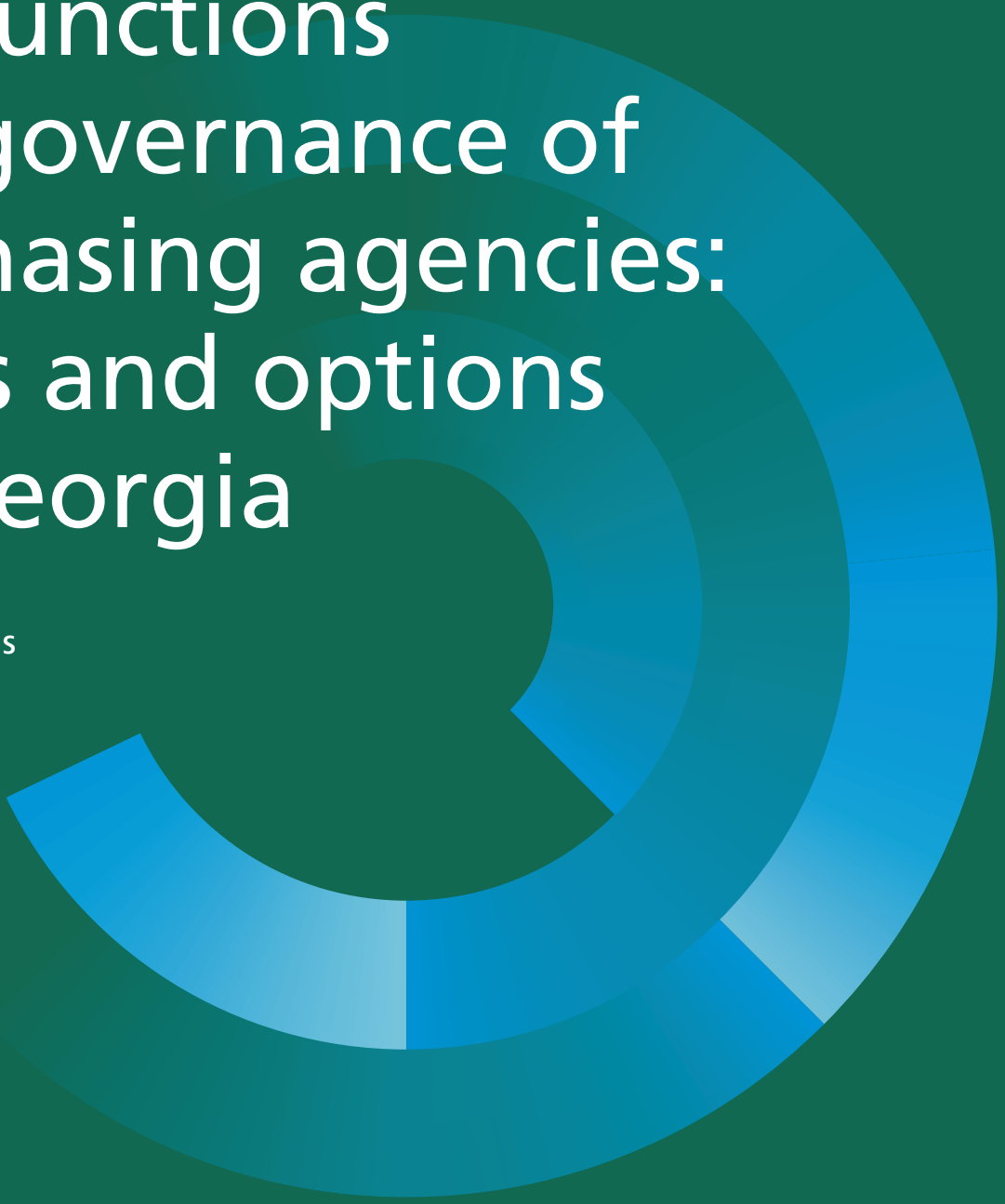
World Health Organization
REGIONAL OFFICE FOR Europe

The functions and governance of purchasing agencies: issues and options for Georgia

Loraine Hawkins



Georgia

Health Financing
Policy Papers

WHO Barcelona Office for Health Systems Strengthening

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). We work with Member States across WHO's European Region to promote evidence-informed policy making.

A key part of our work is to assess country and regional progress towards UHC by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals.

We support countries to develop policy, monitor progress and design reforms through a combination of health system problem diagnosis, analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience. Our office is also the home for WHO training courses on health financing and health systems strengthening for better health outcomes.

The WHO Barcelona Office is part of the Division of Health Systems and Public Health of the Regional Office for Europe. Established in 1999, it is supported by the Government of the Autonomous Community of Catalonia, Spain.

World Health Organization
REGIONAL OFFICE FOR Europe

The functions and governance of purchasing agencies: issues and options for Georgia

Loraine Hawkins

Health Financing
Policy Papers

Abstract

This paper discusses the key functions and governance structures of purchasing agencies in single-payer health systems. It is based on policy discussions that took place between WHO and the Ministry of Labour, Health and Social Affairs in Georgia following the introduction of major reforms to the Georgian health system in 2013. This paper summarises those discussions. It draws on case studies of other countries deemed relevant to Georgia's circumstances, noting some distinctive challenges Georgia faces in strengthening purchasing because of the dominance of private for-profit health care providers that currently face very light regulation. Although the starting point for the paper's analysis is the situation in Georgia, its contents are relevant to debate about the functions and governance of purchasing agencies in other countries at all stages of economic development. The paper concludes that the extent of independence and decision-making authority given to a single purchaser needs to be commensurate with its level of capacity and accountability. To guide detailed decisions on the legal model, governance, powers, functions and structure of a purchasing agency, a government first needs to clarify its vision for the agency, recognizing that it may take time to build up capacity for active, strategic purchasing.

Keywords

Single-Payer System
Insurance, Health - organization and administration
Georgia

Address requests about publications of the WHO Regional Office for Europe to:

Publications
WHO Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø, Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office website (http://www.euro.who.int/pubrequest).

Contents

Figures

Tables

Acknowledgements

This report was prepared by the WHO Barcelona Office for Health Systems Strengthening under the overall direction of Hans Kluge, Director of the Division of Health Systems and Public Health of the WHO Regional Office for Europe. The report was written by Loraine Hawkins, WHO consultant, commissioned by Matthew Jowett, Senior Health Financing Specialist, WHO Barcelona Office, and edited by Sarah Thomson, Senior Health Financing Specialist, WHO Barcelona Office. The production process was coordinated by Juan García Domínguez, WHO Barcelona Office. The report benefited from financial assistance from the Department for International Development of the United Kingdom and we thank them for their support.

Executive summary

Internationally, health systems display a spectrum of possible roles for a purchasing agency. At one end of the spectrum, the agency could be given a limited role as an operational arm of the ministry responsible for health: the agency simply implements health financing policies designed by the ministry. At the other end of the spectrum, the agency could be given a larger role as an active purchaser of health services, with the objective of using health financing policies and levers to shape the health sector and drive health sector performance. In some countries there has been a gradual change in the role of the purchasing agency over time, moving from a limited, passive and mainly financial role to a more active, strategic role.

There is no clear evidence in favour of any one role – there are risks and benefits in giving an independent purchasing agency an active purchasing role (notably the risk of conflict or competition with the ministry over policy and strategy) and in retaining strategic responsibility in the ministry and giving the purchasing agency a narrower role (notably the risk that provider contracting and payment policies are not used to maximum effect). What seems to be most important is coherence and consistency in design: that is, matching the degree of independence and decision authority given to the purchasing agency with its accountability and capacity.

