



Strategic Purchasing Project

Learning Brief 5: Seeing Like a Purchaser

May 2020



Empower communities. Transform lives.

Introduction

This is the fifth Learning Brief in the Community Partners International (CPI) series to transfer knowledge accrued in our Strategic Purchasing Project with the Karen Ethnic Health Organizations Consortium (KEHOC). In this learning brief, we explore the standardization of care, facilities, services and information necessary for ethnic health organizations (EHOs) to cooperate in a purchasing arrangement.

Prior to introducing Strategic Purchasing, a number of changes needed to be made to how clinics operated, beyond the financial aspects of Strategic Purchasing changes. These moved the clinics and services from vernacular, informal health provision towards formal systems that are comprehensible from verifiable data in order to secure payments. The reasons for the informality were myriad, including adaptability to local circumstances, nimbleness to avoid conflict and the challenge of communication in hard to reach areas. The need for formality is derived from the imperative to make costs, quality and coverage of health services comprehensible to a Purchaser (whether the Purchaser is state or donor funded).

This learning brief will describe the elements of the health system that needed to be made visible to a Purchaser and how the CPI-KEHOC project achieved that. It finishes with a reflection on the impacts of increased standardization in care in the project context.

1. Infrastructure

When EHO clinics operated prior to the project, they made the best of the facilities they had, which varied widely. Village leaders or the clinic-in-charges might have made efforts to raise money from township or village authorities of the Karen National Union (KNU), but on an ad hoc basis.

In order to establish consistency of quality for health services, and to promote key priorities of the Purchaser, certain requirements were necessary for the facility infrastructure. Such areas included privacy in the clinic to increase the willingness of women to deliver there rather than in the home, electricity, storage spaces, running water and a toilet to improve hygiene and sanitation.

In order to create a simple and “visible” system that a Purchaser could understand and that could apply to different types of structures for clinics, CPI developed a checklist of requirements. This started with a standard list from the World Health Organization (WHO)’s Service Availability and Readiness Assessment (SARA) and the Burma Medical Association (BMA)’s own guidance, before being updated to make it possible in hard-to-reach areas and fit within the limited budget available. The details of this checklist are contained in Annex A.

Once the checklist was completed, initial surveys of the clinics were conducted to understand what was needed to make each building meet the requirements. Clinics then collected quotes from local suppliers to make the agreed-upon modifications. The best value was selected, the work completed and then the final outcomes checked by a team of CPI and KEHOC staff against the initial plans agreed by the contractors

2. Services - A Package, Medicines and SOPs

Prior to the project, clinic staff offered those services for which they had the skills and resources. This meant that whatever staff was on duty would offer treatment to the best of their understanding to those who visited the clinic. They might also visit other

villages for outreach work as and when that was possible and deemed useful.

For the project, however, this needed to be standardized. Strategic purchasing requires that the Purchaser pays for specific services to be delivered to the selected population. Services are always rationed, whether explicitly or implicitly, because of the limited funds that flow in any health system. Unlike before, however, in a purchasing contract, the rationing is generally preferred to be explicit, either in the form of a positive list or a negative list (which services are covered, or which services are not covered, depending on which is more useful). Learning Brief 3 explained how the package of services was selected in this project.

More is necessary, however, in terms of standardization than selecting a series of named services to be offered. For a Purchaser and Provider to both understand the services that are delivered, the way in which those services are delivered needs to be standardized. Two crucial elements must be codified: firstly, a set of Standard Operating Procedures (SOPs), and secondly, an essential medicines list.

SOPs determine what the process for offering a service should be: from a patient presenting (or an outreach session beginning) to the treatment provided, including all tests and checks in between. The essential medicines list is comprised of the medicines recommended by the SOPs.

Creating the SOPs is therefore critical to understanding the translation of a package of services into diagnosis and treatment of individual patients. CPI and KEHOC worked from contemporary guidelines (the Burma Border Guidelines 2016 Edition, which was originally developed in 2003 by nonprofit and community-based groups supporting health care of displaced people)

and updated these to be compatible with Myanmar Ministry of Health and Sports (MoHS) protocols with the inputs of current KEHOC and CPI technical experts. As explained in Learning Brief 3, there is then another step: turning these SOPs into the way that clinic staff actually interact with their communities. This was done by a two-step process of off-site training and on-the-job checks and supportive supervision to ensure the lessons taught were adhered to with high fidelity.

Finally, the medicines included in the essential medicines list were an additional way to strengthen the SOPs as only authorized medicines were paid for (and therefore required to be available in each clinic). Although modest additional funds were available to cover the cost of medicines beyond the essential medicines list, the amount purchased was minimal. Therefore the only prescriptions funded by KEHOC are those agreed on in the SOPs. The essential medicines list, as described in Learning Brief 4, was costed and purchased based on the SOPs and the estimated population requirements for each.

