countries, and it calls for broad societal transformations (cf. the UHC agenda). In many LMICs, there is unequal access to treatment for noncommunicable diseases (NCDs): whilst the better-off can avail to private facilities (with unchecked quality of care) or outpatient care at hospital level, the poorest households will not find accessible or affordable treatments in their surroundings, not to mention quality care. Improving accessibility – especially geographical and financial – will be key for greater equity.

2.3.1 — Equity is a cross-cutting issue in many countries



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	28 (63.64 %)
3. i disagree	1 (2.27 %)
4. agree but flag	14 (31.82 %)
Total	**44**

2.3.2 — explanation (Page 3)

EN
Please specify below:

2.3.2 — explanation

Rather than saying "unequal access", we might say "inequitable access", where what is key is the discordance between ability to secure services and the need for that care versus ensuring everyone has the same ability to secure services - since that might not be the most efficient thing to do.

6a456bee answered 1 month ago

Equity is also impacted by poorer people being at greater risk of CCs example late detection due to non-responsive health systems or only having access to foods which are cheap but highly unhealthy.

17b7b82a answered 1 month ago

Besides the poor/rich divide I would also highlight the urban/rural divide as well as vulnerable populations, e.g. migrants, ethnic minorities, marginalized populations, etc.

9ec4643f answered 1 month ago

I broadly agree but your statement implies that the quality gap is a result of differences in access. I disagree. Even in the same facility, here are quality gap for different patient groups.

edc53c5f answered 1 month ago

You can ignore my previous comment as this is the point I was trying to make.

edf03eea answered 4 weeks ago

It is good to raise poverty dimension of equity as an example, but make sure we talk about unequal access to care (not just treatment) between different population groups, as defined by many stratifiers, including but not limited to poverty. Quality, while measurable, is very subjective and not black and white (with yes/no dichotomy). Your point here indicates about the basic problem, accessibility (rather than quality) in many developing countries.

7cd5dded answered 4 weeks ago

Agree, NCDA have just published a policy research report looking into out of pocket payments experienced by people living with NCDs which again demonstrates the points raised: "Paying the Price: A deep dive into the household economic burden of care experienced by people living with noncommunicable diseases" - https://ncdalliance.org/resources/paying-the-price-a-deep-dive-into-the-household-economic-burden-of-care-experienced-by-people-living-with-NCDs

a77d36f9 answered 3 weeks ago

1. I don't understand the parenthetic reference to the UHC agenda. 2. "In many LMICs, there is unequal access .." I agree with this statement. But this is not always because the rich can pay for private care. It can also because they get access to high quality intensive public care. For example, in many LAC countries (e.g. Brazil), public sector hospitals are often the best alternative for treating cancers (while the private sector hospitals focus on much

simpler and more lucrative healthcare services like matenral care). 3. In most of LAC, access to care is no longer a problem, even for disadvantaged groups {see articles by Kruk et al). Instead, inequities emerge in terms of the quality of care received. Poor people may get similar access to treatment, but the quality of care that they receive tends to be much worse. 4. Improving accessiblity may be critical in Africa, but in LAC, the critical factor is improving quality of healthcare services such that poor people can get healthcare services they need as often as rich people do.

`b0dba773` answered 3 weeks ago

Equity is not only about geographical or financial access, it should also take into account issues related to catering for people with disability who have NCDs. The facilities in LMCIS may not be prepared to cater for them interms of physical structure.

`29826a7e` answered 2 weeks ago

This lack of equity is more often than not also present for acute diseases and trauma. And it is important to state that economics (or payments needed for care) are not the only barriers to equity: geographic - distance; stigma and discrimination, mistrust in the system of the health care workers, cultural beliefs and traditions etc. also contributes largely to equity issues.

`db7d89a4` answered 2 weeks ago

This point as articulated above aptly describes the general picture of access to chronic care in most LMICs and it will be very importnt to highlight this point. This is because access to quality chronic care is a very scarce commodity in LMICs and this is further scarce among the poor in these settings. Any effort to improve access to high quality chronic care must first address such systemic and persistent inequities in LMICs.

`b06feadc` answered 2 weeks ago

There are other determinants of inequity -- including geographic (remote islands) as well as cultural (Indigenous people may refuse care).

`69938cd2` answered 1 week ago

The literature points to a number of barriers to accessing care beyond geographical and financial (eg. literacy/education, gender, opportunity costs, etc. - please see Levesque et al. 2013). These are also important for improving equity. In addition, the definition above focuses on equity in access to health services. You may also wish to consider mentioning equity in health outcomes which considers the social determinants of health and broader population health.

98e18de7 answered 1 week ago

Yes access, but access to what? I would say “improving access to good quality NCD care”.

d2b2633a answered 1 week ago

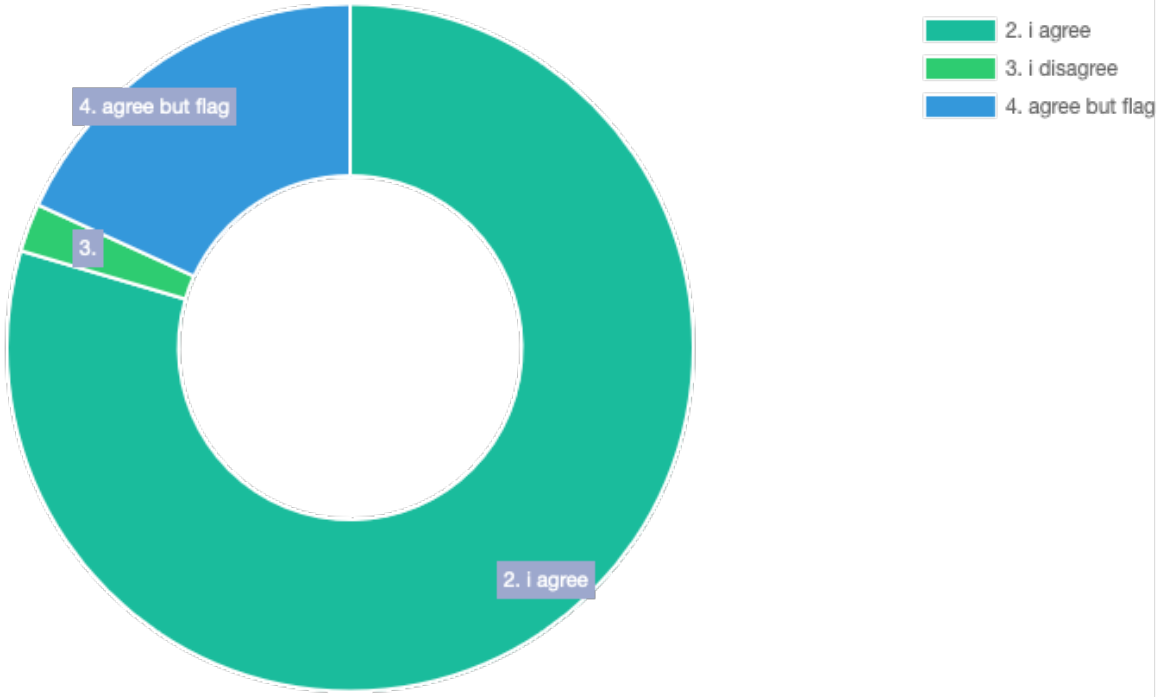
"...whilst the better-off can avail to private facilities" This is not always true. Poor people are extensive users of facilities owned by individual local paramedical staff (nurse, midwife, nurse assistant...) or religious organizations or local associations. Those types of "private" facilities are closer and more accessible to poor people in many contexts than public facilities for several reasons including the possibility to negotiate financial access. Also, public facilities are not always pro-poor facilities.

9a5c49a2 answered 1 week ago

2.3.3 — three other concerns (continuity, person-centeredn (Page 3)

EN
The three other concerns (continuity, person-centeredness and effectiveness) that many panelists raised as frequent relate to major issues with health service delivery for chronic illnesses in LMICs (if we put aside HIV/AIDS which has received considerable attention from the global community over the last twenty years). **Substantial efforts are warranted to establish quality chronic care services.** Whist the issues with effectiveness call for broad action on quality determinants such as continuous training and availability of medicines, issues with continuity and person-centeredness urge us **to develop and roll out new health care models**. Chronic care requires the delivery system to develop new aptitudes (e.g., integration and coordination, longitudinal patient follow-up) and attitudes (e.g., readiness to empower the PwCC).

2.3.3 — three other concerns (continuity, person-centeredn



Choices	#
2. i agree	35 (79.55 %)
3. i disagree	1 (2.27 %)
4. agree but flag	8 (18.18 %)
Total	**44**

2.3.4 — explanation (Page 3)

EN
Please specify below:

2.3.4 — explanation

In addition to aptitudes, and attitudes, we need to revisit incentives - which is the tie-in for purchasing. What is it about the mix of regulations and payments that makes discontinuity, lack of integration, and poor coordination the default or the easier choice? How can we revisit that to make integration aligned with the providers incentives (and knowledge - aptitude, etc.)

6a456bee answered 1 month ago

I agree with the statement however wish to confirm commitment toward the development of models which inclusively respond to CC for persons with communicable and non-communicable diseases on a common health systems-based platform but with condition specific clinical protocols.

17b7b82a answered 1 month ago

I agree with this statement. However, I think it is important to complement this with an urgent call for better prevention. As long as food companies can promote unhealthy diets, and alcohol companies can social benefits of consumin g their drinks,

b0dba773 answered 3 weeks ago

Health care models should be designed with the PwCC, even if this can be potentially go against integration.

db7d89a4 answered 2 weeks ago

Quality as it is written here is very health-system and PwCC centric but I the clinician seems to be absent. My view is that the effectiveness of chronic care will also require focusing squarely on the behavior of providers (as is often done in high-income country contexts) and find ways to align their incentives with chronic care delivery.

495ce785 answered 2 weeks ago

I think the use of the term 'aptitudes' here is not right. I do recognise the likely origins of the choice of these words (a feature of the Flemish parts of the study team if I may humbly suggest). I also think that the survey team's preoccupation with 'empowerment' assumes a certain western, particularly, western european understanding of the situation. This western gaze is rather narrow, and the choice of the words (READINESS to empower suggests that it is a gift for a healthcare worker to give), reflects this narrowness. I do get what you are trying to say, but since you have chance (and you are asking me), you might as well try and revisit the language (and your thinking) a bit.

560d961f answered 2 weeks ago

Similar to my previous comment, people-centredness should also include 'engagement' of the PwCC. When PwCC are given a voice in care planning, shared decision making, etc. and when health workers support the incorporation of the PwCC perspectives in the delivery of their care, health and social care delivery systems will be responsive to the person's chronic care needs.

98e18de7 answered 1 week ago

While these aptitudes are also essential for acute care and both should be combined in one health care system (no vertical programs).

d2b2633a answered 1 week ago

We should include also "timeliness" that requires also specific delivery systems.

9a5c49a2 answered 1 week ago

2.3.5 — across providers, weak commitment to systemic lear (Page 3)

EN

The next statement builds on your answers to round 1 (Questions 1.3.10-1.3.26 related to the bottleneck questions).

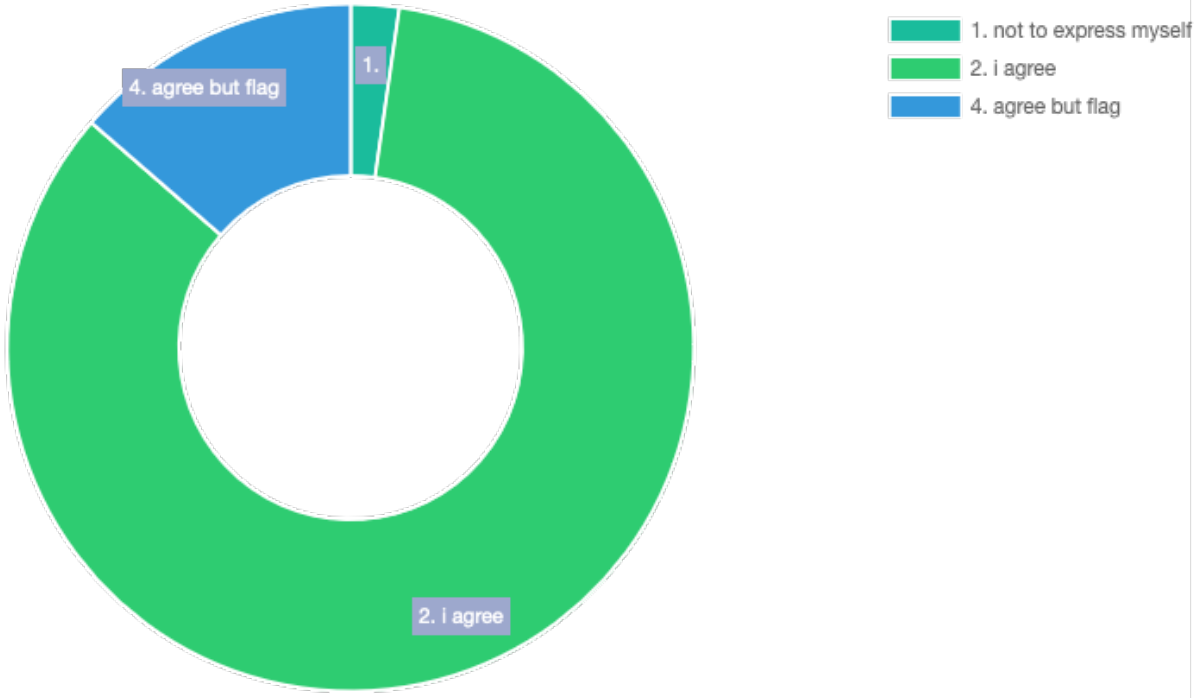
In LMICs, our experts see bottlenecks for quality chronic care at the level of the six building blocks of the health system. Main ones (no hierarchical order) are: underfinancing and lack of pooled funding, insufficient quality assurance, human resources for health, information management system and its digitalization, limited accountability, coordination across providers, weak commitment to systemic learning.

This means that in LMICs, better quality of chronic care will most often require action across the health system.

This necessity to work across the system has two direct implications for members of our panel.

1. Health financing experts should not conceive reforms of purchasing arrangements as stand-alone. Injection of public funds, revision of provider payment mechanisms, redefinition of entitlement and benefit package, etc. can contribute to better quality chronic care, but this will often require that these efforts belong to a broader program of action addressing barriers at the other levels of the health system.
2. Symmetrically, health service delivery and chronic care experts committed to address bottlenecks outside the health financing building block (e.g., reorganization of the model of care) should consider how to leverage changes to purchasing arrangements for their objectives.

2.3.5 — across providers, weak commitment to systemic lear



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	37 (84.09 %)
4. agree but flag	6 (13.64 %)
Total	**44**

2.3.6 — explanation (Page 3)

EN
Please specify below:

2.3.6 — explanation

It's also to think about the sequence of reforms when we consider these complementary building blocks. What are key pre-requisites for any purchasing reforms to be effective? I would say, for example, that

6a456bee answered 1 month ago

I strongly agree with the Statement but wish to highlight that in some LMICs including South Africa, the private sector must be considered as part of the broader program of action.

17b7b82a answered 1 month ago

For financing I would add it is not only about more money, but also doing better with what is already being used. I also feel the issue of access to medicines needs to be mentioned both in terms of availability and affordability.

9ec4643f answered 1 month ago

I would like to reiterate that not only should health financing experts not conceive reforms of purchasing arrangements as stand-alone, health financing experts should also not be the ones conceiving the reforms all on their own (as is problematically currently the situation).

560d961f answered 2 weeks ago

It should be mentioned that health financing incentives have to be aligned with the amount and the quality of health education, preventive activities, and chronic care management. Eventually, it should be aligned with health care outcomes internationally defined for each chronic condition and nationally adapted.

c8b8aeb4 answered 2 weeks ago

Shortage of health professional can be consudered a major issue in middle income countries. This means that priorities or order of factors can vary

7dba40b8 answered 1 week ago

For point 1, you may wish to highlight the need for health financing experts to consider the perspectives of PwCC, their caregivers and health workers when conceiving purchasing arrangements (eg. incorporation of qualitative research). In other words "begin with the end in mind".

98e18de7 answered 1 week ago

○ 2.4.1 — Given the fast-rising burden of

noncommunicable di (Page 4)

EN

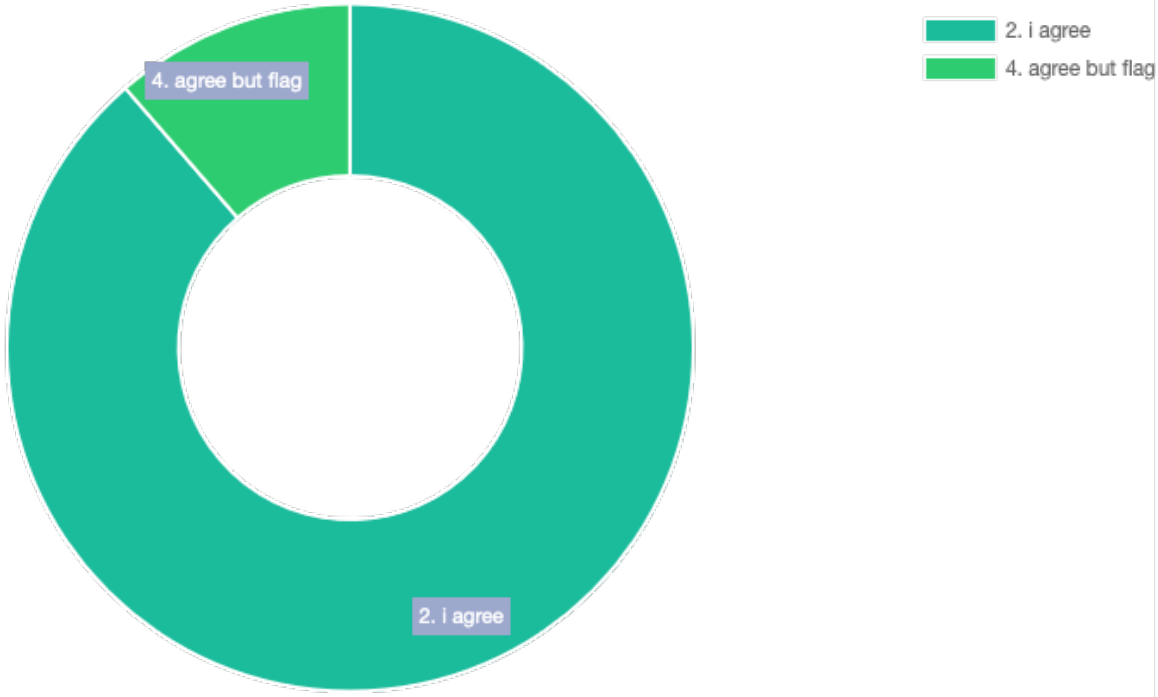
The next statement is in coherence with the general purpose of the Delphi. We invite you to express your agreement with it.

Given the fast-rising burden of noncommunicable diseases and the specific traits of chronic conditions, thinking about the possible contribution of purchasing arrangements to better chronic care is necessary.

Any revision of purchasing arrangements to improve the management of chronic care should be considered along with the broader role of purchasing arrangements (to finance health services, whatever the condition), the broader set of interventions to improve quality of care in general (e.g., training, quality assurance program) and more generally with the concern to support a coherent and performing health service delivery.