If the government has a vision for its purchasing agency to become an active purchaser – financially accountable and also accountable for improving access and health service quality – the agency will need greater independence and authority or influence over health financing policies and strong technical capacity. It is likely to take time to develop the necessary capacity for the purchasing agency to play this role.

If the purchasing agency is independent from the ministry responsible for health, there are lessons to be learnt from international experience about the importance of maintaining policy coordination and coherence with the ministry and establishing clear accountability to a strong, active supervisory structure. The legislation and regulations for the purchasing agency will need to clarify roles and responsibilities and strengthen accountability and coordination with the ministry. It should also build in mechanisms for stakeholder consultation and participation.

Georgia faces distinctive challenges because of the dominance of private for-profit health care providers that currently face very light regulation. The legislation establishing a purchasing agency is likely to need to include provisions to enable the government and the purchasing agency to regulate private health care providers who offer services under publicly financed health coverage and to require them to disclose the information needed to ensure transparency and accountability for public expenditure on health. At the same time, legislation and regulations need to provide some protection for private providers from underpayment and late payment by the purchasing agency.

The Estonian Health Insurance Fund and Thailand's National Health Security Office provide examples of high-performing purchasing agencies with good governance in a middle-income country context. Key success factors identified in studies of these purchasing agencies can be summarised as follows:

- Give the purchasing agency clear, focused objectives in legislation, regulations and internal statutes.
- Design legislation and regulations for the purchasing agency that match its authority and accountability.
- The legal framework and supervisory board for the purchasing agency need to ensure the agency coordinates with the health ministry and the finance ministry and make it clear that the health ministry has leadership on policy, even though the purchasing agency may undertake policy analysis and put policy initiatives to its board and, via its board, to the health ministry.
- A credible and firm budget constraint is needed to help motivate the purchasing agency to negotiate lower prices and seek efficiencies from providers; setting clear criteria and procedures for drawing on any reserves is an important aspect of financial accountability.
- Having a supervisory board with independence, balanced membership and a strong focus on performance monitoring and feedback to management helps to focus the purchasing agency on balancing its budget, operational efficiency and ensuring access to and availability of health services.
- Performance goals and requirements for reporting to the board on access and service availability are critically important to ensuring the purchasing agency focuses on improving health services and responsiveness to beneficiaries.
- Transparency, credible data and good health information systems are key.
- Open, competitive appointments for purchasing agency managers and staff and flexibility over labour contracts are important for ensuring strong managerial and technical capacity.

Above all, coherent and coordinated decision-making and policy stability are needed to allow for effective implementation of a new single purchasing agency.

1. Background

At the end of 2012, the Government of Georgia took on responsibility for purchasing publicly financed health services, a role that had previously been delegated to private for-profit insurance companies. From the beginning of 2013, the Social Service Agency (SSA) in the Ministry of Labour, Health and Social Affairs (MOLHSA) took over the purchasing function under the government's new universal health care (UHC) programme.

Following a request from the MOLHSA in 2013, the WHO Regional Office for Europe – through the WHO Barcelona Office for Health Systems Strengthening – provided technical advice and took part in policy discussions on different options for the governance of purchasing in Georgia. This Health Financing Policy Paper summarises those discussions. The discussions drew on international experience while taking account of the Georgian context. Although the starting point for the paper's analysis is the situation in Georgia, its contents are relevant to debate about the functions and governance of purchasing agencies in other countries at all stages of economic development.

The paper discusses the key functions and governance structures of purchasing agencies in single-payer health systems. It draws on case studies of other countries deemed relevant to Georgia's circumstances, noting some distinctive challenges Georgia faces in strengthening purchasing. It highlights the experience of the Estonian Health Insurance Fund (EHIF), which is seen as being of particular relevance to Georgia given similarities in institutional history and reform objectives and positive assessments of the EHIF.

2. The role and objectives of a purchasing agency

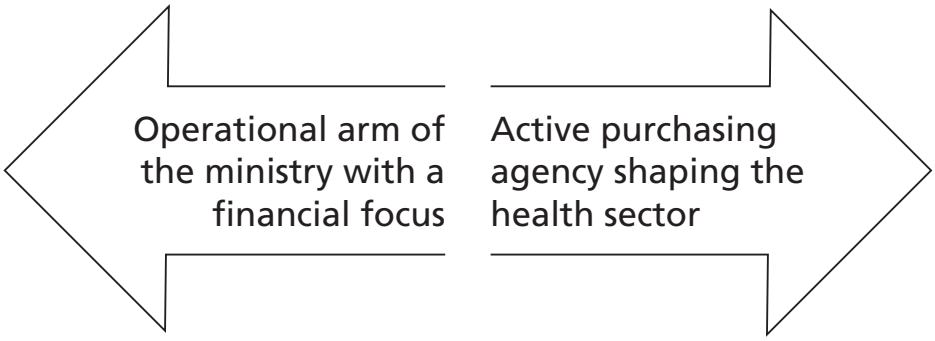
2.1 What role for the purchasing agency?

Internationally, health systems display a spectrum of possible roles for a purchasing agency. At one end of the spectrum, the agency could be given a limited role as an operational arm of the ministry responsible for health: the agency simply implements health financing policies designed by the ministry. At the other end of the spectrum, the agency could be given a larger role as an active purchaser of health services, with the objective of using health financing policies and levers to shape the health sector and drive health sector performance. Figure 1 depicts both ends of this spectrum. In some countries there has been a gradual change in the role of the purchasing agency over time, moving from a limited, passive and mainly financial role to a more active role.

There is no clear evidence in favour of any one role – there are risks and benefits in giving an independent purchasing agency an active purchasing role (notably the risk of conflict or competition with the ministry over policy and strategy) and in retaining strategic responsibility in the ministry and giving the purchasing agency a narrower role (notably the risk that provider contracting and payment policies are not used to maximum effect). What seems to be most important is coherence and consistency in design: that is, matching the degree of independence and decision authority given to the purchasing agency with its accountability and capacity (Savedoff and Gottret 2008, Jesse 2008). To guide detailed decisions on the legal model, governance, powers, functions and structure of a purchasing agency, the government first needs to clarify its vision for the agency – where it would like the agency to be on the spectrum depicted in Figure 1 – recognizing that it may take time to build up capacity for active purchasing.

Fig. 1. The role of a purchasing agency: spectrum of options

Source: Author



The government's vision for the purchasing agency has implications for the role of the health ministry and the finance ministry. If the purchasing agency has no authority over health financing policies or other policies that drive health expenditure for the covered population, it is more difficult to hold it accountable for financial sustainability or access. In this scenario, the health ministry will need to play a much larger role and have much greater responsibility for shaping the health system and driving performance. The health ministry (with the finance ministry and the Cabinet) will be responsible for ensuring that health financing policy commitments are consistent with the budget allocated to the purchasing agency. The health ministry is also likely to have to play a more hands-on role in monitoring the agency's performance in managing expenditure. Conversely, if the government wants the agency to be responsible for financial sustainability and for ensuring access to health services, the agency will need to be given some authority to design and use health financing policies so as to manage expenditure within its budget.