3. Human Resources

Along with the essential medicines list, a crucial part of the SOPs determined who should provide each kind of service, which helped determine which cadres of staff should be present in each clinic.

As with the other elements, staff levels were determined by how many local residents had been able to participate in health training and what the local authorities could support. There was no standard or desired clinic HR structure. In order to pay for services in a standardized system, however, it was necessary to determine who needed to be present in a clinic to carry out the full package of services.

CPI and KEHOC began this process by planning expected caseloads for each cadre of staff based on SOPs and expected disease burdens. To this was added the expected number of outreach services by each cadre, and the level of administrative responsibility. Against all this was balanced the eventual costs.

From this, KEHOC developed a standardized staff set for each clinic (see Annex B). In addition, terms of reference (ToR) were developed to make clear the expected duties of each cadre and how the team works together, balancing clinic needs with a long-sighted vision for how each cadre could relate to MoHS cadres to facilitate future convergence.

The appropriateness of this HR structure will be evaluated using a range of qualitative and quantitative approaches, but is nonetheless a crucial component of standardization, as failure to adhere to it can be easily “seen” by the Purchaser and acted upon. For example, in two clinics there have not been Emergency Obstetric Care (EmOC) workers present, so the clinics have been required by the Purchaser to refer patients that need EmOC (the relative costs between the two approaches, one in which funds go to salaries for EmOC workers and the other for transport and user fees in other facilities, will be compared to estimate cost

effectiveness of each approach).

4. Population

The Purchaser also needs to clearly see the population served and its characteristics: who is covered by the capitation payment; and who is not covered. As explained in Learning Brief 2, the decision was made to target all residents of communities that the clinics initially indicated they believe they serve, with a proviso that this would be re-evaluated after one year. However, even this did not provide information about the population that were sufficient for a Purchaser.

KEHOC were willing to provide the Purchaser with aggregate population numbers for the villages they believed were served by each clinic. However, as this was the first engagement with population numbers and it would be impactful on the estimated payments due, it was felt that the Purchaser needed further evidence about the populations to be served. To this end, a registration process was developed to give each person in these villages a membership card, take key biometric data and inform about the Strategic Purchasing Project. Registration began in June 2018 prior to the start of the project and with the aim of finishing within the first month. However, heavy monsoon rains hindered and delayed

Figure 1: Registration process for community members



both the timeline and procedures of the process.

Initially, the aim was to visit every house and register each member using a mobile application developed for the project. The registrar would take a photograph of each member on their phone, register demographic data in thirteen fields, then create a simple registration card at the door for each individual, containing a number generated by the registration software, name and age.

This handwritten card would then be taken to the clinic to record and create personalized records (which are also contained within the Medical Record Book - see Section 5 below).

Given extensive flooding in Kayin State in 2018, however, the process had to be changed. With limited manpower due to KEHOC's response to the flooding, the process was slowed down and rather than visiting each household, villages were called together in a number of venues. These included schools, village halls, monasteries and churches. Due to the reduced certainty inherent in this approach, it became more important that it was effectively and inclusively done.

The aim of this data collection was to verify the population figures received from KEHOC. In September, when the registration process was complete, the registered population equaled 9,415. This meant that if the population figures of KEHOC were correct, 7% of the population had been missed and had not been registered. This is very likely. However, in addition to the different totals, KEHOC's original village populations did not match the data collected, meaning that the project relied on registered population rather than KEHOC official figures. This reflects the need for the Purchaser to "see,"

unlike the previous operations which were more informal approaches to population health.

To enhance visibility (creating a baseline for future evaluations of impact), a household survey was conducted in March 2019 to understand the needs and wants of the population in question, so that services could be targeted more effectively (by both Provider and Purchaser). [Results of this survey are presented in an accompanying report entitled "The People's Health in Southeastern Myanmar: Results from a Household Survey and the Way Forward."]

5. Information

Lastly, to ensure ongoing visibility of clinic performance, it was necessary for the Purchaser to see information about the quality and quantity of services provided by each clinic on a regular basis. This was resolved in several ways:

A monitoring and evaluation (M&E) system was developed that builds on existing EHO systems to allow for sufficient information to be made visible to the Purchaser. Crucial to this was more reliable and frequent data collection and reporting, from a more-or-less quarterly system to a regular monthly format.

Service utilization logbooks from each clinic are checked and collected by the KEHOC team every month; and data are entered into a database at the KEHOC office in Hpa-An. Data are checked and analyses verified by the M & E team from the Purchaser.

Clinical quality audits are required by the Purchaser, permitted by KEHOC, and conducted by CPI. Each quarter, CPI staff visit clinics with KEHOC staff to both monitor and conduct on-the-job training for clinic staff. Auditors assess the quality

of treatment, service provider-patient relationships, and check on standard infrastructure and emergency and essential medicines. The details of clinical quality audits checklist are contained in Annex C.