It is up to the analysts and policy makers to find the right balance between addressing issues that are specific to a particular health condition and building a coherent health / health financing / quality system. For financing arrangements, the approach recommended by our experts is: ***first check whether the default purchasing arrangements give proper consideration to the specificities of managing chronic illnesses (including multi-morbidities which are often the experience of PwCC); if it is not the case, consider modifying the arrangements so that they contribute to strengthening the quality of chronic care.***

2.4.1 — Given the fast-rising burden of noncommunicable di



Choices	#
2. i agree	39 (88.64 %)
4. agree but flag	5 (11.36 %)
Total	**44**

2.4.2 — explanation (Page 4)

EN
Please specify below:

2.4.2 — explanation

I agree with the statement but wish to clarify whether reference to CC is inclusive of communicable and non-communicable diseases. Perhaps the possible confusion may only apply to my situation where HIV & AIDS is also a CC. In this case, purchasing arrangements will be all inclusive & preferably build on systems already developed to manage HIV & AIDS

17b7b82a answered 1 month ago

I agree with the statement, but I feel that you limit 'purchasing arrangements' to benefit package and/or provider payments. More public budget allocation and investment in chronic care, which is severely under funded as compared to acute care, also is a priority for strategic purchasing.

7cd5dded answered 4 weeks ago

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if the patient does not have enough to eat, the care will always be difficult, we must also see how to bring patients to self-finance, see the possibility of creating mutual insurance between them

c5a7f16f answered 3 weeks ago

Yes, but I would like to see something more here on what the 'specificities' of managing chronic illness are. Are patient experiences, caregiver experiences, health worker experiences as well as their needs / preferences considered when developing these financing arrangements? Having this information will help get us to the outcomes that people want.

98e18de7 answered 1 week ago

It seems to me that separate purchasing arrangements for chronic care only is further complicating existing payment schemes. If the default purchasing arrangements do not give proper consideration to the specificities of managing chronic diseases, this probably holds for the entire care system and I would therefore discuss with policy makers whether the new arrangements should relate to the entire system or only to chronic disease care.

d2b2633a answered 1 week ago

○ 2.4.3 — Accessibility (Page 4)

EN

In our round 1 survey, Questions 1.3-27-1.3.34 invited you to rank dimensions of quality of chronic care as to which one should receive priority attention from the health financing community (with an invitation to focus on what purchasing arrangements can actually do).

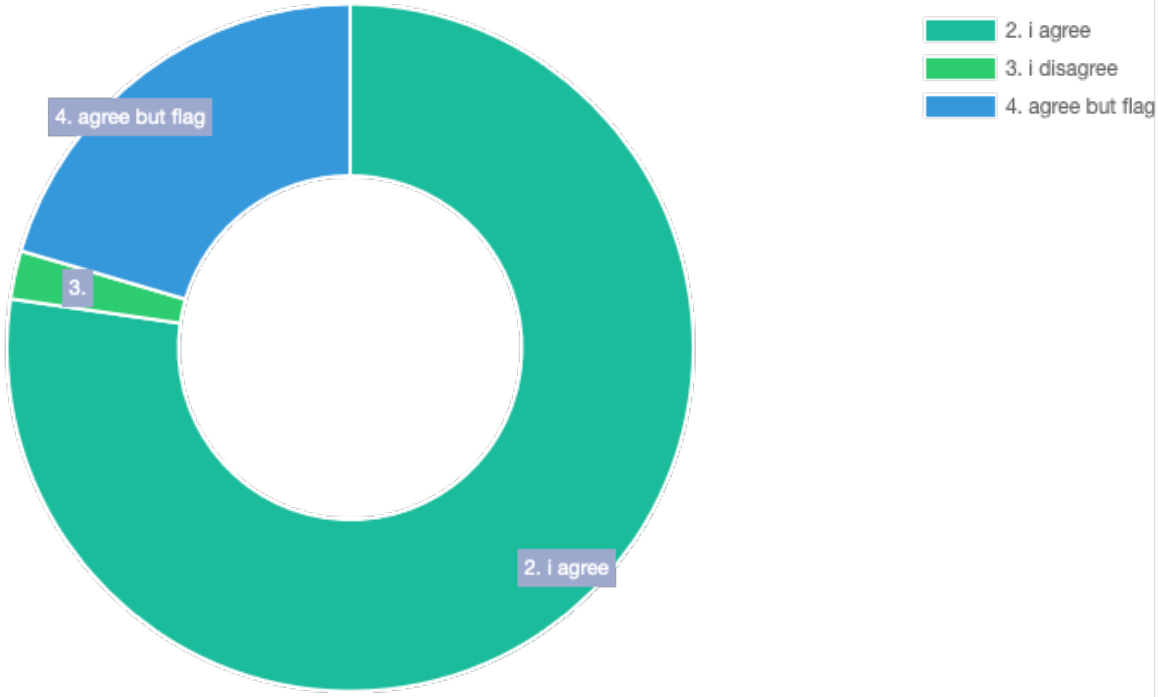
The next statements focus on the four dimensions which go the highest ranking. We have also tried to provide some rationale for this focus from the health financing perspective. Please indicate your agreement with these statements.

Although purchasing arrangements should not be seen as magic bullets, they can offer potential entry points to improve quality of chronic care. As far as LMICs are concerned, the panel of experts recommend countries to lever purchasing arrangements to improve four dimensions of quality in particular.

***Accessibility**. Countries should ensure that their health financing system enhances the availability and accessibility of chronic care. This entails sufficient funding, especially from the national pooled fund, including the health budget. Attention should go to geographical and financial accessibility.*

The effort to move towards universal access to chronic care can be framed by health authorities within the broader primary health care (PHC) and universal health coverage (UHC) agendas. As much as possible, chronic care services should be delivered close to the people, by primary care facilities. Often, especially in rural and poorer areas, these will be public ones. In many countries, availability of good chronic care for all those who need them will require reconfiguring and upgrading public health centers to improve their capacity and performance.

2.4.3 — Accessibility



Choices	#
2. i agree	34 (77.27 %)
3. i disagree	1 (2.27 %)
4. agree but flag	9 (20.45 %)
Total	**44**

2.4.4 — explanation (Page 4)

EN
Please specify below:

2.4.4 — explanation

Purchasing can also drive innovations in access, e.g. including in the benefits package telemedicine or other close-to-community models where its not a cost-effective option to set up a public health center. A good example here is Romania where in Rural and Remote areas, the cost of the financial incentive to get a doctor or nurse to reside has informed deliberations over alternative models even in an EU country, like community health workers and telemedicine that improve access, maintain quality. Purchasing - benefits design and payment models - drive these innovations.

6a456bee answered 1 month ago

I agree but am checking if national pooled funding and the health budget will be inclusive of innovative funding models example taxation from sugar sweetened beverages?

17b7b82a answered 1 month ago

Purchasing can also be used to encourage telehealth, rather than facilities.

edc53c5f answered 1 month ago

Very good statement but they are not necessarily about purchasing but financing as a whole including raising revenues. You can consider revising the first paragraph to make link to purchasing, e.g. prioritization/allocation...

7cd5dded answered 4 weeks ago

we could also consider the creation of mobile clinics to reach more remote corners

c5a7f16f answered 3 weeks ago

But it also equally important to consider availability of trained health workers and their skills mix as part of access. Health facilities may be closer to the community if they donot have adequate trained skilled health workers with skill mix, it is not accessible.

29826a7e answered 2 weeks ago

Chronic patients, especially those with multi-morbidity frequently require specialist care. It should be strengthened by our panel of experts that accessibility should be also guaranteed for specialist care under the coordination of the robust PHC network. In my experience working in Latin America and the Caribbean, fragmented health systems often hamper the required access to specialist care for chronic diseases, imposing financial and geographical barriers. So, we propose to reframe the operational organization of firs-line-health services by adding the support of specialist care for chronic conditions. Strengthening the second level of care (basic specialist care) has the potential to improve overall chronic care in local health systems.

c8b8aeb4 answered 2 weeks ago

Similar to my comment above, there are other barriers to access (education / literacy, gender, etc.) that could be considered here as well (Levesque et al. 2013).

98e18de7 answered 1 week ago

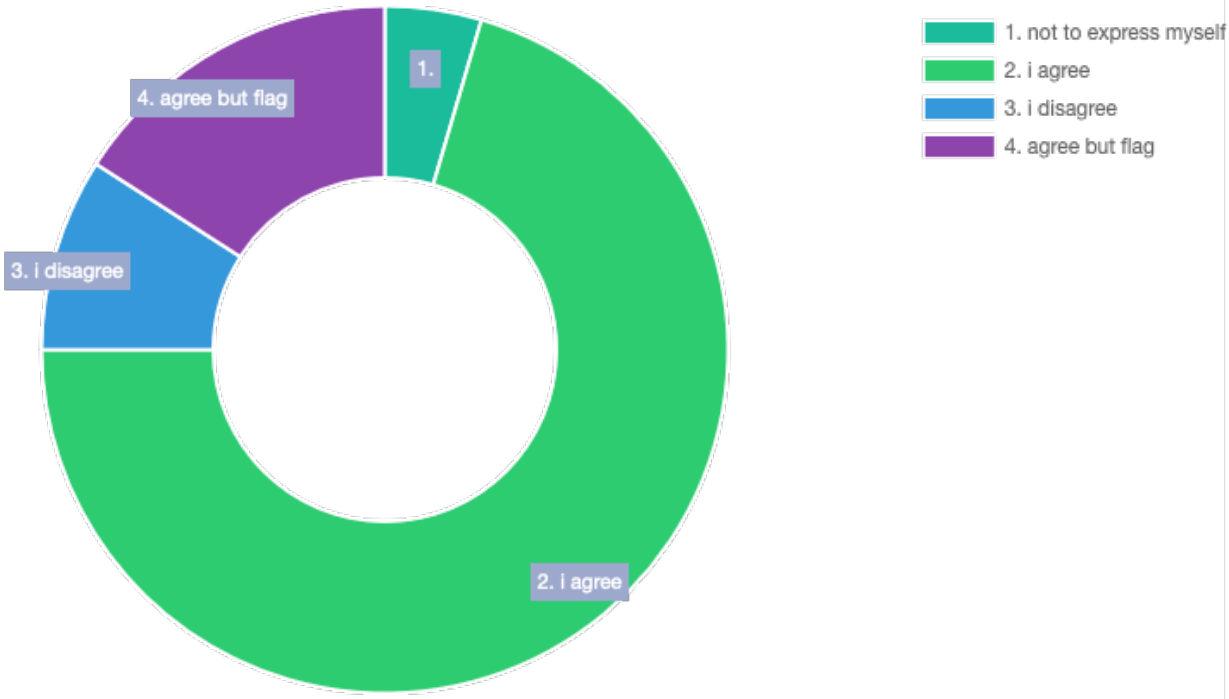
I agree with this statement, but I want to flag the importance of human resources. For primary care, people is more important than institution.

5e94bb18 answered 1 day ago

○ 2.4.5 — The expectation that purchasing arrangements secur (Page 4)

EN
The expectation that purchasing arrangements secure financial access reminds that the solution should not come from (higher) co-payments, especially charged upon the poorest. Very much related to PHC as well is the request that purchasing arrangements pay attention to the experience of PwCC and more fundamentally to empower them in the management of their condition. This gives support to programs mobilizing peer educators as community health workers (CHWs) for specific tasks (e.g., screening, retention, lifestyle coaching).

2.4.5 — The expectation that purchasing arrangements secur



Choices	#
1. not to express myself	2 (4.55 %)
2. i agree	31 (70.45 %)
3. i disagree	4 (9.09 %)
4. agree but flag	7 (15.91 %)
Total	**44**

2.4.6 — explanation (Page 4)

EN
Please specify below:

2.4.6 — explanation

And to a consultative process for designing benefits that includes PwCC in countries with a high chronic disease burden.

6a456bee answered 1 month ago

I agree. 1. I am not clear whether empower includes a concept of providing an enabling environment for example encouraging self-monitoring of diabetes but failing to provide strips and testing devices to patients. 2. As especially LMICs may differ with respect to available human resources, perhaps we may state ... mobilizing trained community level workers including CHWs and peer educators.

17b7b82a answered 1 month ago

I find the statement hard to understand: The expectation that purchasing arrangements secure financial access reminds that the solution should not come from (higher) co-payments, especially charged upon the poorest. - remind who or what? Very much related to PHC as well is the request that purchasing arrangements pay attention to the experience of PwCC and more fundamentally to empower them in the management of their condition. - I find this hard to understand and also why specifically for PHC? This gives support to programs mobilizing peer educators as community health workers (CHWs) for specific tasks (e.g., screening, retention, lifestyle coaching). - Linkage with other points in paragraph hard to follow.

9ec4643f answered 1 month ago

---

we must also empower the families of patients

c5a7f16f answered 3 weeks ago

It is very important to give attention to supervision and capacity building of peer educators to standardize the process. It is also equally important to make sure that the peer educators are adequately compensated for their effort.

29826a7e answered 2 weeks ago

We might want to add, patient association groups and not only CHW or peer educators. We might want to add different medication delivery services. We might want to add self monitoring tools.

db7d89a4 answered 2 weeks ago

I agree with this statement, but I want to flag the importance of human resources. For primary care, people is more important than institution.

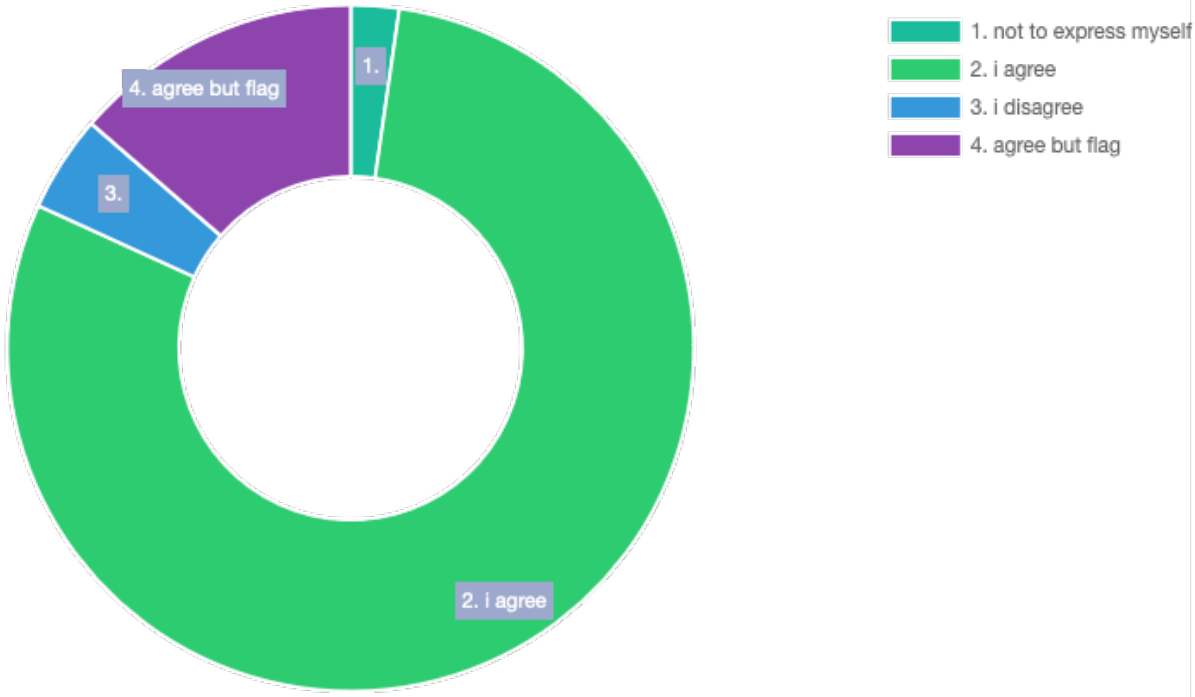
5e94bb18 answered 1 day ago

2.4.7 — Effectiveness (Page 4)

EN

Effectiveness. The existing availability of chronic care at the level of hospitals or in private facilities should not lead to complacency among national health authorities: the assessment of our experts is that **effectiveness of the care already delivered in these facilities is often problematic**. For instance, care cascade analysis in many countries show that too few persons with diabetes or hypertension have their diseases under control. In the health facilities which do not yet deliver chronic care, the roll out of new capacities will take time and effort. Purchasing arrangements can contribute to more effective care by ensuring that the determinants of quality of care (clinical knowledge, availability of medicines, appropriateness of patient data system, etc.) are fulfilled. There should also be some attention to how provider payment mechanisms currently affect outcomes and whether they could be better designed to incentivize quality care for chronic care.

2.4.7 — Effectiveness



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	35 (79.55 %)
3. i disagree	2 (4.55 %)
Total	**44**

Choices	#
4. agree but flag	6 (13.64 %)
Total	**44**

2.4.8 — explanation (Page 4)

EN
Please specify below:

2.4.8 — explanation

Agree. In this case purchasing arrangements must stipulate non-negotiable accountability mechanisms for better clinical governance. It is observed that in most cases clinicians and managers fail to be accountable to respond to a patient's NCD outcomes as they do for HIV & AIDS. Hence for example a patient with uncontrolled hypertension will go untreated until they eventually complicate.

17b7b82a answered 1 month ago

We might also want to improve systems of monitoring and assessing the effectiveness of care for chronic diseases and care programs within an individual health structure as well as in a health system.

db7d89a4 answered 2 weeks ago

Similar to my previous comment, clinician agency seems absent here. For example, the clinician could have the knowledge, have available medications, and a strong patient records systems, and still not provide adequate care. Indeed, I would venture that just improving these more structural health systems changes + knowledge will not lead to better patient outcomes. There needs to be a way to align funding with the actual care being provided, not just knowledge of care or availability of equipment.

495ce785 answered 2 weeks ago

The determinants of quality of care mentioned here are all input determinants. Attention should also be given to process determinants (provider behaviour).

bbe6c1f7 answered 2 weeks ago

Our report should strongly recommend allocating at least 80% of the financial incentives at the PHC level and in integrated networks of first-line health centers with second-level units or hospitals providing specialized support.

c8b8aeb4 answered 2 weeks ago

This statement, as well as most of the other statements in this second round provide not simply one topic that one can (dis)agree with. Rather, the statements provide a lengthy description containing both believes about what should (not) happen in a health care system and several statements that one could agree or disagree with. Other Deplhi studies that I have seen in the past consisted of a set of relatively short and very clear statements instead of summaries/stories that seem to cover several statements. I think the Delphi method is better suited for such "simple" statements than for these lenghty "stories" that we are asked to (dis)agree with.