2.2 The purpose and objectives of a purchasing agency

Legislation establishing a purchasing agency should clarify key elements of the government's vision for the agency. Aspects of the purpose of the agency that are usually included in legislation include the following:

- Population coverage – the people for whom the agency is responsible for purchasing health services.
- The role of the agency as a single purchaser for a defined benefits package.
- Whether the agency is permitted or not permitted to provide health services.
- The objectives the government wants the agency to pursue; these statutory objectives provide the basis for monitoring the agency's performance, and usually include:
  - Financial protection of beneficiaries
  - Fiscal sustainability of the agency
  - Access to and availability of health services
  - Maintaining and improving quality in health service delivery
  - Promoting efficient and effective health service delivery
  - Promoting improvement in the health of the population
  - The agency's own internal administrative efficiency

In well-governed purchasing agencies, the supervisory board or board of directors sets goals and targets and a monitoring framework for the agency, to monitor the agency's performance based on its statutory objectives. Legislation in some countries (eg England) provides for the Minister of Health to issue annual or multi-year objectives and directives to the purchasing agency, which are published. Table 1 illustrates the main goals and monitoring indicators used by the supervisory board of the

Estonian Health Insurance Fund. If the agency does not have a supervisory board, the health ministry would usually take responsibility for monitoring performance, or share this responsibility with the MOF.

Table 1. Monitoring framework for the Estonian Health Insurance Fund

Indicators	Balanced scorecard, goals and targets approved by the supervisory board
Access	Waiting times for services; survey of beneficiary satisfaction with access; use of services; household survey of income and living conditions – barriers to access
Financial protection	Level of out-of-pocket payments (OOPs), coverage
Financial balance	Did EHIF need to draw on its reserves?
Administrative efficiency	Administrative costs no more than 2% of budget

Source: Jesse (2008)

2.3 Legal status and governance

It is desirable to adopt a legal form and external and internal regulations that give the purchasing agency managerial freedom over its human resources (HR) management, internal organizational structure, planning and budget formulation, subject to checks and balances.

Checks and balances may include:

- Regulations to set upper limits on the administrative budget and the remuneration of staff.
- Requirements for the agency's supervisory board or the health ministry or Cabinet (depending on the governance structure adopted) to approve HR policies, plans, budgets and reports.
- Requirements for public consultation and stakeholder consultation on policies and plans.
- Requirements for joint ministry or government approval of some policies (discussed in more detail below).
- Provider mediation and beneficiary complaints or appeals mechanisms.
- Including the agency's expenditure plans in the national budget, for approval by parliament (although it is important for the agency's budget to be presented in output-based programme categories rather than input-based line items and for there to be appropriate flexibility over in-year reallocation of the budget to respond to changes in demand for health services).
- External and internal audit.

- Duties to publish plans and reports.
- Duty to disclose information under Freedom of Information legislation.

There are several broad options for legal form and governance structures. The options listed below all involve the establishment of some form of state institution as a separate legal entity. Under all of these options, the purchasing agency would have a budget that is separate from the health ministry budget and would operate with greater financial and managerial autonomy than a ministry or other budget entity. The options differ in governance structure and in terms of relations with the health ministry.

1. Purchasing agency subordinate to the health ministry, with no board: Under this option, the purchasing agency is a state institution, subordinate and accountable to the health ministry. The director of the agency may have the status of deputy minister or deputy permanent secretary. This model exists in Lithuania and was adopted successfully in the Kyrgyz Republic before 2009. The director may be appointed by the health minister or by the Cabinet on the recommendation of the health minister or on the recommendation of a government appointments commission.

2. Purchasing agency subordinate to the health ministry, with a supervisory board chaired by the minister responsible for health: Under this option, the purchasing agency is a state institution with a supervisory board chaired by the minister responsible for health. This model exists in Estonia, Thailand and the Philippines, among other countries. Under this model, it is good practice for legislation to stipulate clear criteria and transparent processes for the appointment of board members, which may combine appropriate expertise and stakeholder representation. Under this model and under options 3 and 4, the board usually approves the appointment of the director (or chief executive officer) and deputy directors of the purchasing agency. It is good practice for appointments to be made after open competition, based on the recommendation of a government appointments commission.

3. Purchasing agency subordinate to the government as a whole, with a supervisory board chaired by a representative of the Prime Minister (eg a Deputy Prime Minister) or an appointee of the Cabinet or a government appointments commission: Under this option, the purchasing agency is a state institution with a supervisory board subordinate to the government rather than the health ministry. This can lead to unclear accountability, if no one minister has responsibility for oversight. If the responsible minister is the Prime Minister or Deputy Prime Minister, supervision may be weak unless that minister is supported by full-time technical staff with appropriate health and health financing policy capacity to provide analysis and support to the minister.

4. Purchasing agency subordinate to the government as a whole, with a supervisory board made up of stakeholders: Under this option, the purchasing agency is a state institution with a supervisory board subordinate to the government rather than the health ministry. The board is made up of defined stakeholder representatives. The board may elect its own chair or, alternatively, the chair may be appointed by the Cabinet or a government appointments commission.

There is no clear international evidence to suggest that one of the above options performs better than the others in all contexts. Good and bad

examples of all options can be found. All options can be made to work well, if good practices for governance are adopted. The preferred option depends on the government's vision for the purchasing agency and on the context. Table 2 sets out the advantages and disadvantages of each option.

Option 1 is more commonly found in countries where most public funding for the health system comes from the government budget. In these countries, the health ministry and purchasing agency must cooperate closely in formulating and negotiating the annual budget for health. The Lithuania Health Insurance Fund and the Kyrgyz Republic Mandatory Health Insurance Fund (up to 2009) provide examples of option 1 that have achieved reasonable success in moving towards universal health coverage and supporting health reform implementation.

The Estonian Health Insurance Fund (EHIF) and Thailand's National Health Security Office (NHSO) provide good examples of option 2. In both of these countries, the board of the health insurance fund is chaired by the minister responsible for health[1]. In Estonia, the minister responsible for health has power of veto over the HIF director's appointment. This is one possible mechanism for seeking to ensure that there will be cooperation between the ministry and the purchasing agency. In the Philippines, the President appoints the chief executive of the Philippines health insurance fund, which has sometimes led to politicization and weakened the accountability of the chief executive to the board.

In the Netherlands, option 3 has been used to appoint strong, expert boards to social health insurance funds.

German and Austrian sickness funds are good examples of option 4.

[1] The Minister of Social Affairs in Estonia and the Minister of Public Health in Thailand.

Table 2. Advantages and disadvantages of different options for legal form and governance structure

Source: Author

Options	Advantages	Disadvantages and risks	Appropriate context
1. State institution, no board, subordinate to the health ministry (eg Lithuania, Kyrgyzstan before 2009)	• Avoids the costs of having a board • Close coordination with the health ministry	• Higher burden on the health ministry • Less operational autonomy • Less stakeholder participation	Appropriate if the government's vision is for the agency to have a limited role as an operational arm of the health ministry
2. State institution, supervisory board of stakeholders and/or experts chaired by the health ministry (eg Estonia, Thailand, the Philippines)	• Board skills support agency management • More operational autonomy than 1 • Stakeholder participation • Political buffer	• Some risk of poor board appointments – politicization, lack of board skills, conflict of interest • Risk of internal division in Board	More appropriate if the government's vision is for the agency to become an active purchaser
3. State institution, board and chair appointed bty Prime Minister, Cabinet or government commission (eg the Netherlands, Kyrgyzstan since 2009)	• Opportunity to appoint skilled board to support agency management • Greater autonomy than 1 or 2	• Risk of poor health ministry-agency coordination • Higher risk of poor board appointments – politicization, lack of skills, conflict of interest	More appropriate if the government has a tradition of meritocratic, transparent appointments
4. State institution, chair or board elected by stakeholder board members (eg German and Austrian sickness funds)	• Greater autonomy than 1, 2 or 3 • Chair and board may be more stable if the minister changes • Political buffer	• Risk of poor health ministry-agency coordination • Less government control if there is poor board and agency performance • Risk of internal divisions on the board • Some risk of poor board appointments, conflict of interest	More appropriate in contexts with a tradition of stakeholder cooperation. Requires strong regulation.