Routine data quality assurance (RDQA) assessments are conducted jointly every quarter by CPI and KEHOC. The main objectives are to improve qualified data recording system for service provision data given by the clinic and for pharmaceutical data (See Annex D for RDQA details).

Figure 2: Data Management Flow for Service Delivery

Primary Sources

 Patient

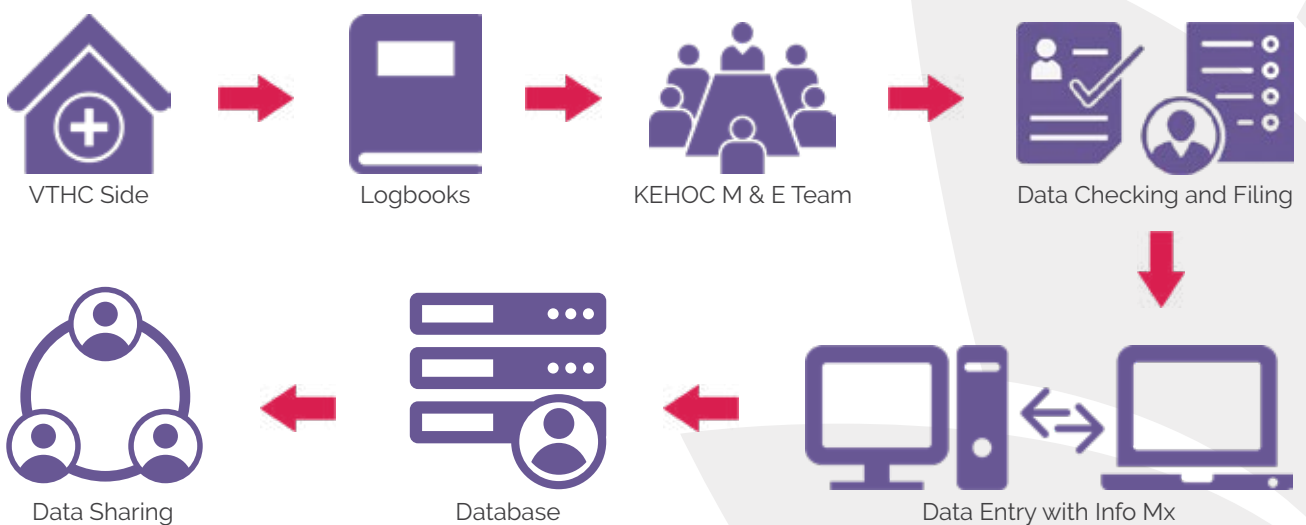
- Registration ID Card
- Medical Record Book

#A0001

 Village Tract Health Center

- Patient Registration Book
- Charts
- Logbooks
- Inpatient Charts
- Pharmacy Forms & Records
- Health Education Records

Data Collection, Analysis and Reporting



6. Reflections on Increased Standardization

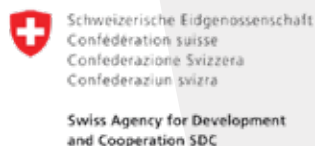
In "Seeing like a State," James Scott negatively appraises the type of simplistic flattening of communities that was a central part of modernist development. A State or Purchaser can never fully understand a village when it "sees" it as a series of population numbers, infrastructure gaps and work targets. Strategic Purchasing, as demonstrated in this brief, makes many of the same simplifications in order to make a system that is scalable and outwardly trustworthy. This shares some of the dangers of the modernist movement and, without serious consideration, could reduce the ability of health staff to adapt effectively to local circumstances.

The project has tried to actively engage with this risk and reduce it. Fortunately, clinical practices are more easily codified than agriculture or education. The training of the EHO staff was already focused on Western medicine, meaning Strategic Purchasing

is not erasing indigenous practices. Furthermore, given the limited funds and resources available prior to the project, the project actually increases rather than replaces the options previously available. Lastly, by careful collaboration with the clinics and the KEHOC headquarters, as well as in the structure of the Steering Committee (or Purchasing Board) which includes representatives with detailed local understanding, the project aims to ensure that the standardization is supplemented with informal understanding of context.

We therefore hope that the ways in which this project "sees" do not flatten variation too drastically, but do increase the knowledge and ability of staff to deliver reliable treatment practices and provide the resources to do that. This approach, including the increased visibility it offers, aims to enable other potential funders (donors and/or a national purchasing agent) to feel prepared to purchase services from EHOs in future.

The Strategic Purchasing Project is a collaboration between Community Partners International, the Myanmar Ministry of Health and Sports, the Access to Health Fund, the Swiss Agency for Development and Cooperation, and the Karen Ethnic Health Organizations Consortium.



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