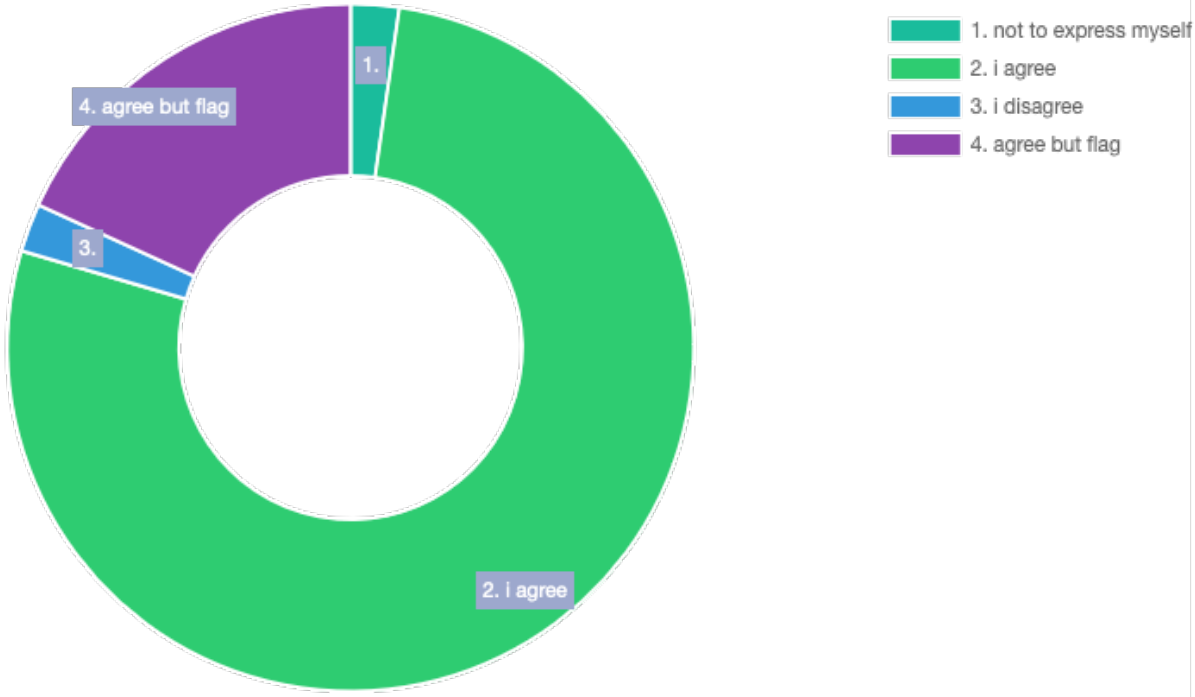
d2b2633a answered 1 week ago

2.4.9 — Continuity and person-centeredness. (Page 4)

EN

Continuity and person-centeredness. When health financing experts and policy makers revise purchasing arrangements, it is crucial that they address the concern for person-centeredness and continuity of care. These dimensions have received so far limited attention in many countries. One important change that purchasing arrangements can enhance is the adoption of a digital record system which enables the longitudinal follow-up of patients, ideally across providers (and thus consolidating their informational integration). Another matter that requires attention is to incentivize health staff to empower PwCC to self-manage their conditions and thus reduce the need for visits to health facilities).

2.4.9 — Continuity and person-centeredness.



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	34 (77.27 %)
3. i disagree	1 (2.27 %)
4. agree but flag	8 (18.18 %)
Total	**44**

2.4.10 — explanation (Page 4)

EN
Please specify below:

2.4.10 — explanation

It is my view that digital record systems enabling longitudinal follow up of patients are central to achieving desired outcomes and this must integrate into national integrated surveillance platforms which are accessed as part of purchasing agreements.

17b7b82a answered 1 month ago

You always need close contact with the sick, so not reducing visits or maximizing contact by telephone, which is not obvious

c5a7f16f answered 3 weeks ago

It is good to incentivize health workers. But this should be done carefully with adequate consultations. It is also important to link the payment of incentives to clearly defined performance output indicators.

29826a7e answered 2 weeks ago

Digital solutions can be very efficient and time-saving. They also often offer a way to improve follow up of patients through availability of all information of patients. However, they have the potential to be problematic in terms of use, maintenance (and troubleshooting) and data protection. This last one can be of more important in LIMC prone to conflicts. Digital solutions should also not undermine the self management and empowerment of patients, by reducing the attention to give patients their health information in hard copy.

db7d89a4 answered 2 weeks ago

Again, it is needed to add the "comprehensive care" dimension, making clear that it means to have a holistic vision of the multiple dimensions of the patients (under PCC vision) but also to assure to offer timely health education, preventive activities, and rehabilitation processes.

c8b8aeb4 answered 2 weeks ago

Digital record system is important, but should be made in a manner that does not shift greater burden on health staff, not decrease their direct contact and attention with patients.

81dd720d answered 1 week ago

In addition, you may wish to mention the importance of health worker competency (eg. skills, knowledge, ability) to provide continuity and person-centred care. A supportive work environment and additional financing (eg. funding for health service delivery initiatives / innovations) can additionally enable health workers to deliver on these goals.

98e18de7 answered 1 week ago

I agree with this statement, but I want to flag the importance of human resources. For primary care, people is more important than institution.

5e94bb18 answered 1 day ago

2.5.1 — through different mechanisms. (Page 5)

EN

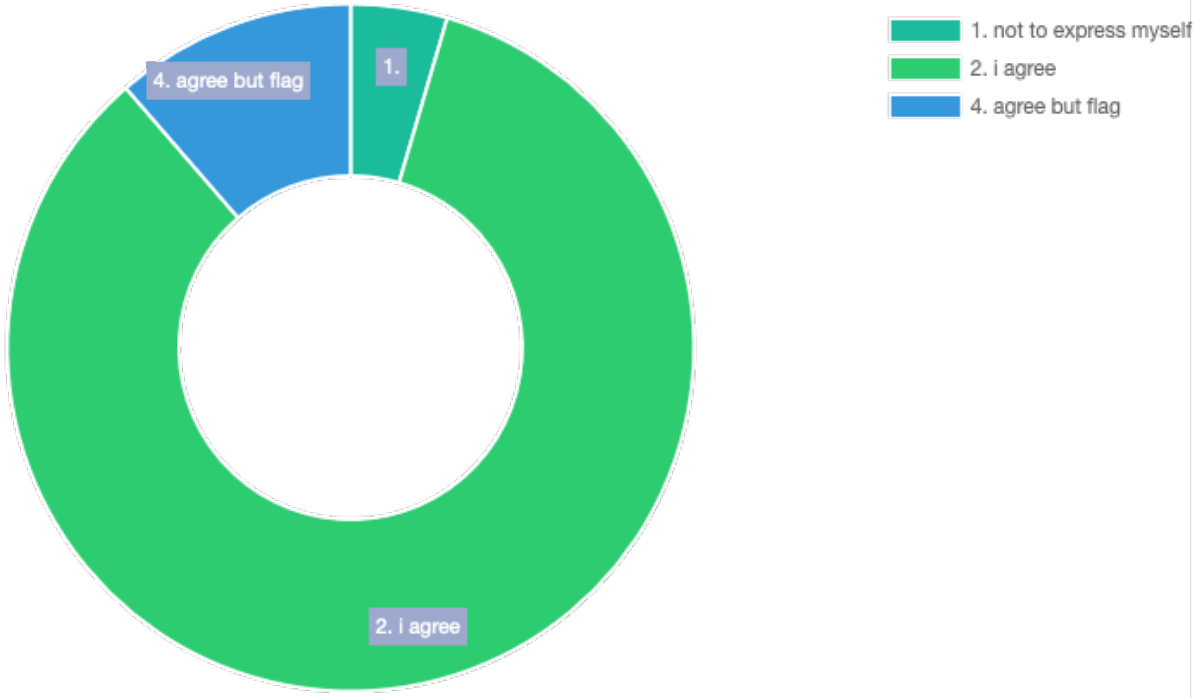
The next statement relates to the theory of change of purchasing arrangements in general. We invite you to express your agreement with or even elaborate on these different mechanisms activated by purchasing arrangements.

Purchasing arrangements can affect positively or negatively quality of care (in general) through different **mechanisms**.

- They enable service delivery by funding resources required to produce care.
- Purposely or not, they shape the incentive structure for health organizations, teams and individual health workers. Those incentives encourage or not organizations and individuals to allocate resources under their control to the benefit of some dimensions of care. By bringing some measures of quality in the payment formula, the purchasing agency can incentivize health care organizations and providers to put effort in some dimensions, but it is important to note that this may also have side-effects, including negatively affecting some determinants of quality of care (e.g., intrinsic motivation) or the provision of non-chronic care.
- Purchasing arrangements can legitimate, require, or enforce desirable or undesirable changes or investment in other determinants of quality of care. For instance, the introduction of a capitation system with empanelment may require that health facilities digitalize their system.
- Change in purchasing arrangements will have to be communicated to stakeholders. This investment in conveying messages (e.g., sharing some data on the burden of disease, creating a sense of urgency, etc.) can nudge providers' attention or decision, remind them of some influential determinants to act upon or present them with a general theory of change. This messaging mechanism will be detrimental if it diverts the health organization staff's attention from issues which had a higher priority.

When reforming purchasing arrangements, it is recommended to consider all these aspects and to make sure that intended and unintended effects are closely monitored, and ideally evaluated with rigorous methods (e.g., impact evaluation).

2.5.1 — through different mechanisms.



Choices	#
1. not to express myself	2 (4.55 %)
2. i agree	37 (84.09 %)
4. agree but flag	5 (11.36 %)
Total	**44**

2.5.2 — explanation (Page 5)

EN
Please specify below:

2.5.2 — explanation

Communication should happen both ways in purchasing. Also critical is the process for designing benefits

6a456bee answered 1 month ago

Would it be necessary to state that care will be provided as per a standard package of care or minimum service benefit?

17b7b82a answered 1 month ago

I agree that close and rigorous monitoring is required, but do not think impact evaluation is generally the best tool to do so. The time delays and costs are too high.

edc53c5f answered 1 month ago

All are good but the first bullet point deserves improvement to incorporate purchasing function and health system dimension, e.g. They enable service delivery by (making fund available for) funding

7cd5dded answered 4 weeks ago

It must also be taken into account that the human dimension risks being lost in favor of the search for more money. See how to minimize the fact that we will create a breed of money-hungry personnel

c5a7f16f answered 3 weeks ago

I would add: purchasing arrangements often focus narrowly on the delivery of health services (e.g. diagnosis and treatment) and in some cases can hinder health worker judgement / critical thinking and actions on what the PwCC may actually need (eg. linkages and coordination between different care settings and with other sectors - especially in addressing the social determinants of health).

98e18de7 answered 1 week ago

Purchasing arrangements should not be merely centered on incentives but rather embrace a holistic strategic purchasing approach with systemc learning at the center.

9a5c49a2 answered 1 week ago

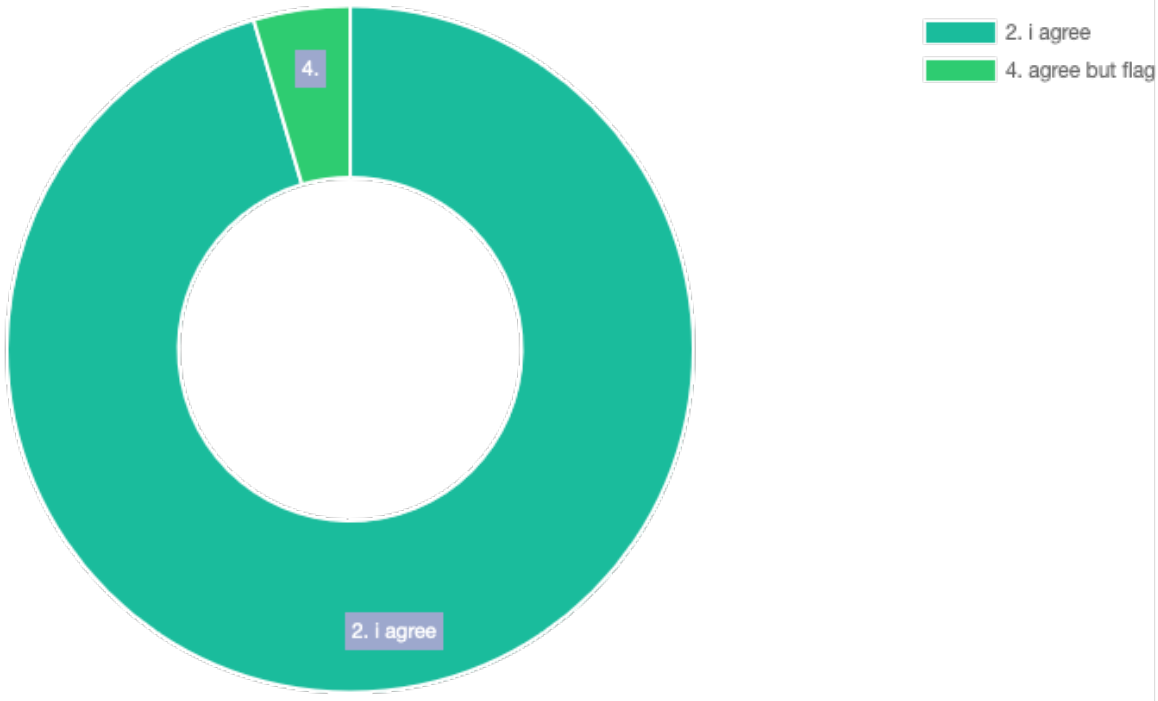
2.5.3 — context matters (Page 5)

EN

The next statements build on your answers and many comments to the questions specific to providers.

Our experts considered the possible role of purchasing arrangements in increasing quality of chronic care by type of provider, including **CHWs, public health centers, private not-for-profit (specialized) centers, private for-profit clinics, hospitals, district offices, patients and their relatives, and purchasing agencies** (as the *principals* for the purchasing arrangement).
In their response, our experts emphasized a key fact across provider types: context matters (a lot). There is no universal proposition that applies to any category of provider in any context. Some payment models may be ideal from a theoretical perspective, but their effect on the quality of care by a certain type of provider in a specific context will largely depend on the whole nexus of institutional arrangements and other contextual factors. Tailoring of purchasing arrangements is key. Often, some specific provider payment mechanisms will have to be revised to adapt to new conditions, seize new opportunities or address new challenges.

2.5.3 — context matters



Choices	#
2. i agree	42 (95.45 %)
Total	**44**

Choices	#
4. agree but flag	2 (4.55 %)
Total	**44**

2.5.4 — explanation (Page 5)

EN
Please specify below:

2.5.4 — explanation

I consider that overall, it is worth value to mentioning that purchasing arrangements should be seen as a key factor of alignment between means and objectives regarding chronic care that always has to be operationalized in line with the stewardship functions of the health of the national and local health authorities.

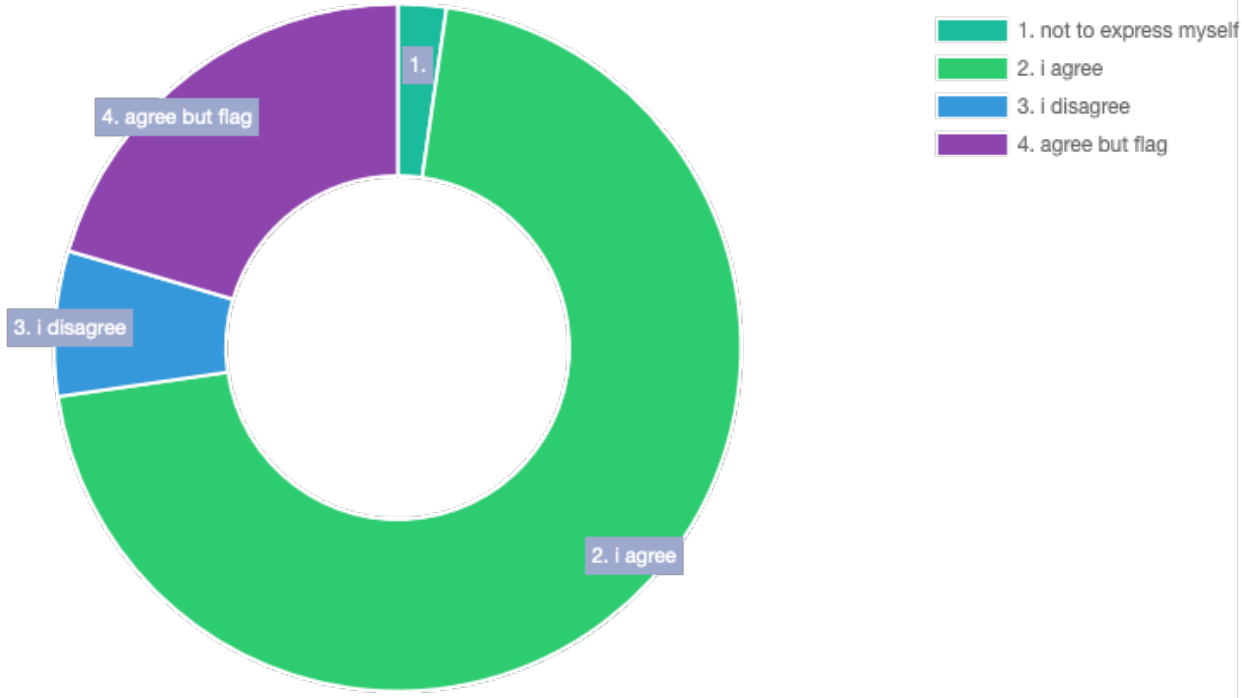
c8b8aeb4 answered 2 weeks ago

2.5.5 — Patients and relatives (Page 5)

EN
Our experts have embraced the spectrum of providers we have proposed and have been supportive for a purchasing arrangement perspective for all of them, but have expressed caution as for paying patients.

Our experts do not recommend systems rewarding patients for successfully taking care of themselves (for instance, a financial reward for success in smoking cessation). If any compensation is paid, the focus should be on encouraging appropriate health seeking behaviors, for instance through a voucher, a conditional cash transfer or a reimbursement of costs (e.g., transport).
Our experts think it would be fair to offer financial support to family relatives of patients on a limited basis, but this may require quite advanced safety net mechanisms. Ensuring that households with a PwCC are entitled to social welfare support (for instance, through the recognition that having a chronic condition is an extra source of economic vulnerability) may be the most practical step to take.

2.5.5 — Patients and relatives



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	31 (70.45 %)
3. i disagree	3 (6.82 %)
4. agree but flag	9 (20.45 %)
Total	**44**

2.5.6 — explanation (Page 5)

EN
Please specify below:

2.5.6 — explanation

Agree. This point highlights urgency for planning between health and social services especially to agree on the financial implications of providing social care which must occur concurrently. Providing appropriate health care will be in vain if social/economic needs are not met.

17b7b82a answered 1 month ago

In part, this is a question of relative cost-effectiveness given the scarce resources.

edc53c5f answered 1 month ago

Please note that 'enable people with a chronic condition' to know their condition/risk, screening, also is a high priority care service to be considered/included in purchasing package

7cd5dded answered 4 weeks ago

I do not agree with the last paragraph

a8f4759b answered 3 weeks ago

we must also see how to bring patients to self-finance, see the possibility of creating mutual insurance between them

c5a7f16f answered 3 weeks ago

I would like to statement to be clear that while outcomes would not be paid for there is evidence that rewarding beviours is beneficial. Paying for behavours is complex and needs to be monotored and calibtated at intervals.

865f9c1e answered 3 weeks ago

Well established evidence report the high financial burden of care among PwCC. As a result, financial support to family and relatives is not out of order but the mechanisms to roll out this must be thoroughly and carefully considered. Similar support for the very poor in LMICs have faced massive and incredible implementation bottlements and issues around targeting and sustainability of such initiatives. In short, although the issue about providing financial support is lauded, this can be approached with caution.

b06feadc answered 2 weeks ago

Incentivising patients to engage in smart preventative behaviour (rather than health seeking) through some personal benefit may be the most efficient use of resources for the health system.

bbe6c1f7 answered 2 weeks ago

I agree with the statement, but not with conditional cash transfers specifically, as I find them ethically problematic/debatable.