2.4 Options for supervisory board membership

If option 2 is selected – a purchasing agency with a supervisory board chaired by the health minister – legislation should specify the composition of the supervisory board for the purchasing agency. The composition of the Estonian Health Insurance Fund (EHIF) supervisory board provides a good example (Riigikogu 2000):

- The supervisory board has 15 members.
- It is chaired by the *minister responsible for health*, who ensures coordination and communication between the EHIF and the health ministry.
- The participation of the *finance ministry* on the board is important in a single-payer system financed through taxation, to ensure strong fiscal discipline and to function as an economic counterweight to the MOSA and other board members who have an interest in advocating for more resources for health (Savedoff and Gottret 2008). The finance ministry is well placed to supervise expenditure control and coordinate budget formulation.
- In Estonia, the chair of the *parliamentary committee responsible for health* and another person elected by the whole parliament serve on the board.
- *Employers* (through the Employers' Association) nominate five further members. This is appropriate in Estonia because most EHIF revenue comes from payroll taxes. Employer representatives take a strong interest in EHIF efficiency and financial control as well as in the health of the workforce. They also bring strong financial and managerial skills to the board and experience in corporate governance.
- Finally, *beneficiary representatives* are appointed based on procedures defined in regulation and include, for example, representatives of the pensioners' organization, patients' association and mother and child welfare organizations.

It is good practice to adopt regulations prescribing procedures for credible civil society organizations or forums to nominate and elect beneficiary representatives, rather than allowing individuals to be appointed based on political discretion.

In addition, it may be useful to include on the board representatives of government agencies with roles that need to be coordinated with the purchasing agency (for example, agencies responsible for insurance or other schemes for vulnerable groups, pensioners or disabled people) or agencies that have policy and technical expertise relevant to monitoring purchasing agency performance (such as national centres for disease control or health information).

Employer representation is more appropriate where the purchasing agency is financed largely through payroll taxes. However, where employer representation is less relevant, alternative mechanisms will be needed to ensure that there are appropriate financial, managerial and legal skills on the board. One option would be to provide for additional expert directors to be appointed based on explicit criteria. A search committee could be used to identify and recommend candidates.

Some countries include representatives of health care provider organizations on their board, such as representatives of the hospital association or medical and nursing professional associations. Although this has the potential advantage of fostering engagement and buy-in from the health delivery system to the purchasing agency's strategies, it also leads to potential conflict of interest and runs the risk of making the board divided and dysfunctional. This risk may be manageable in countries where health care provider organizations have a strong professional, technical orientation and have a tradition of constructive relationships with the government over health. Estonia and Thailand, along with many other countries, have chosen to use other forums for consultation and negotiation with providers. For example, the purchasing agency can engage these organizations in advisory committees on specific issues such as clinical quality or the development of evidence-based guidelines.

2.5 Defining the role and duties of governance and management structures

The governance role and duties of the supervisory board (under Option 2) or the health ministry (under Option 1) need to be set out clearly in legislation, regulation and the internal charter or rules of the purchasing agency.

The supervisory board usually:

- Selects the management board (chief executive officer, chief financial officer etc) through open competition.
- Monitors management board performance in achieving the purchasing agency's statutory objectives.
- Approves the strategy, plan, budget, annual reports and accounts.
- Approves policy proposals and draft regulations formulated by the purchasing agency for health ministry of Cabinet approval, as specified in legislation.
- Has a statutory duty to ensure the financial sustainability and efficient use of resources of the purchasing agency.
- Approves the use of reserves (finance ministry approval may also be required depending on the size of reserves).

- Has a duty to ensure the purchasing agency complies with law, regulation and its charter or internal rules.
- Has a duty of transparency to publish decisions, board minutes etc.
- Should not intervene in operational management decisions; the law may stipulate that the board is not permitted to intervene in certain management decisions (eg staff appointments).

If there is no supervisory board (as in Option 1), the above functions would usually be the responsibility of the health ministry (and the Cabinet in the case of major decisions).

The management board has operational management responsibility and is responsible for oversight of the regional offices of the purchasing agency. Legislation may mandate certain key responsibilities and functions for the management board, such as:

- Assessment of the health needs of the community.
- Planning, forecasting or actuarial analysis and budget formulation.
- Production of quarterly and annual reports to the board.
- Formulation of internal policies and rules.

3. Decision-making authority: the purchasing agency and health financing policy

The role of the purchasing agency in making decisions on various health financing policies differs across countries. Greater authority is given to the purchasing agency in countries where it is an active purchaser, accountable not only for financial protection and financial sustainability, but also for access to health services and health service delivery quality improvement.

Legislation governing the purchasing agency should specify clearly which agency or branch of government is responsible for making decisions on each of the main components of health financing policy. If the purchasing agency is to be held accountable for controlling its expenditure within a fixed budget, it needs to be given some authority over policy levers that will enable it to do so – in other words, its authority needs to be aligned with its accountability. The following paragraphs set out typical roles for key entities.

Parliament: All single-payer health systems give parliament authority over population coverage and the payroll tax or contribution rate or the budget allocation for the health system. The law may also specify criteria or processes (eg forecasting or actuarial studies) to ensure that the purchasing agency's revenue or budget is adequate to meet its expenditure commitments. Most countries also give parliament authority over the broad scope of the benefits package, with details set out in regulation. Alternatively, the legislation may set criteria for determining the benefits package. However, some budget-financed countries with mainly public health service delivery systems do not have an explicit benefits package (eg Latvia, the United Kingdom).

Health ministry: Most countries give the health ministry authority over policy advice to government on the benefits package, service standards and strategic policies on health financing. However, law or regulation may require the health ministry to seek the advice of the purchasing agency before making decisions on these policies because they have implications for the purchasing agency's ability to manage within its budget. In practice, the purchasing agency may also do a lot of the analysis to formulate and cost policy proposals.

If the purchasing agency is independent of the health ministry (as in Options 2-4 above), there is a need to establish formal processes to ensure coordination over the development of health policies and strategies that have implications for health financing. Possible coordination mechanisms include a policy/strategy committee, annual agreements on work programmes and formal membership and terms of reference for joint health ministry-purchasing agency working groups on policy development and implementation.

Independent agencies: Most countries give independent agencies authority over accreditation of health care providers, beneficiary complaints and appeal and external financial audit of the purchasing agency.

In countries with an independent *accreditation agency*, it is important for the purchasing agency to promote compliance by requiring accreditation as a condition for contracting or using payment incentives to encourage providers to achieve higher levels of accreditation. In countries without quality accreditation (for example, the Philippines), the purchasing agency has been allowed to develop accreditation. This has the advantage of encouraging the purchasing agency to focus on quality improvement in its contracts, not

just on service costs and volume. In addition, the purchasing agency may be better placed than an independent agency to ensure the accreditation system is financially sustainable. However, providers and professionals may mistrust the purchasing agency. If there are separate licensing and accreditation agencies, the aim should be to minimize duplication of reporting and inspection and ensure alignment and consistency in performance requirements used by the purchasing agency, by these agencies and by the health ministry.

Usually there is a first-level mechanism for receiving and responding to *complaints* about service delivery at provider level. A second level of complaints about service delivery and a first level of appeals over benefits coverage may be managed at the purchasing agency level. Only unresolved complaints and appeals would then be considered by an independent agency or ombudsman.

Some countries also use independent agencies to carry out *audits* of provider data used for payment – for example audit of medical coding data used for DRGs or pay-for-performance or audit of patient registers for capitation.

Purchasing agency: Many countries give the purchasing agency authority over provider payment design and contract design; price setting; and clinical guidelines. However, some countries give the health ministry the lead role in designing *provider payment methods*, with the purchasing agency's role limited to analysis of financial implications and detailed operationalization.

Where *price setting* is concerned, the purchasing agency is usually best placed to obtain the cost data needed for pricing and to conduct negotiations with providers over pricing where necessary. It may also be able to use competition to set prices for some services. Legislation in some countries stipulates principles for pricing to provide assurance to health care providers that prices will be set at levels that cover the costs of efficiently delivered services. Other countries require health ministry and/or finance ministry approval of price lists. This provides a buffer for the purchasing agency and also helps to ensure balance between the goals of service quality and expenditure control. Some countries have an independent price regulatory agency (eg the United Kingdom) and/or an independent agency to hear appeals over pricing. Private providers may have greater confidence in an independent regulator than in the purchasing agency or health ministry, but this option creates greater fiscal risk.

Clinical guidelines for rational use of tests and drugs and for clinical prioritization or rationing within the benefits package are important tools for the purchasing agency to use to ensure value for money and to improving the effectiveness and efficiency of service delivery. However, providers and professionals may mistrust the purchasing agency, perceiving it to have a vested interest in cheaper care. Because of this, some countries give the health ministry or professional bodies the lead role, with the purchasing agency role limited to advice on financial implications and detailed operationalization. Some countries have independent advisory commissions or an independent agency to carry out this role (eg the National Institute for Clinical and Health Excellence in the United Kingdom), to increase professional trust and participation in the process, although this can introduce fiscal risk unless the work of these commissions or agencies is

subject to criteria or principles to ensure that guidelines are affordable for the country.

Table 3 illustrates who has decision-making authority for key health financing policies in four countries. Although Estonia's health insurance fund has limited decision authority, in practice it is the main source of advice on health financing policy and plays a lead role in developing clinical guidelines, so it is very influential on health policy even though it must obtain the health ministry's agreement and government approval for most policy decisions. Although the Philippines health insurance fund has high decision-making authority over health financing policies, in practice it has failed to achieve its potential to become an active purchaser because it only finances a small share of total spending on health, it provides shallow benefits for inpatient care and limited coverage of outpatient services and it cannot control balance-billing and extra-billing by providers.

Table 3. Decision-making authority by policy area in selected countries with a single purchasing agency

Source: Author

Policy area	Estonia	Latvia	Lithuania	Philippines
Public revenue source	Earmarked payroll tax	Budget	Earmarked tax and budget	Earmarked payroll tax and budget (premiums for poorer people)
Vision for the agency	Active purchaser	Plans services and manages the health budget	Weaker purchasing role than Estonia (mainly financial)	Limited role due to the purchasing agency's small share of health financing
Policy issues	**Decision-making authority**			
Tax rate or budget allocation	Parliament	Parliament/finance ministry/health ministry/ NHS negotiation	Parliament/finance ministry/health ministry/ NHS negotiation	Congress
Benefits package	Criteria in law; government (EHIF advises health ministry)	Government/health ministry/NHS (not explicit)	Government/health ministry	Criteria in law; purchasing agency
Provider payment	Government (EHIF advises health ministry)	NHS	Purchasing agency	Purchasing agency
Pricing	Health ministry (EHIF advises)	NHS (health ministry for medicines)	Health ministry	Purchasing agency
Quality standards	Independent agency	Independent agency	Independent agency	Purchasing agency (health ministry has duplicate system)
Clinical guidelines	EHIF	NHS, professions	Health ministry, professions	Purchasing agency and health ministry (duplication)
Beneficiary appeals and complaints	EHIF process and independent agency	Not well developed	Not well developed	Purchasing agency process
Provider complaints and mediation	EHIF process	NHS (not well developed)	Purchasing agency (not well developed)	Purchasing agency process

4. The functions and internal structure of the purchasing agency

4.1 General functions

Table 4 lists the range of possible functions of the purchasing agency. For some functions, the government faces a choice: either to give the purchasing agency lead responsibility or alternatively to give primary responsibility to the health ministry or an independent agency, with the purchasing agency role limited to providing data and analysis.

The functions in italics in Table 4 are those that could be located in the purchasing agency or the health ministry. If the purchasing agency is given responsibility for the functions in italics, the health ministry will need to retain strategic policy and technical capacity to oversee these functions, as the government's principle policy adviser on health. Conversely, if these functions remain the responsibility of the health ministry, the purchasing agency will still need some in-house analysis capacity to provide technical input to the health ministry on these functions.

When the purchasing agency is established as an independent agency, it is important to ensure that health information systems and other databases (such as beneficiary databases) are not duplicated. There is a need to establish database management and health information system (HIS) and ICT services and systems development as joint functions serving the health ministry, the purchasing agency and, where relevant, other agencies. Several options could be considered for the location of joint HIS/ICT functions:

- Remain in the health ministry: This may be the simplest option, but it would require mechanisms to ensure good coordination with the purchasing agency and responsiveness to its needs.

- Shift to the purchasing agency: The advantage of this option is that the purchasing agency is the main client for HIS and it may also have more budget and HR management flexibility than the health ministry to recruit and retain IT staff and invest in systems development.

- Establish HIS/ICT functions as a separate agency, subordinate to a joint board comprising the health ministry, the purchasing agency and other relevant agencies: This option is more complex to implement, but it has the advantage of balancing the interests of all the users of data and coordinating them. It may reduce the risk of agencies duplicating and developing parallel systems.

Table 4. Checklist of possible purchasing agency functions

Policy and strategy
• Agency strategy and planning
• Review of agency performance
• Benefits package design
• Provider payment and contract design
• Pricing / costing
• Clinical guidelines development and prioritisation/rationing
Purchasing
• Contracting and provider relations
• Provider monitoring and analysis
• Claims administration and control
• Procurement or tendering for services
• Data audit
Corporate services
• Finance: payment, accounting, reporting
• Budget forecasting and negotiation
• Legal, administration
• Human resources management
• Communication, public relations
IS/ICT
• Shared database management: beneficiaries, providers, health services
• Health information systems development
• Internal IS/ICT for agency operations
Customer services
• Beneficiary enrolment and information
• Complaints and appeals
• Beneficiary surveys and consultation

Source: Author

There is considerable variety in how purchasing agencies organize their functions in terms of internal organizational structures. There is no one preferred model. It is desirable to give the purchasing agency's board and management some flexibility to design and adjust their structure over time. Some purchasing agencies may have a separate internal unit for each of the functions listed in Table 4, grouped into three to six directorates.

The internal structure of the Estonian Health Insurance Fund is set out in Table 5 below. Its structure is very flat and streamlined. In 2011, it had 212 staff (for a population of around 1.3 million). It integrates related functions into single units. For example, the health care division is responsible for all aspects of purchasing health services except outpatient medicines and is responsible for related policy and strategy. Regional offices have the functions of contracting and provider relations, provider monitoring and customer services at sub-national level.

Table 5. Internal structure of the Estonian Health Insurance Fund

Management board Policy area			
4 regional office board members	**Board member (chief operating officer) purchasing and customer services**	**Chair of the management board (chief executive officer) Corporate**	**Board member (chief finance officer) Finance and IS/IT**
Regional office 1	Medicines	Legal	Finance
Regional office 2	Health care	Administration	ICT
Regional office 3	International relations	Human resources	Systems development
Regional office 4	Customer services	Communications	

Source: Author

4.2 Purchasing

The following paragraphs review different aspects of purchasing.

Purchasing of state-financed vertical public health programmes: In some countries, health ministries retain responsibility for purchasing vertical public health programs or manage these programs directly. However, there are many examples of giving the purchasing agency this function. It can be more efficient to give a single agency responsibility for purchasing both diagnosis and treatment services and preventive programs provided to individual patients, such as immunization, antenatal care and cancer screening. This can foster greater synergy and coordination between preventive and curative care, as well as reducing the transaction costs of contracting. Having said that, parallel vertical public health programmes can provide a stronger managerial focus for specific programmes, which may be desirable for critical or fragile programmes that have not yet achieved high population coverage rates.