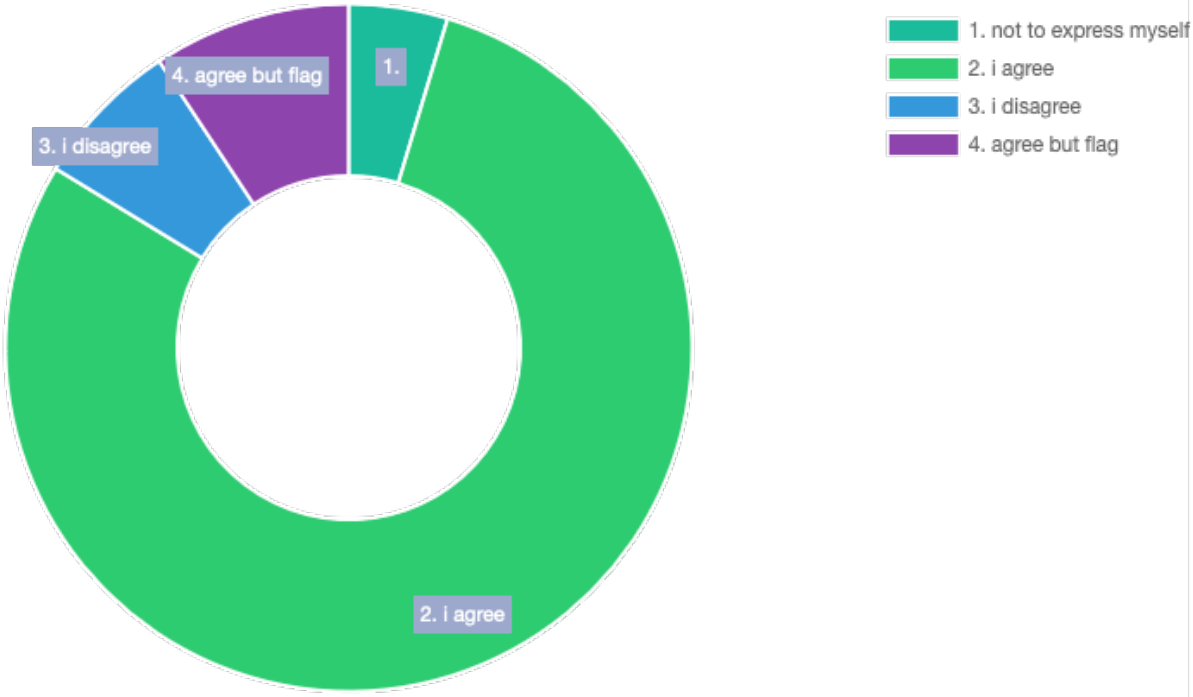
81dd720d answered 1 week ago

○ 2.6.1 — that CHWs can contribute to quality chronic care (Page 6)

EN
Our experts assess that CHWs can contribute to quality chronic care, especially to the dimensions of accessibility and efficiency. If CHWs are themselves PwCC, their personal experience can be an asset to support continuity (e.g., encourage their peers to have a good observance of the treatment plan) and person-centeredness (e.g., credible tips for adapting livelihood).

If a national program mobilizes CHWs to better address NCDs (e.g., for screening, for peer support), sustainable financing should be put in place for it. The financing should ensure that key inputs are covered (e.g., diagnosis tests), including costs incurred by CHWs. The latter deserve a financial compensation. In LICs, if CHWs are themselves PwCC, the compensation could include some benefits in kind (e.g., free treatment).

2.6.1 — that CHWs can contribute to quality chronic care



Choices	#
1. not to express myself	2 (4.65 %)
2. i agree	34 (79.07 %)
3. i disagree	3 (6.98 %)
4. agree but flag	4 (9.3 %)
Total	**43**

2.6.2 — explanation (Page 6)

EN
Please specify below:

2.6.2 — explanation

We should keep in mind other job responsibilities of CHW besides NCD care . Most of the CHWs would be also involved with other national programs and maternal & child health

e15461db answered 4 weeks ago

Community based approach should not only be based on the work of CHW, as more and more burden is put on them for more and more health topics , while other solutions for increased access are insufficiently being proposed. PHC staff could do outreach. More PHC could be made available. Patient associations could step in. etc.

db7d89a4 answered 2 weeks ago

Free, publically accessible chronic care treatment for CHWs should not be dependent on their work at CHWs. I do not support the example provided in the last sentence.

bbe6c1f7 answered 2 weeks ago

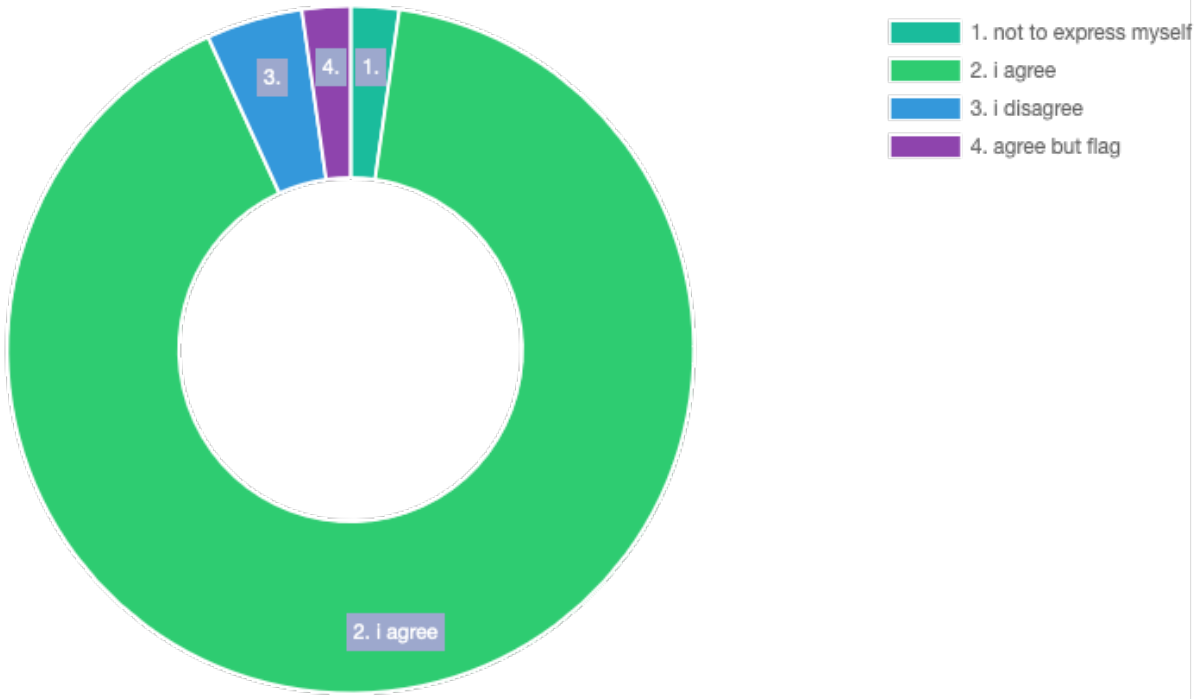
I disagree with compensation in kind for CHWs. If we want to strengthen local health systems (WHO as well as the Antwerp ITM have defended that point of view in global health) CHWs imply in chronic care should be formalized as much as possible, not only to provide motivation and fairness in labor/employment remuneration but also to guarantee that CHWs would be a sustainable strategy for local health systems.

c8b8aeb4 answered 2 weeks ago

2.6.3 — payment to CHWs (Page 6)

EN
For payment models for the CHWs, different options can be considered. The main recommendation is that the overall contractual arrangement should ensure that prerequisites for quality care are fulfilled; these include, among others, a well-defined scope of work, prior training on assigned tasks and continuous training on other skills, equipment with screening material, an obligation to report activities and supervision.

2.6.3 — payment to CHWs



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	40 (90.91 %)
3. i disagree	2 (4.55 %)
4. agree but flag	1 (2.27 %)
Total	**44**

2.6.4 — explanation (Page 6)

EN
Please specify below:

2.6.4 — explanation

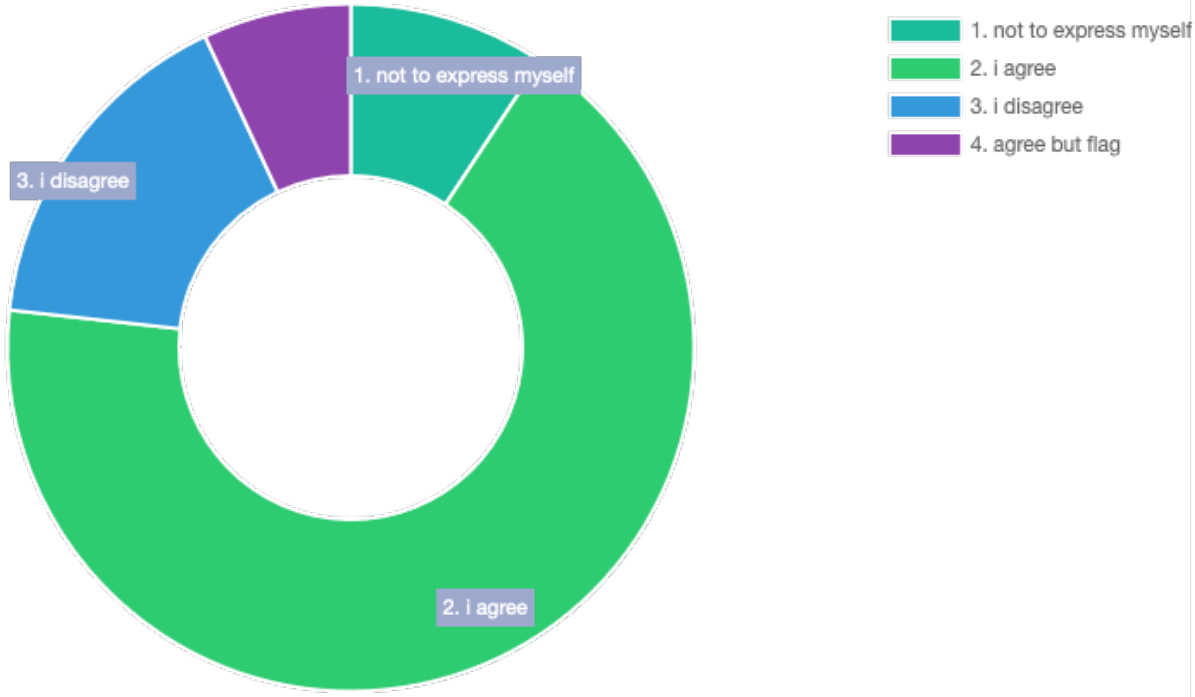
It is also equally important to take note of acceptability of the CHW by the community when selecting CHW for this role. Communities need to be consulted through their representatives'.

29826a7e answered 2 weeks ago

2.6.5 — pay-for-performance for CHWs (Page 6)

EN
If the context is favorable (e.g., the country has a positive experience with similar arrangements with other levels of care or other health needs), a pay-for-performance arrangement can be considered. It could for instance reward the CHWs for persuading people at risk to take a test and come to the health center for a proper diagnosis.

2.6.5 — pay-for-performance for CHWs



Choices	#
1. not to express myself	4 (9.3 %)
2. i agree	29 (67.44 %)
3. i disagree	7 (16.28 %)
4. agree but flag	3 (6.98 %)
Total	**43**

2.6.6 — explanation (Page 6)

EN
Please specify below:

2.6.6 — explanation

As you noted above, this is unlikely to be sufficient given the steep drop in the care casdade. I would consider this a partial intervention / statement.

edc53c5f answered 1 month ago

Pay-for-performance arrangement can be considered in some situations, it will need to be integrated with the incentives that are given through other programs. e.g in India, incentives are given to CHW for hospital deliveries, full immunization of the child etc. The amount should be at par with other programs.

e15461db answered 4 weeks ago

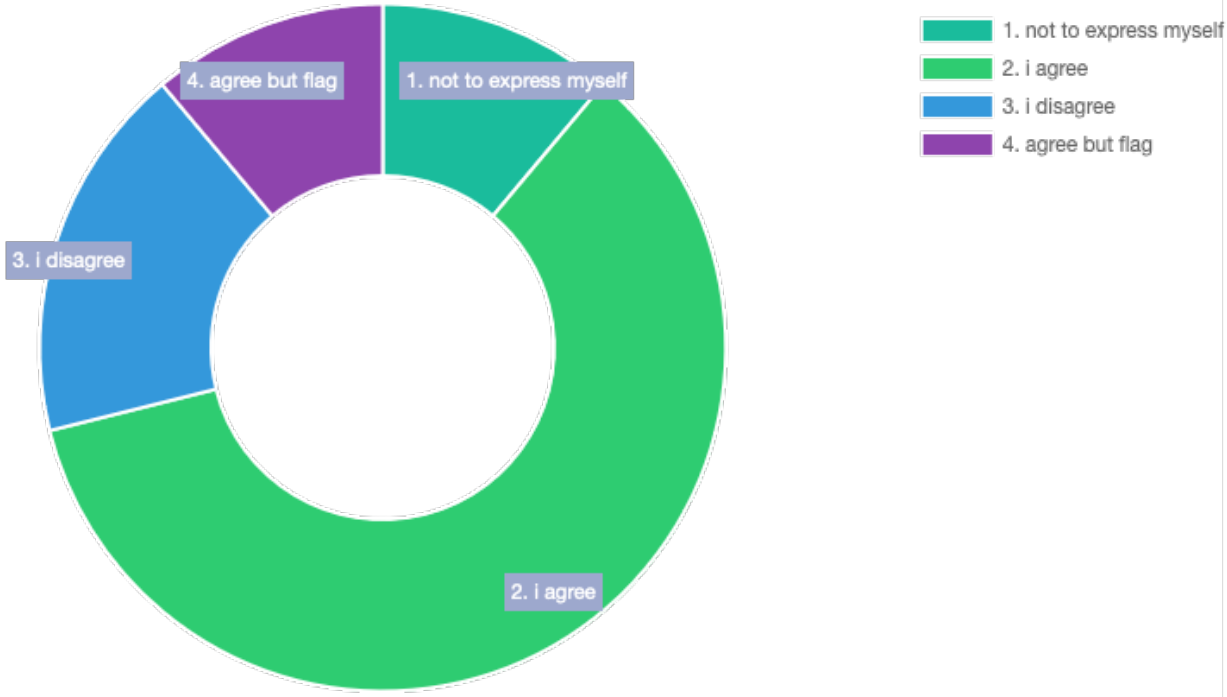
There is a need to have a robust verification mechanism on this. There is also a need to have client satisfaction survey to assess the client satisfaction aspect. Otherwise, this method may have unintended consequences as CHWs may administer tests for those who donot require to improve performance and this may result in wastage of the limited resources affecting efficiency.

29826a7e answered 2 weeks ago

2.6.7 — purchaser for CHWs (Page 6)

EN
The panelists recommend entrusting the payment of CHWs to health centers or the health district office. But other options, like a non-health administration involved in rural or urban development or NGOs can be considered. If quality of care by health centers is low and if the CHWs are also PwCC, their empowerment as champions may require that they do not rely on health centers for their payment.

2.6.7 — purchaser for CHWs



Choices	#
1. not to express myself	5 (11.11 %)
2. i agree	27 (60 %)
3. i disagree	8 (17.78 %)
4. agree but flag	5 (11.11 %)
Total	**45**

2.6.8 — explanation (Page 6)

EN
Please specify below:

2.6.8 — explanation

I believe that models may vary even within countries for example in some provinces CHWs are paid through persal systems like other health workers and in others, they are paid by NGOs who receive government grants.

17b7b82a answered 1 month ago

I agree but suspect it is less the *quality* of the health centers but rather the management capacity of the center and also the entire payment infrastructure (e.g., late payments from the central funds will lead to late payments at the frontline)

edc53c5f answered 1 month ago

I'm not sure what the last paragraph is thinking about

a8f4759b answered 3 weeks ago

It is important to make sure that important stakeholders involved in social sector are involved in this exercise. The district health administration and health facility should be part of it and work and guide others involved in the social sector.

29826a7e answered 2 weeks ago

I agree with this statement but also want to add that the payment could be through the national health service, the same payment mechanism considered for mainstream health workers e.g. nurses.

da55c53c answered 2 weeks ago

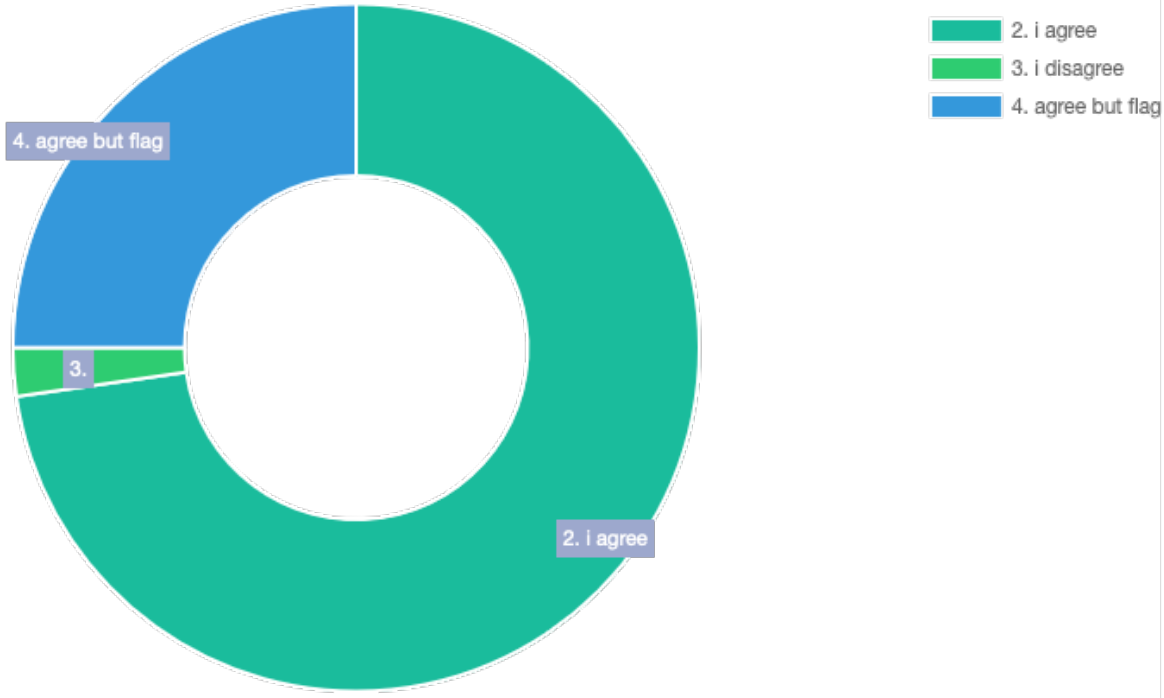
2.7.1 — Ensure that all key conditions for quality of care (Page 7)

EN

Our experts propose to assign a central role to public health centers in the management of chronic illnesses. They are seen as particularly key to ensure accessibility, efficiency, equity, person-centeredness and continuity. There may be few alternatives available in rural areas.

The first concern of our panelists is to ensure that all key conditions for quality of care to be delivered are fulfilled. This should be the prime focus of purchasing arrangements with public health centers. National guidelines, quality assurance mechanisms, training, availability of equipment, a minimal laboratory capacity and some supervision are needed. In many LMICs, this may require a substantial upgrade of public health centers. There is a strong call for governments to increase budget for that capacity upgrade.