Financing for infrastructure investment (capital finance): Some countries include the annualized cost of capital (depreciation and financing costs) in their prices for services. Others exclude it (including Germany, which has many private providers). Capital grants can be used to encourage optimal service development, so if the government wants the purchasing agency to be an active purchaser, shaping health service delivery, it may be beneficial to give the purchasing agency a role in allocating capital. In addition, giving the purchasing agency this role facilitates coordination of investment and recurrent budget allocation decisions. However, a capital allocation role increases the governance risks of the purchasing agency because decisions about capital grant allocation involve some bureaucratic discretion.

Pharmaceuticals (defining the list of covered drugs, pricing, procurement and logistics): Giving the purchasing agency responsibility for setting the reimbursable list and pricing can create important synergies; it allows the purchasing agency to make trade-offs between different therapies based

on evidence and it also gives the purchasing agency an additional lever to use in controlling expenditure. However, the governance risks of decisions about drug reimbursement are high. Many countries use a joint commission or independent agency to set the reimbursable drugs list or regulate drug prices, to provide checks and balances. It is generally undesirable for the purchasing agency to have a procurement or logistics function, because purchasing agencies – and state institutions more generally – are not usually as well suited as the private sector to manage a responsive drugs supply chain function. Plus, medicines procurement is highly prone to corruption. It may be preferable to include medicine costs in contracts with hospitals and, for primary care medicines, to contract with private pharmacy distributers and retail pharmacies.

Provider contracting versus claims reimbursement business models: Purchasing agencies in many single-payer health systems with universal health coverage (including Estonia and Lithuania) are able to simplify their administration by avoiding a transactional business model for paying hospitals and primary care providers on the basis of individual claims. Instead, they pay providers on the basis of aggregate contracts that specify cost and volume for different categories of services, together with service standards for access and quality. The purchasing agency monitors provider performance against contracts on at least a quarterly basis.

In countries that do not yet cover the whole population, or where there are different benefit packages for different categories of people, it is necessary to pay on the basis of individual claims. However, after the purchasing agency has taken on responsibility for purchasing a single benefits package for all residents and once it has accumulated more data on utilization, it would be feasible to transition from claims reimbursement to a provider contracting model. This would simplify the purchasing agency's administration and enable it to become a more streamlined, strategic organization. Some countries outsource claims administration functions (eg the Medicare scheme in the United States). However, this would not be straightforward in countries – like Georgia – where private insurers are the only organizations that currently have capacity for claims administration and where private insurers also own health care providers; there would be a conflict of interest.

Contracting networks of providers under 'accountable care' agreements: This is the direction of reform in the United States and a number of European Union countries. Through these reforms, countries are seeking to align the financial and clinical responsibility of providers and encourage networks of providers to take responsibility for coordinating patient care across different providers. These reforms are intended to reduce hospitalization and encourage better management of prevention and care for people with long-term (chronic) conditions.

The main feature of these reforms is that the insurer contracts with networks of providers that cover the whole continuum of care – primary care providers, other community-based providers and hospitals – to take responsibility for managing all care for a defined patient population within a defined budget. Under these so-called accountable care contracts, the insurer may share financial risks and savings with the provider network to encourage providers to control utilization and provide care for patients in the most

cost-effective setting. Contracts with accountable networks typically also incorporate pay-for-performance to reward quality improvement and better outcomes for patients.

These reforms are complex, however. Before they can be implemented it is necessary to build the foundations of costing and provider payment systems for primary care, other community-based services and hospitals. It could be desirable to ensure that the legislation for the purchasing agency permits these kinds of accountable care contracts with provider networks.

5. The purchasing agency's financial liabilities

The government or finance ministry is ultimately the guarantor of the financial viability of the purchasing agency in any tax-financed system where the purchasing agency is a public agency. A key issue the government therefore faces is how to ensure a credible budget constraint for the purchasing agency and how to give the purchasing agency strong incentives to manage its expenditure in a fiscally sustainable way.

5.1 Accountability and incentives for maintaining fiscal balance

Usually the purchasing agency's legislation will set a duty for the Board of the purchasing agency to ensure fiscal sustainability. Legislation may give the government powers to sanction the purchasing agency in case it fails to meet its financial duties. The law usually gives the government power to dismiss members of the supervisory board or management board in event of a failure of duties. In the United Kingdom, managers of health purchaser organizations face loss of career prospects, reputational damage and more intrusive monitoring if they overspend their budgets.

The purchasing agency's financial duties may be expressed as a duty to break even. In some countries (eg the United Kingdom), the single purchaser is given a multi-year budget of three or more years and may be given flexibility to break-even over this longer period. In some health insurance systems which are financed in part by taxes, the law stipulates that the budget allocation to the purchasing agency becomes an asset owned by the purchasing agency (eg Lithuania), allowing the purchasing agency to use any unspent balances each year to build up reserves. Alternatively, to create incentives for the purchasing agency to control expenditure over the medium term, the finance ministry can agree to allow the purchasing agency to carry forward a share of or all unspent budget funds from one financial year to the next year.

The Estonian Health Insurance Fund Act (Riigikogu 2000 as amended, 2009) states that the EHIF cannot be bankrupt and that the state is liable for the EHIF's obligations if the legal reserve is insufficient due to various reasons specified in the law. The Act also stipulates that the supervisory board and the management board are liable for any harm they do to the EHIF and for failure to perform their duties, including their financial duties, for a period of up to five years. The EHIF pays for liability insurance for board members, although board members remain liable for a portion of the costs.

5.2 Ensuring a credible budget constraint

If the budget constraint for the purchasing agency is set at too low a level, either beneficiaries or providers or both will be exposed to risk. Private providers may withdraw from the scheme if prices are set below cost or if the purchasing agency is unable to pay for all the services used by beneficiaries.

Or they may 'balance-bill' patients for any costs above those reimbursed by the purchasing agency. Conversely, if the budget is too open-ended, the purchasing agency will have weak incentives to control its finances. Under this scenario, the burden of monitoring and control of the purchasing agency's expenditure falls heavily on the health and finance ministries.

The purchasing agency's legislation can include provisions designed to strengthen the credibility of the budget constraint. For example, the legislation could include a statutory duty for the purchasing agency (or the health or finance ministry of the government) periodically to carry out or commission a costing and forecasting study of the budget required by the purchasing agency to deliver the benefits package. This duty could be framed as a requirement for periodic actuarial assessment of the premium required per beneficiary, but not all countries use actuaries and not all countries express the required budget as a per beneficiary premium.

In some predominantly government budget-financed health systems (eg Australia, New Zealand), the finance ministry is required to carry out long-term fiscal projections for all government expenditure, including projections of health expenditure, and publish them every five years. In Thailand, the National Health Security Office (NHSO – the government budget-financed single payer for health insurance for the poor and informal sector workers) is required to produce an annual actuarial assessment of the increase in per capita funding needed to cover the costs of the benefits package. This cost estimate is then used as the NHSO's budget proposal in negotiation with the finance ministry over the budget for the NHSO's capitation medical fund. However, the government has only once agreed to fund the full amount of the actuarial estimate (in 2008). The actual budget allocation is influenced by the government's budget priorities and fiscal space.

5.3 The role of reserves

Countries that finance health coverage predominantly through payroll taxes (eg Estonia and Lithuania) are usually required to establish reserves to manage the risk of payroll tax revenues declining during periods of macroeconomic downturn. The Estonian Health Insurance Fund builds up a legal reserve of 6% of its annual budget for this purpose. Use of this reserve requires finance ministry approval. This type of reserve is not directly relevant to government budget-financed purchasing agencies.

Purchasing agencies may be required to set aside a second type of reserve to manage the risk of variation in expenditure liabilities due to variation in demand for health care or health care prices during the fiscal year. The Estonian Health Insurance Fund, for example, is required to set aside 2% of its budget at the beginning of the year as a reserve for managing the risk of variation in its obligations. Use of this reserve requires supervisory board approval.

Estonia's 6% legal reserve funds are managed by the finance ministry on its behalf. The 2% reserve is held in the form of liquid assets. These are managed by a trustee appointed by the supervisory board. Lithuania's health insurance fund is also authorized to establish reserves, although until

2009 it received over half of its revenue from the government budget. It is authorized to invest its reserves in government securities.

It is less common for government budget-financed purchasing agencies to establish formal reserves. Until 2009, Latvia's Compulsory Health Insurance State Agency was financed through a mix of earmarked income tax and general government budget transfers. During this period, it had the authority to form a reserve fund and add any surpluses from previous years to this reserve. However, after 2009, when Latvia shifted to financing its health service fully from the government budget, the reserve fund was eliminated.

Other countries (eg the United Kingdom) prefer to set a firm budget limit for the health system because the finance ministry believes that official reserves would undermine incentives to control expenditure, resulting in the reserve being drawn down every year as a matter of course. In practice, however, regional purchasing agencies in the United Kingdom set aside around 2% of their budget at the beginning of the year as a contingency fund to avoid over-spending, which can result in strong sanctions.

6. Regulating private providers

Unlike purchasing agencies in Estonia and most European Union countries, Georgia's purchasing agency faces the challenge of contracting predominantly with private for-profit providers in both the hospital and primary care sectors. The Philippines health insurance fund also faces this challenge in urban areas.

Table 6 and Figure 2 show the share of public hospital beds and hospitals in a range of OECD countries. Several countries have mixed hospital systems and purchasing agencies reimburse care in both public and private facilities. The United States Medicare system is the best-developed example of a social insurance scheme that contracts predominantly with private providers, including with many for-profit providers.

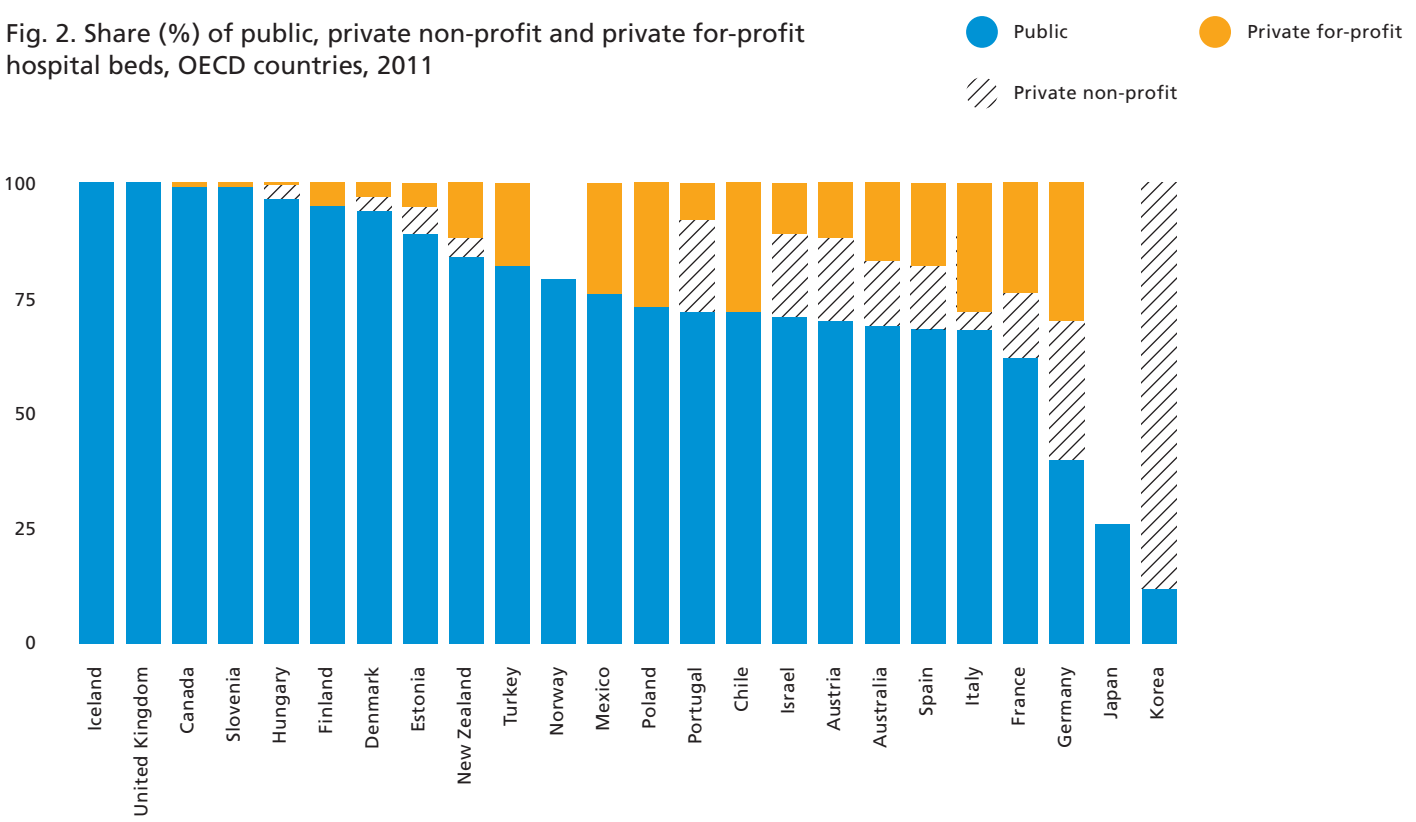
A much larger number of countries has predominantly private provision of primary care and faces the challenge of dealing with large numbers of highly independent private practices – including the United Kingdom, Canada, Denmark, New Zealand, Australia, Germany and France.

Table 6. Share (%) of all hospital beds owned by the public sector, OECD countries, 2011 or latest available year

> 90%	50-89%	0-49%
Canada	Australia	Belgium
Czech Republic	Austria	Germany
Denmark	Chile	Greece
Finland	Estonia	Japan
Hungary	France	Korea
Iceland	Israel	Netherlands
Slovenia	Italy	Philippines
United Kingdom	Mexico	Slovak Republic
	New Zealand	Switzerland
	Norway	United States
	Poland	
	Portugal	
	Spain	
	Turkey	

Source: OECD health data 2015

Fig. 2. Share (%) of public, private non-profit and private for-profit hospital beds, OECD countries, 2011



Source: OECD health data 2015

6.1 Balancing the powers of the state with protection for providers

The United States Medicare programme (a single-payer scheme for people aged over 65) provides a good example of how to use statutory powers and contractual conditions to regulate the conduct of private and public health care providers. The legislation governing the Medicare scheme (the Social Security Act, US Congress 1935, as amended) requires any provider who wants to participate in the scheme to comply with a range of regulatory requirements as a pre-condition for receiving payment from Medicare. These requirements include the following:

- Providers must furnish annual cost reports in formats defined by Medicare; late reporting can result in non-payment by Medicare; the cost report covers all costs and all sources of revenue of the provider.
- Providers are subject to audit of their claims, medical records and cost reports by the Office of the Inspector General of the Federal Department of Health and Human Services and by auditors contracted by the Secretary of the Department.
- Providers must agree not to bill patients for additional fees and charges above the Medicare price schedule.
- Providers must release patient data to Medicare's third party claims administration contractors.
- Providers must provide patients with information on their rights under Medicare.
- Hospitals must maintain an agreement with a quality improvement organization.
- Providers must retain medical records for five years.
- Providers must disclose any financial interests they hold in other providers to whom they refer patients.
- Medicare has the right to terminate its agreements with a participating provider, based on criteria set out in legislation.
- Medicare has the right to make public on its website data on the quality, efficiency and costs of care of hospitals that participate in Medicare.