2.7.1 — Ensure that all key conditions for quality of care



Choices	#
2. i agree	32 (72.73 %)
3. i disagree	1 (2.27 %)
4. agree but flag	11 (25 %)
Total	**44**

2.7.2 — explanation (Page 7)

EN
Please specify below:

2.7.2 — explanation

This depends on the country. In Romania, over 90% of primary providers are private. A focus on public centers would be tantamount to reducing access to care across the board. The mix of providers in health systems is one of the reasons why purchasing can be a powerful tool where there is significant purchasing power since those incentives can shift even providers in the private sector. I think this statement should be modified accordingly.

6a456bee answered 1 month ago

Perhaps strengthening national integrated surveillance systems especially patient level data is included in the list.

17b7b82a answered 1 month ago

It may not require an increased budget but a reallocation (and better execution) of existing resources, e.g., build fewer hospitals.

edc53c5f answered 1 month ago

In certain contexts ministries of health who have this perspective often prefer to ignore the private health sector and the opportunities to harness their potential for improved patient outcomes, whether it be access to medicines, proximity of care, better quality than public sector, strong commitment to patient outcomes. I feel a statement like this just gives more ammunition for public entities to see the private sector as the enemy/competition, and to avoid conversations about potential efficiencies in use of public funds that could be achieved through PSE models. Instead potentially will just continue asking for more money from their ministries of finance and donors/Banks in the hopes of making public services more attractive and pulling the population back to them, and with mixed track records may or may not have convincing arguments for successfully convincing financiers to invest more. I think what should be advocated in countries with the PS does play a role in chronic care is to be open to mixed service delivery models where there are roles for both public and private providers in improving access and quality in particular for the poor.

48319912 answered 1 month ago

Some HCs may simply do not have enough staff and therefore before training, please add a point of human resource.

7cd5dded answered 4 weeks ago

It is not clear to me why the facilities would necessarily require a physical upgrade to provide quality chronic care. Perhaps the reason for this can be made clearer through an example.

bbe6c1f7 answered 2 weeks ago

Just out of curiosity; on 'disagreeing' i do not get an option to comment (like in the case of the previous section where CHWs are proposed as target for a potential pay for performance, with a focus on quality of care arrangement - the latter statements are too vague to agree with. 'It depends' off course, however, i believe there is a real limit to using CHWs - or lots of time from volunteers - for massively expanding care delivery). Anyway, on the PHCs and upgrading. Off course, and 'it depends' on the context, however, investing in structural quality like is

proposed here, are famously inefficient and ineffective. Trainings, guidelines, physical upgrading etc.... as a prelude to quality of care are usually a waste of resources. In the real world there is always a lack of resources, and one has to establish health service quality improvements within a certain budget. Within that budget, one has to prioritize, and if one has to prioritize, within a limited budget, as a matter of principle, i would not go for 'low hanging fruits' such as infrastructure or guidelines. On the contrary, in such instances, i would go full in on content of care improvements (process quality), and certain outcome quality metrics (such as patient exit interviews, content of care tracers etc.).

4be93ebb answered 1 week ago

In several countries, Non-state owned facilities (private facilities) are more people-centered than public facilities. Let's be careful with the consideration that public facilities are pro-poor. This is not always the case. Public or private, the organisation cultures and the specific practices of facilities must be carrefully assessed.

9a5c49a2 answered 1 week ago

I agree with this statement, but I want to flag this extra point for your consideration for your report that in settings where public health centres are infeasible as the sole solution, it may be useful to contract with some sustainable NGO or private providers.

5e94bb18 answered 1 day ago

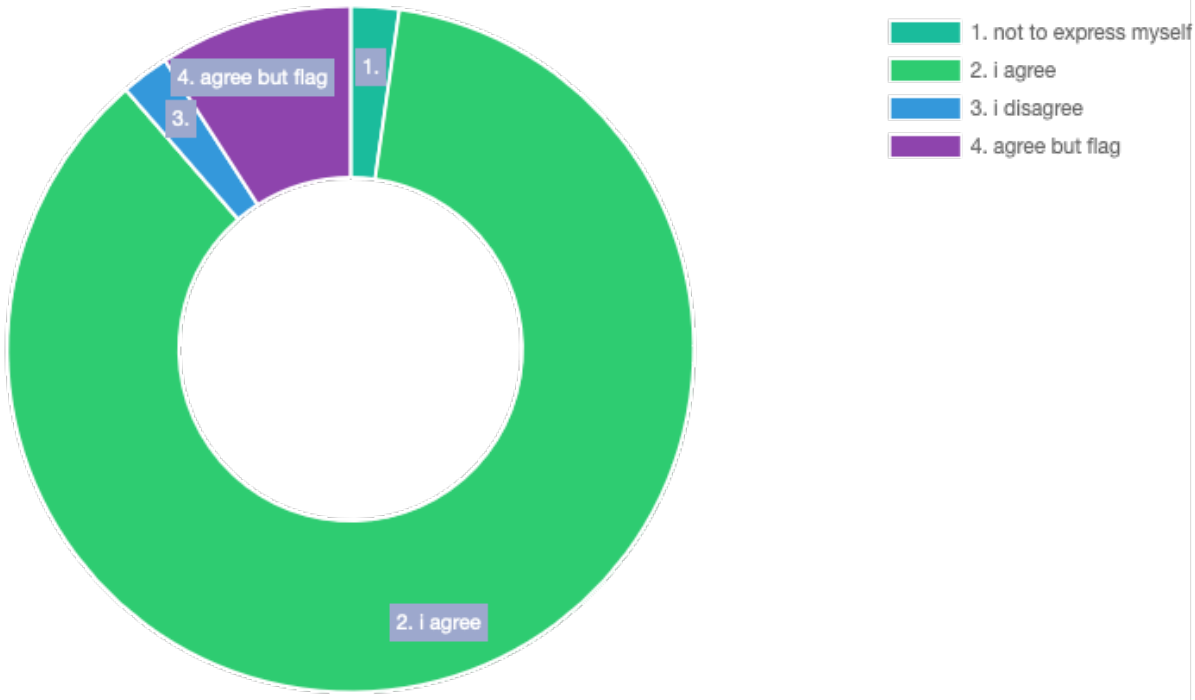
○ 2.7.3 — payment model for public health centers (Page 7)

EN

A majority of our experts have recommended that the extra allocation of financial resources to the health centers take into account the volume (83% of respondents), the quality of services (83%) and the socio-economic conditions (60%) of the served population. There was a strong majority against charging user fees at public health centers: treatment for chronic illnesses should be covered by the pooled fund and co-payment be limited.

On top of what existing purchasing arrangements allow (for instance, under the civil service system, it is probably possible to reward the staff accepting to work in remote areas, to require young doctors to start in rural areas and more generally to better manage career path), there was a consensus among our experts that capitation models can be a way to take volume and socio-economic conditions into account, without encouraging over-prescription and cost-escalation. Capitation sets interesting incentives, as it encourages the health center to keep the patient healthy: indeed, the healthier the patient, the less he uses the health center, and the more the health center retains from the prospective capitation payment it has received. Different options – with different degrees of sophistication – can be considered by countries.

2.7.3 — payment model for public health centers



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	38 (86.36 %)
Total	**44**

Choices	#
3. i disagree	1 (2.27 %)
4. agree but flag	4 (9.09 %)
Total	**44**

2.7.4 — explanation (Page 7)

EN
Please specify below:

2.7.4 — explanation

Interesting to explore the newer payment models emerging in Europe and North America that reward coordination of care across providers - including population-based payments.

6a456bee answered 1 month ago

I fully agree with the ideal pooled fund with limited/no co-payment. But this does not mean we immediately remove user fees, which remain an important source of funding in the context where public funding and social health protection coverage remain insufficient like Cambodia. Please specify what are ideal wishes/solutions and what can be temporary solutions (I don't like idealists, but realists). I also favor capitation but please put a caution by proposing to carefully test it and document it before scaling up nationwide

7cd5dded answered 4 weeks ago

it depends not only on the health centers, but also on the patients. How to encourage patients to be healthy in this system?

a8f4759b answered 3 weeks ago

This hypothesis can be a good initial theory. It must be carefully checked and confirmed in the learning process around the implementation. It may be true in some contexts and may not work in others.

9a5c49a2 answered 1 week ago

2.8.1 — capitation with empanelment (Page 8)

EN

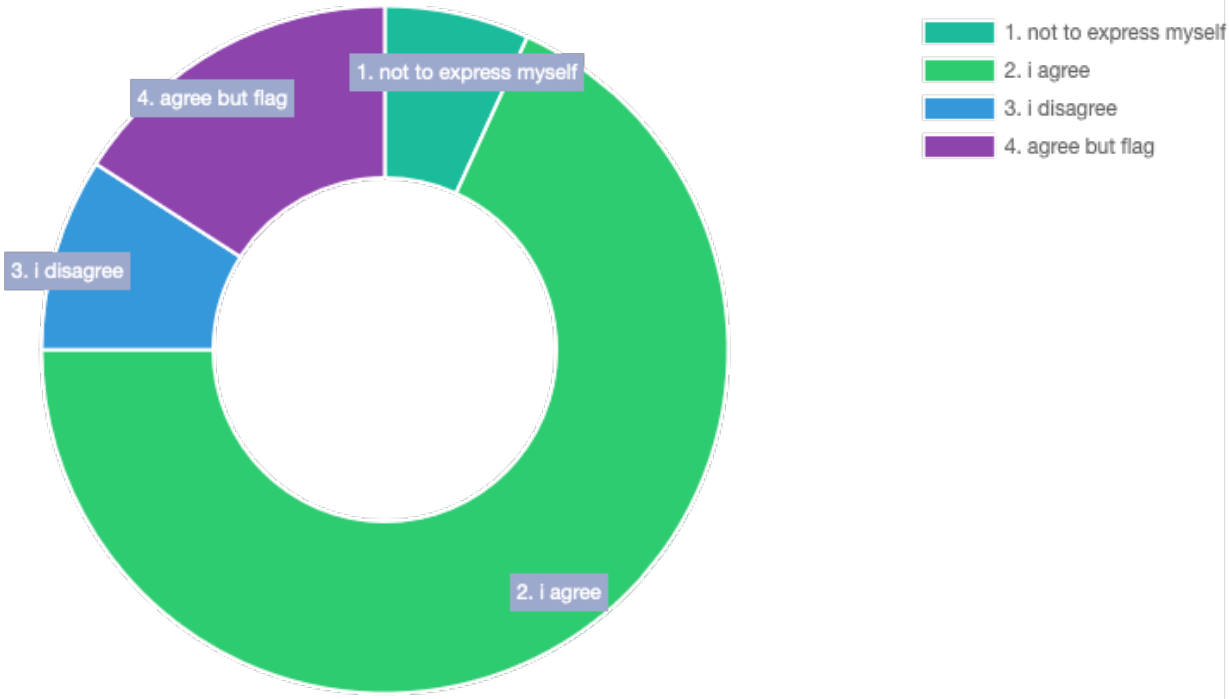
The next statement invites you to dig a bit deeper into the potential of capitation with empanelment.

According to this system, patients have to choose the health center where they register. Health centers then receive a prospective fix payment at a given frequency (e.g., each quarter). The payment is kept by the facility even if the patient does not come to the health facility during the covered period.

Capitation with empanelment is seen as having a high potential for better management of chronic conditions, given that it would strengthen the relationship between the PwCC and her/his health center and enables the patient's longitudinal follow-up by providers. This would be beneficial for person-centeredness and continuity of care.

Organizing a capitation system not limited to PwCC might be the ideal goal, but empanelment of everyone may not be a feasible option in most LMICs. Encouraging first the empanelment of people who need longitudinal follow-up, like PwCC, is a reasonable first step for piloting this provider payment model.

2.8.1 — capitation with empanelment



Choices	#
1. not to express myself	3 (6.82 %)
2. i agree	30 (68.18 %)
3. i disagree	4 (9.09 %)
4. agree but flag	7 (15.91 %)
Total	**44**

2.8.2 — explanation (Page 8)

EN
Please specify below:

2.8.2 — explanation

I agree with the principle however there should be an option to establish a national registration system which accommodates for patients to access care in different geographic areas as well as varying levels of care using a common patient identifier. this mobility will enable longitudinal follow-up as they move along care pathways.

17b7b82a answered 1 month ago

I would add the necessity of rigorous evaluation of the pilot projects.

edf03eea answered 4 weeks ago

See also my comment right above. Despite its strong potential, there is no strong evidence about its success so far and if it is to be implemented, I prefer a careful testing and it is not only for chronic care services but also other non-contingencies (preventive or predictable health services), including maternal and child health services, and perhaps the whole primary care services at HCs

7cd5dded answered 4 weeks ago

this is relative: the capitation system itself is not an element that would solve the financing

a8f4759b answered 3 weeks ago

Context with displacement of populations (for whichever reason : conflict, climate, economic, seasonal,...) would need different provisions to ensure displaced or migrating or fleeing PwCC still get access.

db7d89a4 answered 2 weeks ago

Capitation with empanelment and some quality-linked incentive payment would ensure best possible quality outcomes.

bbe6c1f7 answered 2 weeks ago

I agree with this statement, but I want to flag this extra point for your consideration for your report: capitation with empanelment may lead to cherry picking if there is no risk-adjustment. If there is risk adjustment, there may also be gaming behavior in upcoding. So it is important to have some regulation in place.

5e94bb18 answered 1 day ago

2.8.3 — pay-for-performance (Page 8)

EN

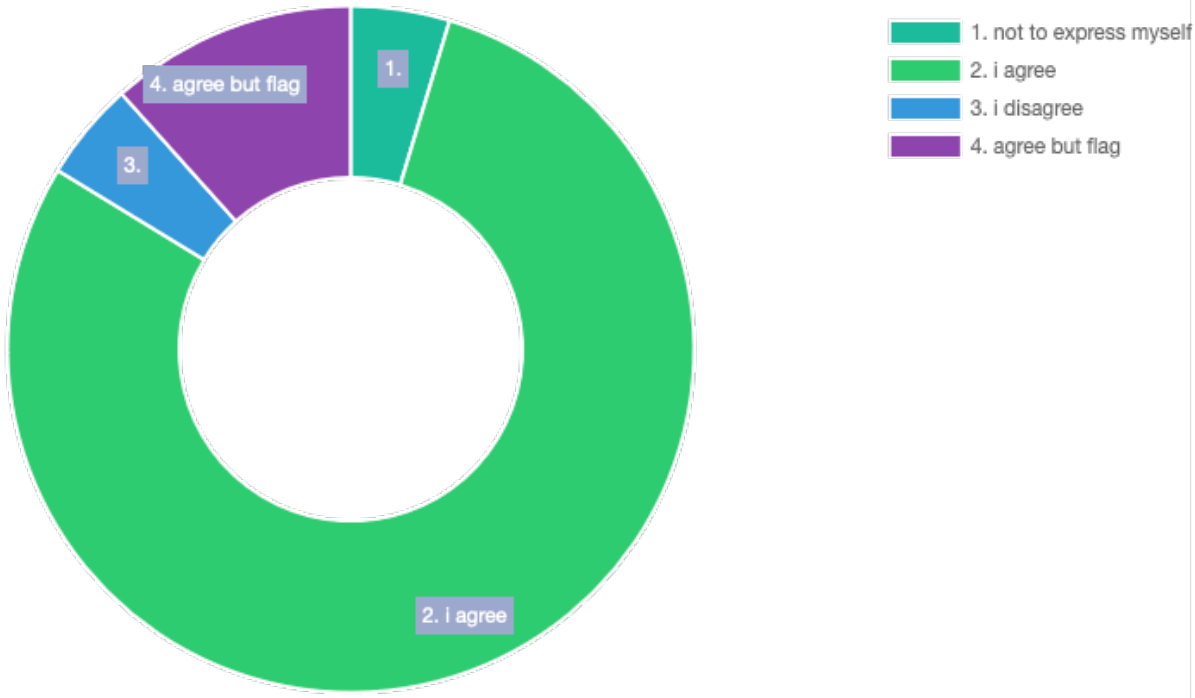
The next statement invites you to be more specific about the potential of pay-for-performance for public health centers.

Experts of the panel were open to different options for rewarding quality.

In places where there is an effective pay-for-performance program, adding some chronic care indicators to the checklist (possibly with a removal of other indicators not bringing value anymore) is an option. A possible first step could be to reward actions which should be done already (e.g., screening pregnant women for hypertension, diabetes and HIV and ensuring the appropriate follow-up). One prerequisite to move in this direction is the establishment of a good individual digital data system.

In general, our experts expect a mixed provider payment approach. They recommend being flexible and on a learning and adaptative mode. They recommend a strong focus on the patient's experience and outcomes.

2.8.3 — pay-for-performance



Choices	#
1. not to express myself	2 (4.65 %)
2. i agree	34 (79.07 %)
3. i disagree	2 (4.65 %)
Total	**43**

Choices	#
4. agree but flag	5 (11.63 %)
Total	**43**

2.8.4 — explanation (Page 8)

EN
Please specify below:

2.8.4 — explanation

I agree that the patients experience must be considered. I dont fully agree with payment for performance as this depends on many variables, many of which are outside the control of both the provider and the patient for example a provider may provide the best care while the context of the patient living in poverty remains unchanged. I propose that a minimum benefits framework is applied and while monitoring inputs at provider level and outcomes at patient level.

17b7b82a answered 1 month ago

While you referred to capitation earlier, now you state mixed provider payment approach. Do you mean performance-based and input-based combination or a combination of capitation for HCs and other for higher level of care? Please specify. But I like the learning and adaptive mode

7cd5dded answered 4 weeks ago

Digital systems need to be considered with care, see previous comment. There are clear advantages and benefits, but there are also risks (malfunction, connection issues, maintenance needs, data protection breaches etc.). Rewarding for screening during pregnancy does not seem to be so interesting: 1. Most of the hypertension, diabetes will be pregnancy related and resolved after delivery. HIV is a must for PMTCT. 2. Giving incentives for a "standard " screening such as in pregnancy might have an opposite effect on other types of screening (eg. malnutrition) if not rewarded with incentives.

db7d89a4 answered 2 weeks ago

Not only P4P, but other payment methods that takes into account performance indicators, should aim to include chronic care indicators.

d123bd0f answered 2 weeks ago

Another pre-requisite you may wish to include is health worker competency (knowledge, skill and ability) to deliver these interventions.