Providers are not obliged to contract with Medicare but, if they do, Medicare has considerable powers to obtain information from them and regulate the prices they charge. In practice, the majority of providers participate in the scheme.

The Medicare legislation also balances these powers with some protections for providers. The legislation sets out the principles or criteria Medicare should use in setting prices for different categories of services. These

principles and criteria ensure that the prices Medicare pays cover the cost of (efficient) service delivery. The legislation also obliges Medicare to pay on time and has established an independent Provider Reimbursement Review Board (appointed by the health minister) to hear the complaints of providers who are dissatisfied with the final determination of Medicare on payment or delay in payment.

6.2 Alternatives to regulation

Some countries have found it difficult to adopt regulation of the sort used by Medicare to prevent private providers from balance-billing or extra-billing patients and to oblige providers to report their costs. The Philippines has faced this problem in contracting with private providers, but it has recently begun to contract with selected public and non-profit providers to provide services without balance-billing and it has been able to work with these public and non-profit providers to obtain costing data for developing its provider payment system.

France, Australia and New Zealand have not been able to regulate balance-billing by independent, private primary care practices or to require practices to report costs. This is due to entrenched political opposition by powerful medical associations. France and Australia tackled this problem by offering a higher rate of payment and simpler claims administration processes to primary care doctors who agreed not to balance-bill patients. Both countries offered payment rates that were high enough to attract a sufficient number of primary care doctors to accept a contract that restricted balance-billing. New Zealand adopted a slightly different approach. It was able to negotiate an agreement with doctors to eliminate balance-billing for some high priority services (maternity care, services for children under six years) and offer reduced user charges to some patient categories (vulnerable groups, pensioners, patients with certain chronic illnesses), while allowing doctors to charge unregulated user charges for other patients. New Zealand has also used competitive processes and selective contracting – tendering and pilot programmes – to contract selected providers to provide low-cost services to vulnerable populations in areas of socio-economic deprivation. Non-profit organizations have played an important role in providing these services.

7. Conclusions

The extent of independence and decision-making authority given to a single purchaser needs to be matched by its accountability and commensurate with its level of capacity. If the Government has a vision for its purchasing agency to become an active purchaser – financially accountable and also accountable for improving access and health service quality – the agency will need greater independence and authority or influence over health financing policies and strong technical capacity. It is likely to take time to develop the necessary capacity for the purchasing agency to play this role.

If the purchasing agency is independent from the ministry responsible for health, there are lessons to be learnt from international experience about the importance of maintaining policy coordination and coherence with the ministry and establishing clear accountability to a strong, active supervisory structure. The legislation and regulations for the purchasing agency will need to clarify roles and responsibilities and strengthen accountability and coordination with the ministry. It should build in mechanisms for stakeholder consultation and participation.

Georgia faces distinctive challenges because of the dominance of private for-profit health care providers that currently face very light regulation. The legislation establishing the purchasing agency is likely to need to include provisions to enable the government and the purchasing agency to regulate private health care providers who offer services under publicly financed health coverage and to require them to disclose the information needed to ensure transparency and accountability for public expenditure on health. At the same time, legislation and regulations need to provide some protection for private providers from underpayment and late payment by the purchasing agency.

The Estonian Health Insurance Fund and Thailand's National Health Security Office provide examples of high-performing purchasing agencies with good governance in a middle-income country context. Key success factors identified in studies of these purchasing agencies can be summarised as follows:

- Give the purchasing agency clear, focused objectives in legislation, regulations and internal statutes.
- Design legislation and regulations for the purchasing agency that match its authority and accountability.
- The legal framework and supervisory board for the purchasing agency need to ensure the agency coordinates with the health ministry and the MOF and make it clear that the health ministry has leadership on policy, even though the purchasing agency may undertake policy analysis and put policy initiatives to its board and, via its board, to the health ministry.
- A credible and firm budget constraint is needed to help motivate the purchasing agency to negotiate lower prices and seek efficiencies from providers; setting clear criteria and procedures for drawing on any reserves is an important aspect of financial accountability.
- Having a supervisory board with independence, balanced membership

and a strong focus on performance monitoring and feedback to management helps to focus the purchasing agency on balancing its budget, operational efficiency and ensuring access to and availability of health services.

- Performance goals and requirements for reporting to the board on access and service availability are critically important to ensuring the purchasing agency focuses on improving health services and responsiveness to beneficiaries.

- Transparency, credible data and good health information systems are key.

- Open, competitive appointments for purchasing agency managers and staff and flexibility over labour contracts are important for ensuring strong managerial and technical capacity.

Above all, coherent and coordinated decision-making and policy stability are needed to allow for effective implementation of a new single purchasing agency.

References

Changuridze T, T Ugulava, A Duran, T Ensor and E Richardson (2009) Georgia: Health System Review. Health Systems in Transition 11(8). Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies

Jesse M (2008) Governance of the Health System, Health Insurance Fund and Hospitals in Estonia. Health Financing Policy Paper 2008/4. Copenhagen: WHO Regional Office for Europe

Riigikogu (2000 as amended 2009) Estonian Health Insurance Fund Act. Tallinn: Riigikogu. Available at: http://www.haigekassa.ee/eng/legislation

US Congress (1935 as amended) Social Security Act, Title XVIII – Health Insurance for Aged and Disabled. Washington DC: US Congress. Available at: http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

Savedoff W and P Gottret (2008) Governing Mandatory Health Insurance: Learning from Experience. Washington DC: The World Bank

Smith O (2013) Georgia's Medical Insurance Program for the Poor, Washington DC: The World Bank. Available at: http://documents.worldbank.org/curated/en/2013/01/17207976/georgias-medical-insurance-program-poor

World Bank (2012) Georgia Public Expenditure Review: Managing Expenditure Pressures for Sustainability and Growth. Washington DC: The World Bank

World Health Organization (2015), Global health expenditure database. Available at: http://www.who.int/health-accounts/ghed/en/

WHO, USAID, World Bank (2014) A review of UHC reforms introduced in Georgia since February 2013

This paper discusses the key functions and governance structures of purchasing agencies in single-payer health systems. It is based on policy discussions that took place between WHO and the Ministry of Labour, Health and Social Affairs in Georgia following the introduction of major reforms to the Georgian health system in 2013. This paper summarises those discussions. It draws on case studies of other countries deemed relevant to Georgia's circumstances, noting some distinctive challenges Georgia faces in strengthening purchasing because of the dominance of private for-profit health care providers that currently face very light regulation. Although the starting point for the paper's analysis is the situation in Georgia, its contents are relevant to debate about the functions and governance of purchasing agencies in other countries at all stages of economic development. The paper concludes that the extent of independence and decision-making authority given to a single purchaser needs to be commensurate with its level of capacity and accountability. To guide detailed decisions on the legal model, governance, powers, functions and structure of a purchasing agency, a government first needs to clarify its vision for the agency, recognizing that it may take time to build up capacity for active, strategic purchasing.

World Health Organization
Regional Office for Europe
UN City, Marmorvej 51, DK-2100
Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01
Email: contact@euro.who.int
Website: www.euro.who.int