98e18de7 answered 1 week ago

2.8.5 — convergence between capitation and individual data (Page 8)

EN

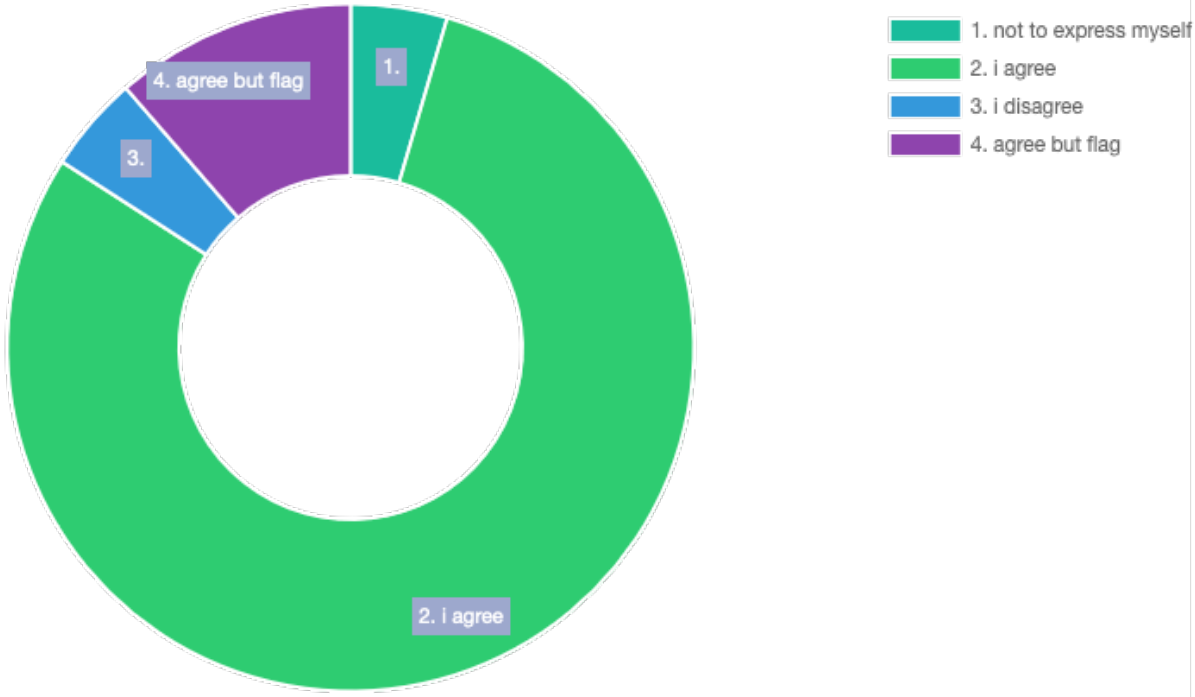
Convergence between capitation and individual data

We would like to get your view on some possible points of guidance for the many countries which will have to upgrade their public health centers to deliver (better) chronic care. We build on the view that actions should not be limited to purchasing arrangements only.

In most settings, the required changes are not limited to the purchasing arrangement: a whole coherent set of changes is needed to capacitate public health centers to provide quality chronic care.

The introduction of the capitation payment (possibly with its pay-for-quality top-up) provides an opportunity to introduce, where it is still absent, a data system allowing longitudinal follow-up of the patient, ideally an electronic health record (EHR) system, i.e. a cloud-based system allowing recording by different providers and facilities, or at least an electronic medical record system maintained at the level of the health center. Ideally, the EHR should tap the unique identifier from the civil registration system. The unique identifier and the EHR could allow the introduction of a capitation with empanelment. Such innovations (i.e., capitation with empanelment and individual digital data system) can and should be piloted at small scale initially.

2.8.5 — convergence between capitation and individual data



Choices	#
1. not to express myself	2 (4.55 %)
2. i agree	35 (79.55 %)
3. i disagree	2 (4.55 %)
4. agree but flag	5 (11.36 %)
Total	**44**

2.8.6 — explanation (Page 8)

EN
Please specify below:

2.8.6 — explanation

I would not push for a "cloud-based" solution, a system does not necessarily need to be cloud based to be able to share information between facilities. I like the idea of piloting this.

9ec4643f answered 1 month ago

I agree fully that an individual system is central to desirable health and developmental outcomes. My observation is that ensuring a system which is aligned to and interfaced with all sources of data is complex but can be achieved for example a system exists which receives a failed HbA1c result; sends the result to a CHW component which enable a visit to explore why the patient failed the HbA1c, to alert the patient to the result and ensure the patient visits a health facility for follow up.

17b7b82a answered 1 month ago

I agree with this statement but wanted to flag that there are also health sector stakeholders (partners, MOHs) that are in parallel advocating for a unique identifier specific for the health sector instead of civil registration, or in addition. In countries where governments are investing in CRVS I find it counterproductive for sector specialists/agencies to be advocating for establishment of parallel systems and using needs/scenarios like EHR/EMR short-term requirements to advance their agenda to the detriment of the CRVS agenda.

48319912 answered 1 month ago

I would mention the importance of data protection here particularly if cloud based solutions are planned. Unfortunately, the need for cybersecurity imposes additional costs and the need for highly qualified personnel.

edf03eea answered 4 weeks ago

Similar to my comment above, you may wish to include health worker competency (knowledge, skill and ability) to support the delivery of continuous / longitudinal care, including competency in the use of digital technology. In addition, while the electronic data system can help supporting patient monitoring / follow up, digital technologies are only a means to delivering continuous care. Continuous care requires other actions such support (leadership, managerial and financial) to health workers to innovate and deliver this type of care.

98e18de7 answered 1 week ago

○ 2.8.7 — on other actions to upgrade public health centers (Page 8)

EN
The introduction of the capitation scheme should also go with an assessment of the technical expertise in the health center. Often it will confirm the need for an upgrade of knowledge across the health center team. Some specific trainings addressing key skill gaps, including most probably how to teach the PwCC how to self-manage her/his condition and how to use the patient file system, will have to be implemented.

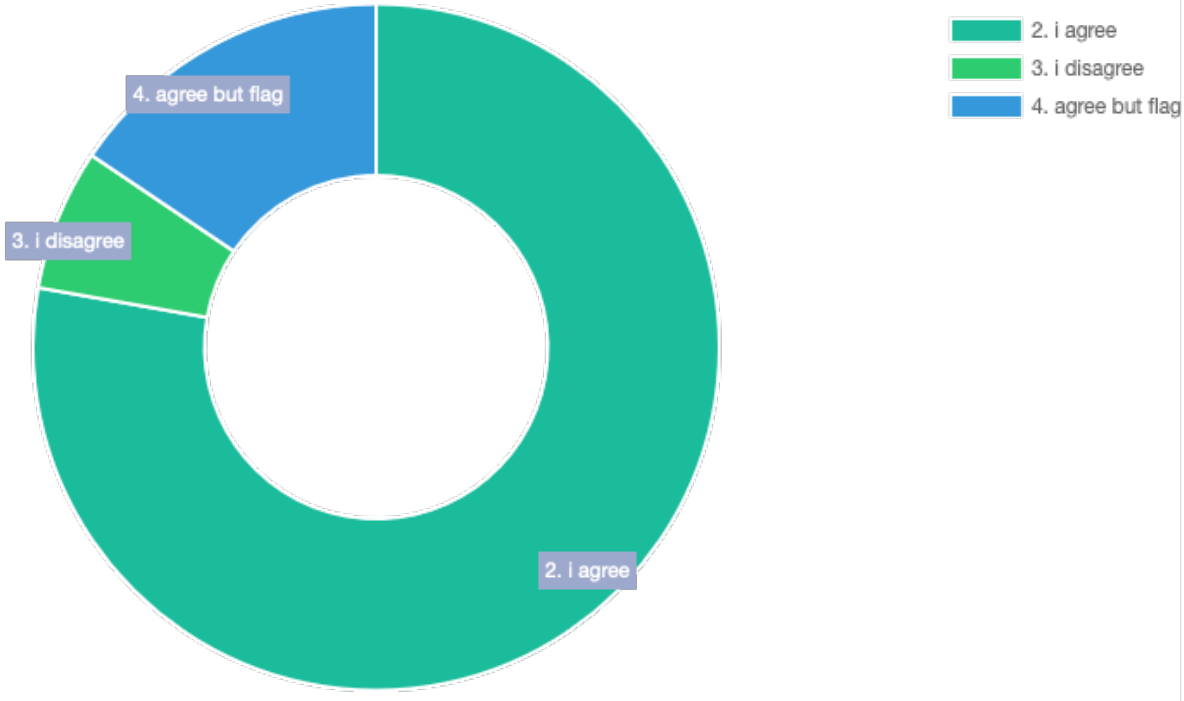
If CHWs are involved in the service delivery, the intervention will also have to consider how they will synergistically support the health center in its central role of health care management (this strengthens the case for an EHR system, with a smartphone component for CHWs).

Availability of medicines at the health center will be key for building a credibility in chronic care management. The intervention also offers the opportunity to review the essential drug list and the procurement system to ensure availability of required medicines at the health center level. List of medicines can be longer in health centers with a medical doctor.

If, because of the weaknesses of public health centers, PwCC have developed the habit to go to private facilities or to hospitals for their chronic conditions, the pilot project will also have to implement an integrative system reassuring PwCC on the benefits to get some services at health center level. Having at least one medical doctor can be an asset for the credibility of the health center.

There are various guides, including by WHO (e.g., the PEN strategy), which can help to organize a national plan and to inspire the design of a pilot project.

2.8.7 — on other actions to upgrade public health centers



Choices	#
2. i agree	35 (77.78 %)
3. i disagree	3 (6.67 %)
4. agree but flag	7 (15.56 %)
Total	**45**

2.8.8 — explanation (Page 8)

EN
Please specify below:

2.8.8 — explanation

Rather than having a "doctor" it may be more important to have staff at any level that is trained in NCD care.

edc53c5f answered 1 month ago

I agree that appropriate care pathways must be encouraged. You may also consider models which are aligned to but not the same as WHO PEN, for example the Adult Primary Care Tool is considered as this tool is located within an Integrated clinical services management model.

17b7b82a answered 1 month ago

Not realistic to have one medical doctor per PHC in many countries. Could explore what services can be provided at PHCs with just nurses, vs. PHCs with doctor. Then for those PHCs without a medical doctor, establish teleconsultation between PHC and facility level where doctor is for NCD patient consultations and follow up. Could be linked with EMR if also in place or under development and part of the PPM and assessment of quality of care and application of SOPs for different categories of health facilities. For example, at a PHC without doctor, nurses will schedule patient-nurse-doctor teleconsultation with medical doctor at secondary hospital. Services at PHC could not be purchased at all or deducted for incomplete provision of service package in the event the teleconsultation not completed. Incentives and HR requirements at hospital level would need to be explored and monitored to see volume of TC vs. availability of staff to do them at hospital level.

48319912 answered 1 month ago

in addition, training in personnel and financial management will be required

c5a7f16f answered 3 weeks ago

I agree with all of this statement EXCEPT the paragraph starting "If, because of the weaknesses of public health centers ..." The other statements are accurate and generalizable. The paragraph on what happens when public health centers are "weak" is speculative, sterotyped, and not accurate to most contexts.

b0dba773 answered 3 weeks ago

Guidelines like WHO PEN are fine for knowing what should be done and what items should be available. But I think winning the public trust will also require finding ways to make sure that these things get done and that the experience of seeking care in a public facility is less unpleasant.

495ce785 answered 2 weeks ago

You may wish to also consider adding: - Availability of diagnostics (in addition to medicines) - Continuous quality improvement (e.g. PDSA cycles), driven by health facility and patient data - Related to the above, appropriate scope of practice (for health workers) and health facility accreditation (e.g. measures to support quality of care at facility level) may also help provide a vision for quality chronic care management Also: having a medical doctor may improve the credibility of the health centre in some contexts; however, a well-trained and skilled nurse (especially advanced nurse practitioners) also has the ability to manage patients with chronic care.

98e18de7 answered 1 week ago

2.9.1 — Private not-for-profit facilities (Page 9)

EN

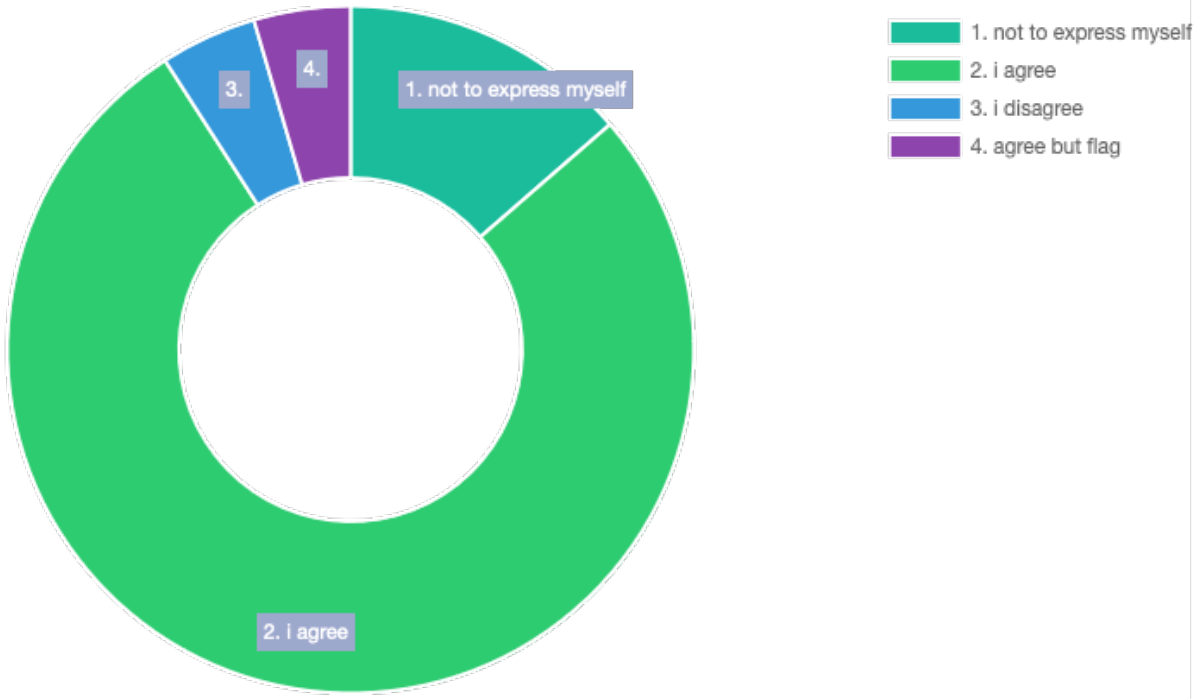
The next two statements build on your answers and many comments to the questions specific to these providers.

Private not-for-profit and private for-profit providers. Our experts have also been asked about conditions to be put on **private not-for-profit and private for-profit providers** before any reimbursement by some pooled fund managed by the public authorities (e.g., social health insurance, budget). Our panel recommends **the purchasing agency to be strict on both the eligibility criteria and the mechanisms to ensure accountability.**

Private not-for-profit facilities

As for the contracting and payment arrangement, possible options for private not-for-profit facilities include a multi-year block grant contract (with obligation for the facilities to report frequently, including with a narrative report) or different variations of a capitation system. If the private not-for-profit facility is a center specialized in chronic diseases, the capitation could be with an empanelment of PwCC. Monitoring of performance should be in place and a pay-for-performance can be considered. Ideally, the latter should focus on outcomes (disease under control). Such an advanced payment system requires a reliable EMR, and probably a supportive leadership. If the center is a specialized center, the purchasing agency should make sure that the arrangement clearly identifies the systemic role assigned to the center, and ensure its commitment to the best integration with the rest of the health system, including public health centers and hospitals. Adoption of the EHR system used by public facilities (or at least interoperability) could be put as a requirement, but integration should also be sought on service delivery (e.g., diagnosis) and many other aspects (supervision, peer exchange, training, research, etc.).

2.9.1 — Private not-for-profit facilities



Choices	#
1. not to express myself	6 (13.64 %)
2. i agree	34 (77.27 %)
3. i disagree	2 (4.55 %)
4. agree but flag	2 (4.55 %)
Total	**44**

2.9.2 — explanation (Page 9)

EN
Please specify below:

2.9.2 — explanation

I still think public-private partnership, mainly through purchasing arrangements, has a strong potential in a context of relatively weak governance. A contract with selected/assessed/accredited private providers by a third party purchaser is an entry point for regulations, access to their data and quality assurance.

7cd5dded answered 4 weeks ago

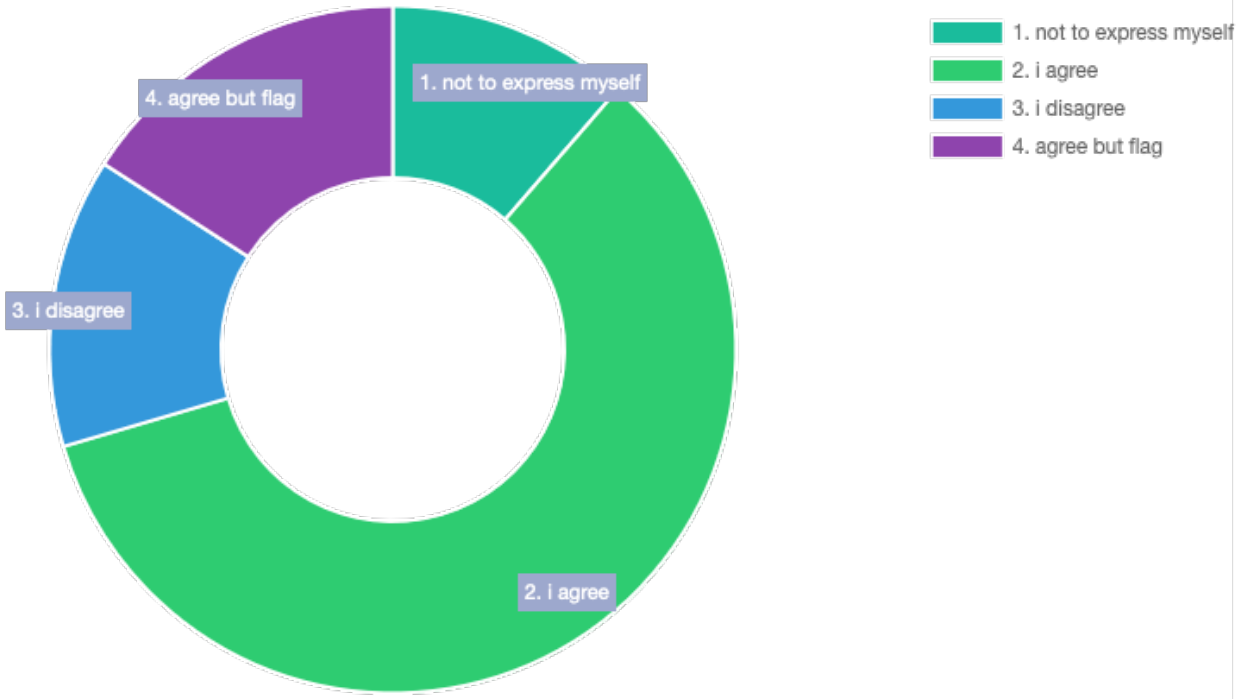
Would consider certain circumstances related to political or economical instability that may prevent multiyear block contracts.

e557abb7 answered 3 weeks ago

2.9.3 — private-for-profit clinics (Page 9)

EN
Our experts recommend being conservative with enrollment of private for-profit clinics under the pooled funding. The objective should be to integrate them more effectively into the whole health system. Their eligibility to reimbursement from the pooled fund should be conditioned on **advanced accountability in terms of transparency and data reporting**. The panel expects that they will request to be enrolled under an output-based payment and this is probably the most acceptable solution.

2.9.3 — private-for-profit clinics



Choices	#
Total	**44**

Choices	#
1. not to express myself	5 (11.36 %)
2. i agree	26 (59.09 %)
3. i disagree	6 (13.64 %)
4. agree but flag	7 (15.91 %)
Total	**44**

2.9.4 — explanation (Page 9)

EN
Please specify below:

2.9.4 — explanation

See my comment right above

7cd5dded answered 4 weeks ago

This may only apply to homogeneous health systems .Not fragmented ones.

e557abb7 answered 3 weeks ago

1. I agree with first two sentences. 2. I think their eligibilty for reimbursement should require much more than transparency and data reporting. It should also require some efforts at accreditation, measurement of quality, etc. 3. I don't see why the private for-profit clinics would ask for output-based payment systems instead of straight "fee for service."

b0dba773 answered 3 weeks ago

I agree totally with this statement to be very conservative about this group because, the main challenge with the private for profit clinics in thr health sector in most LMICs is the fact of regualtory, transparency and accountability mechanisms.

b06feadc answered 2 weeks ago

I do not understand why private for-profit providers cannot also be paid on a capitation basis with a performance component. I suggest that the statement be made clearer in terms of what is meant (examples provided) of an output-based system.

bbe6c1f7 answered 2 weeks ago

In many Latin American countries that have had market-oriented healthcare reforms such as Colombia, Chile, Peru, and many Centro American countries it would be almost impossible to exclude private for-profit clinics of nationwide schemes for better chronic care, particularly in the main cities. Hence, the idea is to establish clear contractual duties and reinforce the stewardship functions of the national and local health authorities. It is very important to limit the participation of private for-profit clinics in the PHC network and to use them more for supportive specialized care and the secondary and tertiary level of care. Differential treatment should be considered for general practitioners working in community settings, which should be integrated into the PHC networks.

c8b8aeb4 answered 2 weeks ago

Outputs in addition to process indicators may be more practical and useful, using the strengths of each to compensate for the other's weaknesses. Depending on the components included.

81dd720d answered 1 week ago

○ 2.9.5 — Capitation for private-for-profit practitioners (Page 9)

EN

The statement below tries to propose a way forward for a capitation system for private-for-profit practitioners.

Offering private practitioners to access funding from the pooled fund under a capitation system should however be considered as a possible option to offer them. This might be appealing to a new generation of medical practitioners who are committed to family medicine. This capitation system for private practitioners has its design costs (e.g., proper costing of the benefit package which will have to be offered for free) and transaction costs (e.g., negotiation with private providers, data monitoring), it should thus be piloted and possibly iterative in its improvement.

2.9.5 — Capitation for private-for-profit practitioners

Choices	#
1. not to express myself	4 (9.09 %)
2. i agree	30 (68.18 %)
3. i disagree	5 (11.36 %)
4. agree but flag	5 (11.36 %)
Total	**44**

2.9.6 — explanation (Page 9)

EN
Please specify below:

2.9.6 — explanation

Something should be mentioned that the costs and approach should not be different from the private not for profit or public system ensure that each sector gets the same amount and is also monitored in the same way.

`9ec4643f` answered 1 month ago

Capitation is an option for primary chronic care, both public and private providers, but integrated in a broader package of primary care (not as a stand alone capitation, expensive and difficult administration).

`7cd5dded` answered 4 weeks ago

Money for private interests?

`a8f4759b` answered 3 weeks ago

This statement strikes me as entirely speculative with no basis in evidence. I think it is more useful to discuss whether capitation is likely to lead to positive outucomes for the public sector (in terms of reducing costs or expanding output).

`b0dba773` answered 3 weeks ago

private for profit are likely to use more or more expensive medication/diagnostics, as they are frequently contacted and supported by pharmaceutical industry. Therefore a capitation system should include looking at prescription in terms of items and frequency.

`db7d89a4` answered 2 weeks ago

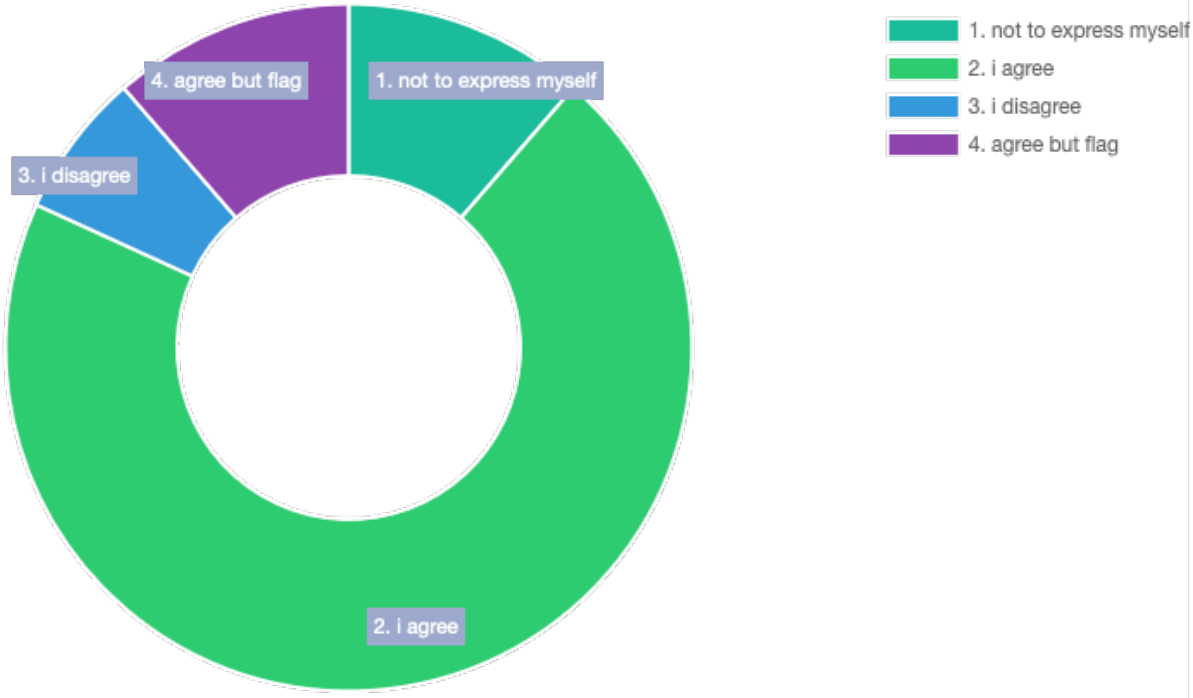
2.9.7 — prescription protocol for chronic illnesses (Page 9)

EN

The statement below tries to propose a way forward for handling over-prescription if private providers are not under a capitation system.

In many countries, requesting private providers to comply with **prescription protocol for chronic illnesses** would probably be very beneficial for the PwCC attending their services. We can anticipate gains in terms of effectiveness, efficiency, continuity, patient-centeredness, accessibility, but also safety. In general, it is recommended that enrollment of private practitioners in a pooled fund is developed with a declared commitment by the purchasing agency to analyze prescription behaviors (see also further on private retail pharmacies). One reason for that is nowadays some of the most expensive medicines relate to chronic conditions. If they are reimbursed by the pooled fund, they can quickly weight heavily on the whole budget.

2.9.7 — prescription protocol for chronic illnesses



Choices	#
Total	**44**

Choices	#
1. not to express myself	5 (11.36 %)
2. i agree	31 (70.45 %)
3. i disagree	3 (6.82 %)
4. agree but flag	5 (11.36 %)
Total	**44**

2.9.8 — explanation (Page 9)

EN
Please specify below:

2.9.8 — explanation

Merely requesting compliance may be insufficient and strong monitoring may be a prerequisite. Monitoring private prescriptions seems very difficult in most LMICs.

edc53c5f answered 1 month ago

I agree but note that the Essential Medicines List (EML) will be a key component of the minimum services benefit package in models being considered.

17b7b82a answered 1 month ago

Based on my experience, commitment to analyze prescription behaviors does not necessarily lead to sanctions/penalties and consequently prevent/mitigate prescriptions. Alternative to capitation, a case-based payment with several case categories, e.g. simple case without complications, case with complications, case with co-comorbidities, each with clear treatment protocols can be considered for piloting

7cd5dded answered 4 weeks ago

In this case there is a need to devise a mechanism to check whether private providers comply with prescription protocol for chronic illnesses

e15461db answered 4 weeks ago

All the actors paid by a central purchasing agency should be obligated to follow standardized treatment protocols. It is instrumental to increase treatment adherence, cost control, and improved coverage and effectiveness at a population level.

c8b8aeb4 answered 2 weeks ago

○ 2.10.1 — the hospital in the whole health system. (Page 10)

EN

The next statement builds on your answers and comments. We have tried to better circumscribe the role of the hospital in the whole health system.

Hospitals have a key role to play in management of NCDs – the seven aims of quality of care are crucial at their level. This is obvious for cancer, for which they are the main platform. They will also handle all the exacerbated cases caused by a prior poor management of the chronic conditions (e.g., strokes, diabetes coma). Strong first line services will ensure that hospitals and their specialized medical staff are not encumbered by the daily management of chronic illnesses. Purchasing arrangements should support a focus of hospitals on investigation and diagnosis (e.g., cancers), intervention and inpatient care.

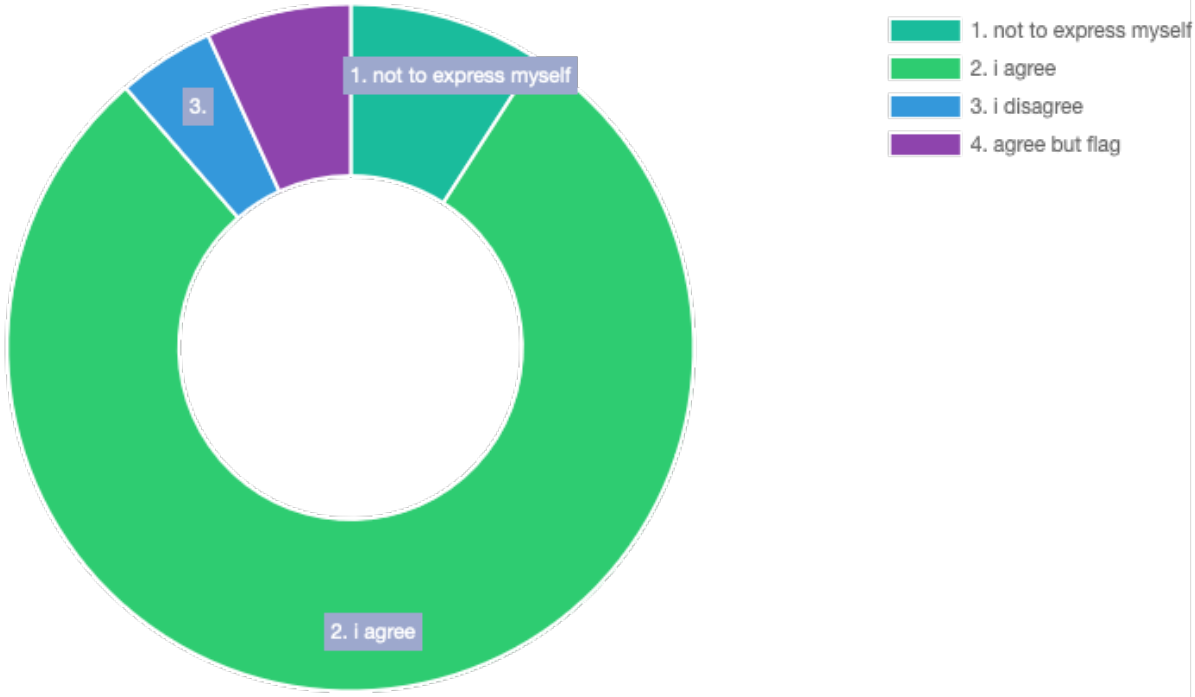
Among our experts, there was a very strong majority for an allocation based on volume (89%), and majorities for paying for quality (70%) and for socio-economic considerations (54%). For linking the payment to the volume, the formula should have the sophistication that the health system can afford. Advanced case-based payment organized around a long list of disease-related groups (DRGs) is not a realistic option for LICs – simplified systems could be explored. Provider payment reforms in those countries should be incremental and chronic conditions will not be the drivers of hospital payment reforms.

For MICs opting for DRGs, technical assistance should be looked for, as the undertaking is quite heavy. It could make sense to embed this reform into a larger hospital reform (e.g., some careful autonomization). NCDs are not the best reason to motivate such reforms, but they should be a matter of attention.

Across settings, provider payment reforms for hospitals should strive for the best integration of hospitals into the whole health system: their contribution to the PHC agenda lies in focusing on what first line services cannot and should not do. They should also play their part in strengthening the continuity of care, including by counter-referral notifications (including for patients who did not know that they had a chronic condition).

Hospital financing in most LMICs will remain shaped by a set of mixed payment mechanisms. Securing the 24/7 availability of services – even during pandemic like COVID-19 – suggests that the permanence of service must be funded.

2.10.1 — the hospital in the whole health system.



Choices	#
1. not to express myself	4 (9.09 %)
2. i agree	35 (79.55 %)
3. i disagree	2 (4.55 %)
4. agree but flag	3 (6.82 %)
Total	**44**

2.10.2 — explanation (Page 10)

EN
Please specify below:

2.10.2 — explanation

Hospitals should be part of robust integrated healthcare networks under the PHC approach. It would assure that hospitals comply with the support function (particularly in terms of specialized care) to the first-line health services.

c8b8aeb4 answered 2 weeks ago

For "Purchasing arrangements should support a focus of hospitals on investigation and diagnosis (e.g., cancers), intervention and inpatient care", I would also suggest adding something on: coordination of care with other health facilities / settings / social services / community-based groups prior to discharge to support continuity of care, transition out of the hospital and restoration of health.

98e18de7 answered 1 week ago

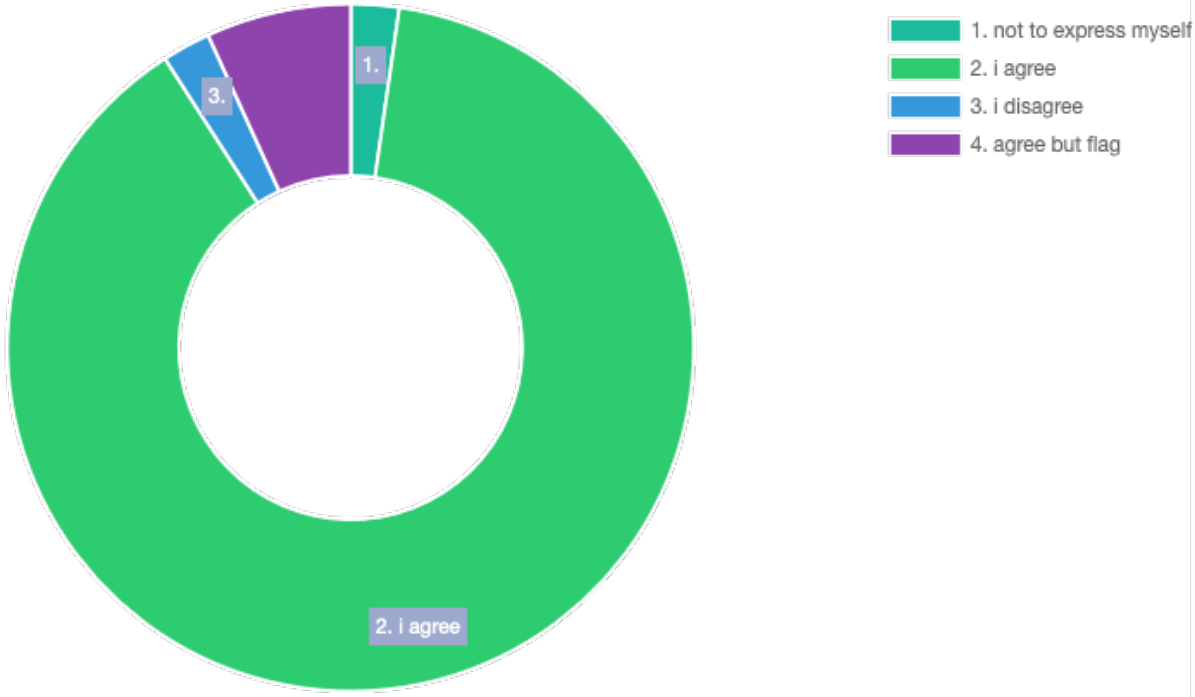
I agree with this statement, but I want to flag this extra point for your consideration for your report. It is worthwhile to pilot payment mechanism that goes beyond single institutions. Some shared savings schemes may be piloted for a local “accountable care organisation” or “medical alliance” incoporating both hospitals and priamry care providers.

5e94bb18 answered 1 day ago

2.10.3 — telemedicine (Page 10)

EN
Our panel of experts welcomed developments in LMICs for **teleconsultation** (understood as patient-to-provider) and **tele-expertise** (understood as professional-to-professional). The benefits of teleconsultation for the PwCC could be in terms of accessibility (e.g., for patients with mobility constraints to visit their first line services) and continuity of care (e.g., possibly to have a medical follow-up and a renewal of prescription, without travel or face-to-face contact, as during the COVID lock-down). The benefits of tele-expertise between a first line provider and a specialist medical doctor are in terms of indirect accessibility to advanced services (for instance, for PwCC living on a small island) and effectiveness (reliability of the diagnosis and appropriateness of the prescription) and efficiency. In many LMICs, just like in HICs, **there is still a need to pilot, document and probably fine-tune several aspects of these solutions**. Pooled funds should learn how to compensate providers doing teleconsultation and specialist doctors advising first line doctors.

2.10.3 — telemedicine



Choices	#
1. not to express myself	1 (2.27 %)
2. i agree	39 (88.64 %)
3. i disagree	1 (2.27 %)
4. agree but flag	3 (6.82 %)
Total	**44**

2.10.4 — explanation (Page 10)

EN
Please specify below:

2.10.4 — explanation

Another option could be a three way appointment: tele-consultation-expertise where patient comes to PHC center for appointment, nurse connects with doctor, and they conduct together. Brings medical doctor closer to patient and primary care nurse and supports continuity of care

48319912 answered 1 month ago

I will add the consultation by WatsApp, not everyone knows how to have a computer, I already do it

c5a7f16f answered 3 weeks ago

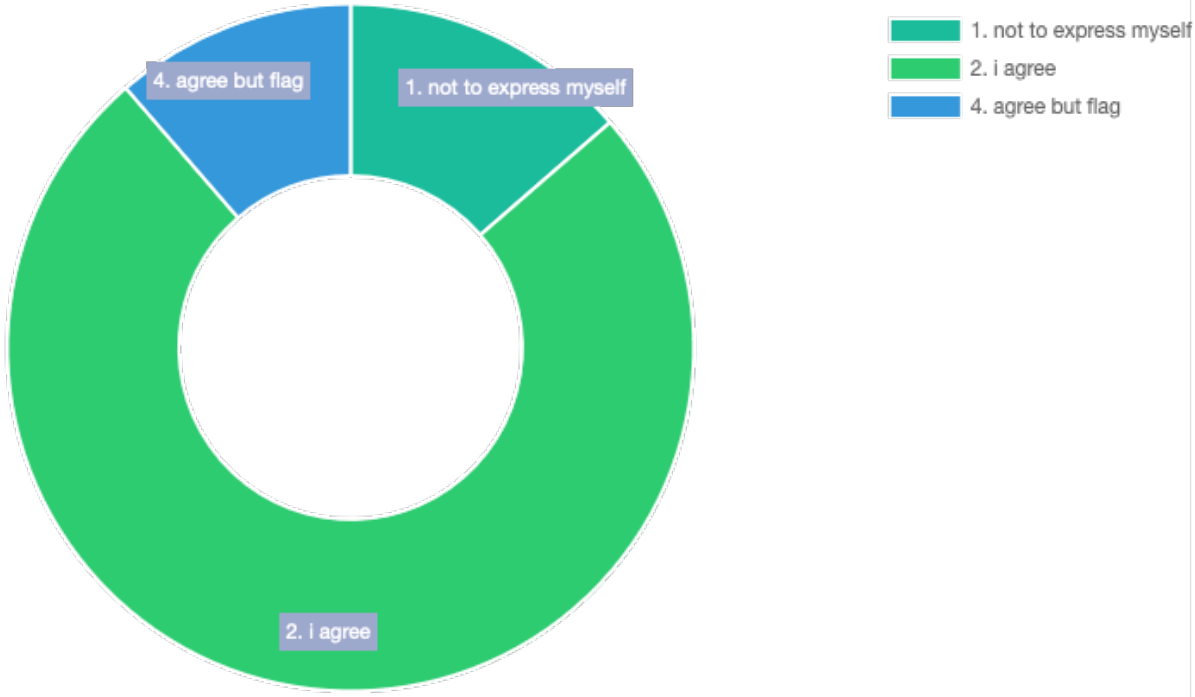
Note that tele-expertise can also be shared between health care teams (e.g. various health professionals) across different care settings, and should not only be limited to doctors.

98e18de7 answered 1 week ago

2.10.5 — private retail pharmacies (Page 10)

EN
In many LMICs, medicines bought at **private retail pharmacies** are not yet covered by pooled funds and are thus paid by patients themselves. There is growing evidence that medicines for chronic illnesses are an important driver of catastrophic health care expenditure. The high out-of-pocket payment burden leads to incomplete and discontinuous therapies not allowing to bring the chronic disease under control. Our panel was asked whether countries should set up purchasing arrangements ensuring coverage by the pooled fund of medicines for chronic illnesses. Again, **our panel was supportive for piloting or scaling up such a solution, but with several caveats**. Our experts assess that retail pharmacies are insufficiently regulated in most LMICs, and in many of them, unregulatable in the current state of affairs. So, only MICs, and probably not all of them, are ready for such a development. For those, the ambition should be that the arrangement covers all the medicines on the national essential drug list, with clear reimbursement rate, through ideally an e-prescription system ensuring that the subsidy is directly charged to the pooled fund and not pre-paid by the patient. This will have to be piloted step by step. Starting with medicines for chronic conditions could be a smart proposition. This is a group of patients for whom an advanced follow-up system is anyway required (see above); thus, the data system might be compatible with what is required by the subsidized medicine scheme. These are also medicines which can be costly for the patients, but also for the whole society – limiting the scheme first to **generics** and securing enough monitoring control are key.

2.10.5 — private retail pharmacies



Choices	#
1. not to express myself	6 (13.64 %)
2. i agree	33 (75 %)
4. agree but flag	5 (11.36 %)
Total	**44**

2.10.6 — explanation (Page 10)

EN
Please specify below:

2.10.6 — explanation

The caveat would be for the above to be complemented by a systematic process for sharping the essential medicine list - one that considers budgetary impact, cost-effectiveness, the burden of disease, and effectiveness, even if only by reviewing the literature. The costs to the government of providing a medicine package can be significant and in many countries, the medicines on the list are influenced by political factors/

6a456bee answered 1 month ago

Perhaps you may consider reviewing/evaluating existing chronic disease medicine distribution systems noting that distribution systems must be linked to close patient monitoring for example patients who are deemed controlled are decanted to a system whereby they receive medication either at their homes or at an accessible point however it was discovered that many of these patients revert to uncontrolled status but fail to receive the necessary medical interventions.

17b7b82a answered 1 month ago

We are referring to the current fact with weak care delivery system and thus people make use of pharmacies as their first level care. I believe that if patients seek care from a provider, they may receive prescription and necessary medicines supplied there. I prefer using pooled fund to finance an integrated package of care, including screening, consultation, diagnosis, counseling, care and treatment including supply of medicines. Please note that when public funding is strong, there is no market for pharmacies, e.g. the case of TB medicines.

7cd5dded answered 4 weeks ago

I disagree with this statement and I will propose setting up a pharmacy for the project or use the one of the sanitary facilities with a window for this type of medication

c5a7f16f answered 3 weeks ago

Issues with private retail pharmacies are not only due to high prices asked or the delivery of medication outside of the national essential drug list, but also the quality of their procurement. So a risk assessment and quality controls should be included to avoid having low quality or fake drugs, before considering purchasing arrangements ensuring coverage by the pooled fund of medicines for chronic illnesses.

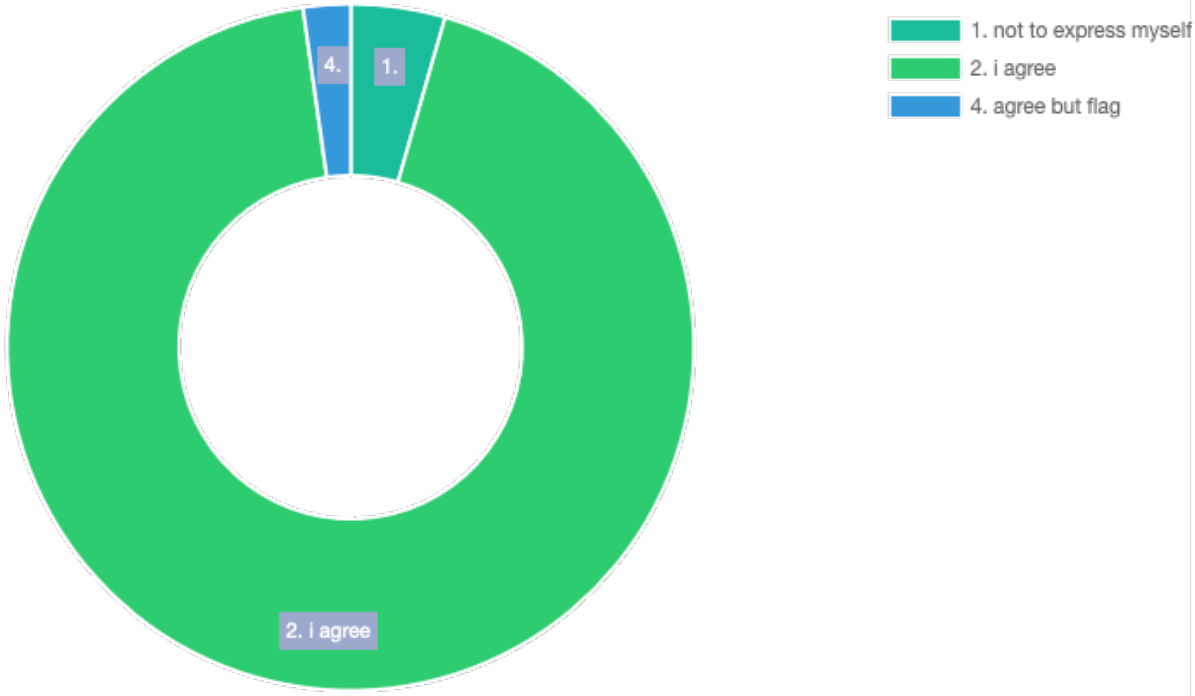
db7d89a4 answered 2 weeks ago

○ 2.10.7 — decentralised coordination bodies (e.g., health di (Page 10)

EN

Our panel believes that **decentralized coordination bodies** will be key to rolling out delivery models supportive of better management of chronic care in LMICs. Required capacities at their level are not specific to chronic conditions, but in most LMICs, coordination bodies like district health offices will have to build a stronger understanding and expertise in chronic illnesses. They will have to develop their capacities in coordination of providers, including towards private facilities and social affairs actors (a weak point in many settings) and learning (especially from the routine information system after its upgrade with the digitalization of patient files). The panel does not call for a revolution in their financing model, but setting a link with some measures of quality might be welcomed in some settings.

2.10.7 — decentralised coordination bodies (e.g., health di



Choices	#
1. not to express myself	2 (4.44 %)
2. i agree	42 (93.33 %)
4. agree but flag	1 (2.22 %)
Total	**45**

2.10.8 — explanation (Page 10)

EN
Please specify below:

2.10.8 — explanation

the decision-makers must do some general direction/recommendations

a8f4759b answered 3 weeks ago

2.11.1 — arrangements aggregating providers (Page 11)

EN
Our experts were also asked to consider purchasing arrangements that aggregate providers together.

Bundled payment:

As a reminder, "bundling" means grouping together several components of health care delivered by several providers for a specific intervention and paying for the whole "bundle" together, e.g., across disciplines and care levels. It provides incentives for the integration of care and patient-centered collaboration and coordination across providers. Bundling is based on the expected costs of a patient's case, an episode, or care over a specified time period, whereby payment is made to a provider network.

Our experts welcome this new way to pay for health services, but acknowledge that the supporting evidence, even in high-income countries, is still limited . Theoretically, the bundled payment model may positively contribute to quality dimensions such as effectiveness, efficiency, continuity and person-centeredness, as it creates incentives for better coordination between the different health care providers but also for investing in teaching PwCC how to self-manage their condition.

Ceiling on aggregate payments:

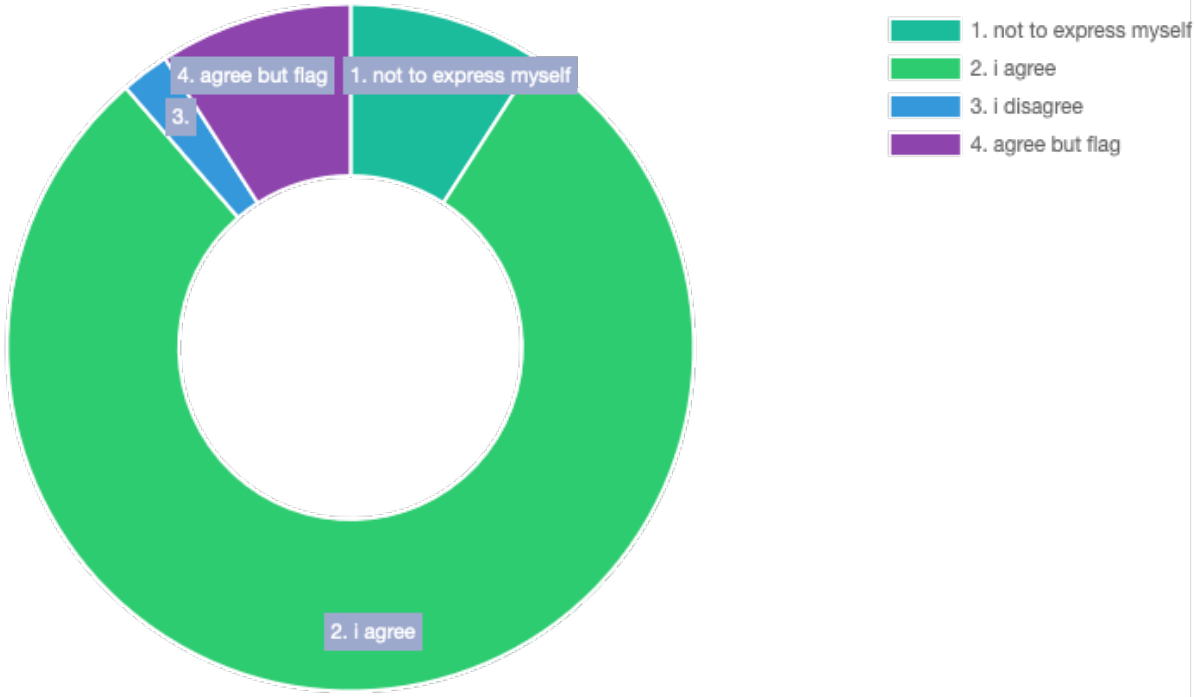
Another strategy is to set a ceiling to the aggregated co-payments paid by the patient across providers for a given time period. Above a given ceiling, possibly set according to the household income, patients are exempted from co-payment (or all co-payments are reimbursed). This solution allows to protect persons with a chronic condition from catastrophic healthcare expenditure and poverty and secures good continuity of care.

The experts also believe that a ceiling on aggregate payments can positively contribute to quality dimensions such as equity, financial accessibility and thus improve continuity and effectiveness of the care management.

Our experts however recommend realism as for the feasibility of these two aggregative models of payment. Their assessment is **that the bundled payment model and the ceiling on aggregate payment are not feasible options in most LICs:** these solutions are too demanding in terms of coordination, data system and financial management to be implemented in poor-resource settings.

Our experts are more positive on the applicability of these two solutions in MICs. They recommend piloting and even scaling up, but only once a proof of concept is available. As for the bundled payment model, they recommend not to initiate it as a stand-alone solution: it should be part of a broader effort in favor of health care integration.

2.11.1 — arrangements aggregating providers



Choices	#
1. not to express myself	4 (9.09 %)
2. i agree	35 (79.55 %)
3. i disagree	1 (2.27 %)
4. agree but flag	4 (9.09 %)
Total	**44**

2.11.2 — explanation (Page 11)

EN
Please specify below:

2.11.2 — explanation

Please note that the more advanced system of payment (though can be ideal), the higher capacity of both human resource, ITC and system is needed, and also the higher cost incurred. So, I prefer a relatively simple method for developing countries

7cd5dded answered 4 weeks ago

Might also be difficult in MICs

e557abb7 answered 3 weeks ago

While bundling arrangements have the potential to make a difference, putting them in place within public services will require undoing existing (often traditional line budgeting) arrangements, and therefore would be difficult to initiate. However, these arrangements can be part of how pooled funds organise their contracts with private providers (for profit and non-profit alike).

560d961f answered 2 weeks ago

I agree with this statement, but I want to flag this extra point for your consideration for your report. I think shared saving schemes across provides may be more helpful in shifting care and resources from hospitals to primary care, in order to achieve better people-centeredness and quality of care.

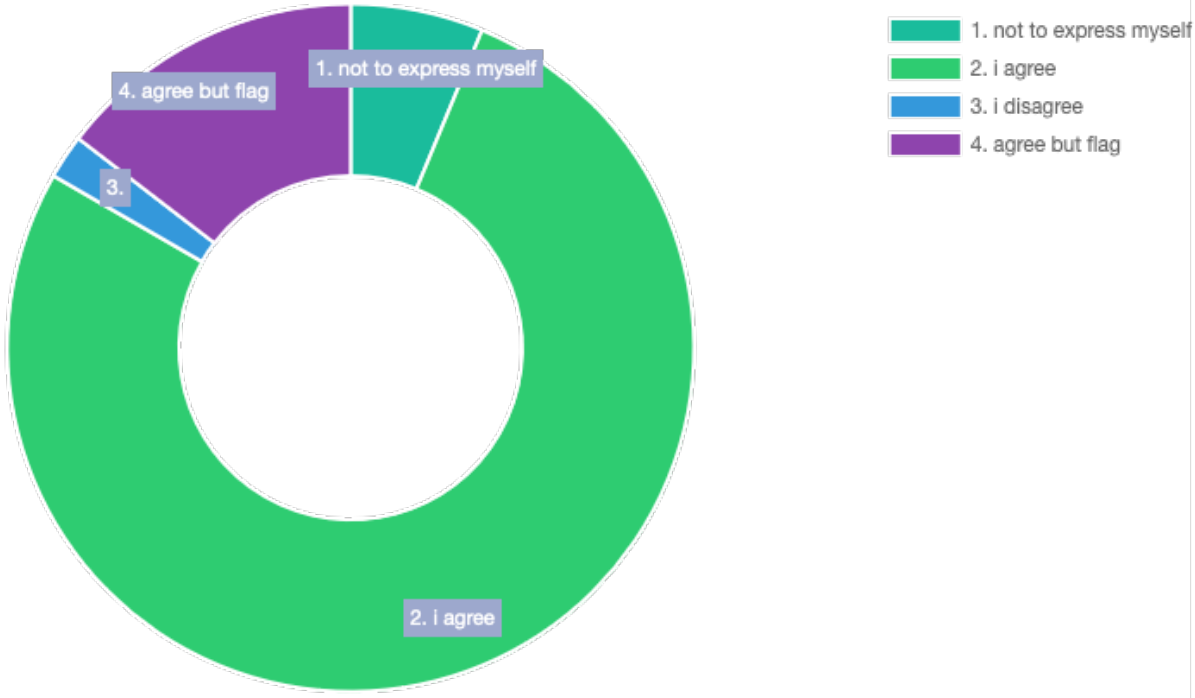
5e94bb18 answered 1 day ago

2.11.3 — purchasing agencies (Page 11)

EN
All these possible modifications to or leveraging of purchasing arrangements for better quality chronic care will require capable purchasing agencies. Our panel of experts assess that in most LMICs, **purchasing agencies** will have to strengthen their capacities. Most purchasing agencies fail to exploit the wealth of data generated by payment systems (and even more, data from other sources). They have been capacitated to process claims and payments, not to generate intelligence for the health system. Often, they do not see themselves as having a role in influencing the quality of care.

Several of the paths for action listed in this document (e.g., introduction of capitation system at health center level, better monitoring of private facilities, analysis of medicine prescription) do require that countries strengthen their purchasing agencies. This can be done step-by-step on a learning mode, with the support of the broader knowledge ecosystem. The latter will be particularly key for securing efficiency at system level, thanks to health technology assessment. Determination of a national benefit package will also contribute to equity and enhance the possibility to enforce guidelines to the benefit of effectiveness and safety.

2.11.3 — purchasing agencies



Choices	#
1. not to express myself	3 (6.25 %)
2. i agree	37 (77.08 %)
3. i disagree	1 (2.08 %)
4. agree but flag	7 (14.58 %)
Total	**48**

2.11.4 — explanation (Page 11)

EN
Please specify below:

2.11.4 — explanation

I fully agree with the step by step/learning mode statement as two terms that seem to be thrown around quite a lot these days (at least in the countries where I work) are HTA and national benefit package, and unfortunately interpreted by governments (finance, health, social protection) as things that can be done quickly and are not

heavily resource dependent. Short/medium term activities (say update reimbursement rates for an existing social health protection scheme for the poor where we know rates are too low for facilities to procure sufficient meds for chronic patients/NCD care) are ignored or become muddled with the longer term processes. Not sure who continues to push ideas like this but feel there needs more work on sensitizing and ensuring our clients actually understand implications of proposing HTA or NBP processes in terms of timeline and resources and balance what we think we can do in the short term to improve health outcomes of the poor and vulnerable while planning for these longer more resource intense processes/ambitions.

48319912 answered 1 month ago

WHO and us as expert panel should make more emphasis on the importance of management. It would be sad if our report would be limited to only theoretical statements. We have to encourage application by improving the stewardship and managerial capacity of health actors, particularly health authorities and the purchasing agencies, and financially responsible entities (teams) at the macro, meso, and micro levels. The further step could be to propose a set of implementation research following the panel recommendations in the diverse WHO regions. Please take me into account if you consider such an initiative useful and feasible.

c8b8aeb4 answered 2 weeks ago

This is an important issue. Indeed, purchasing agencies need to be nudged to see themselves as having a role in influencing the quality of care. This must however be balanced against the tendencies of purchasing agencies to overreach and to try and control everything and become too big for their boots. Limiting their mandates to perhaps accounting+ and keeping a focus on the core functions may help ensure that purchasing agencies do not step on other powerful actors' toes, and thus do not get mired in unnecessary and often paralysing power politics. Purchasing agencies must squarely and explicitly sit under and be answerable to existing stewardship mechanisms of the health system, the public finance system, the public administration system, the research system, and crucially, the political system.

560d961f answered 2 weeks ago

You may wish to consider adding that qualitative data (in addition to quantitative data) on patient experience, caregiver experience and health worker experience are also important for ensuring that the design and care provided to PwCC is responsive to their needs and preferences. Therefore, collaboration between purchasing agencies and those conducting 'health policy and systems research' is an important way forward.

98e18de7 answered 1 week ago

I agree with this statement, but I want to flag this extra point for your consideration for your report: Purchasing is not just about HTA and benefit package design. Monitoring and regulation is critical, it also requires medical expertise that may be expensive to develop. Thus it is important to have a sustainable pool of expertise that form the basis of a learning system.

5e94bb18 answered 1 day ago
