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DEFINING INSTITUTIONAL ARRANGEMENTS WHEN LINKING FINANCING TO QUALITY IN HEALTH CARE: A PRACTICAL GUIDE


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The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this six-year, $209 million global project increases the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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DEFINING INSTITUTIONAL ARRANGEMENTS WHEN LINKING FINANCING TO QUALITY IN HEALTH CARE: A PRACTICAL GUIDE

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ACRONYMS

ASSIST	USAID's Applying Science to Strengthen and Improve Systems
BPJS-K	Badan Penyelenggara Jaminan Sosial-Kesehatan (Social Security Agency for Health in Indonesia)
CMS	U.S. Centers for Medicare & Medicaid Services
DAI	Development Alternatives Inc.
DRG	Diagnosis-Related Group
EHIF	Estonia Health Insurance Fund
GHS	Ghana Health Service
HFG	USAID's Health Finance and Governance Project
ISO	International Organization for Standardization
IHI	Institute for Healthcare Improvement
JCI	Joint Commission International
JLN	Joint Learning Network for Universal Health Coverage
KARS	Komisi Akreditasi Rumah Sakit (Indonesia's Hospital Accreditation Committee)
KBK	Kapitasi Berbasis Komitmen (Indonesia's Commitment-Based Capitation System)
LMIC	Low- and Middle-Income Countries
MOH	Ministry of Health
NHIA	National Health Insurance Authority (Ghana)
NHSO	National Health Security Office (Thailand)
NQTC	National Quality Technical Committee
PhilHealth	Philippine Health Insurance Corporation
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

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[1] ASSIST is a five-year project of the Office of Health Systems of the USAID Global Health Bureau, designed to improve health and social services in USAID-assisted countries, strengthening their health systems and advancing the frontier of improvement science. USAID ASSIST is implemented by URC. along with EnCompass LLC, FHI 360, the Harvard University School of Public Health, HEALTHQUAL International, Initiatives Inc., the Institute for Healthcare Improvement, the Johns Hopkins Center for Communications Program, and WI-HER, LLC. For more information on the work of the USAID ASSIST project, please visit www.usaidassist.org or email assist-info@urc-chs.com

[2] The Joint Learning Network for Universal Health Coverage (JLN) is an innovative community of policy-makers and practitioners from around the world engaged in practitioner-to-practitioner learning to address challenges and co-produce practical solutions to implementing reforms toward universal health coverage. For more information, see: www.jointlearningnetwork.org

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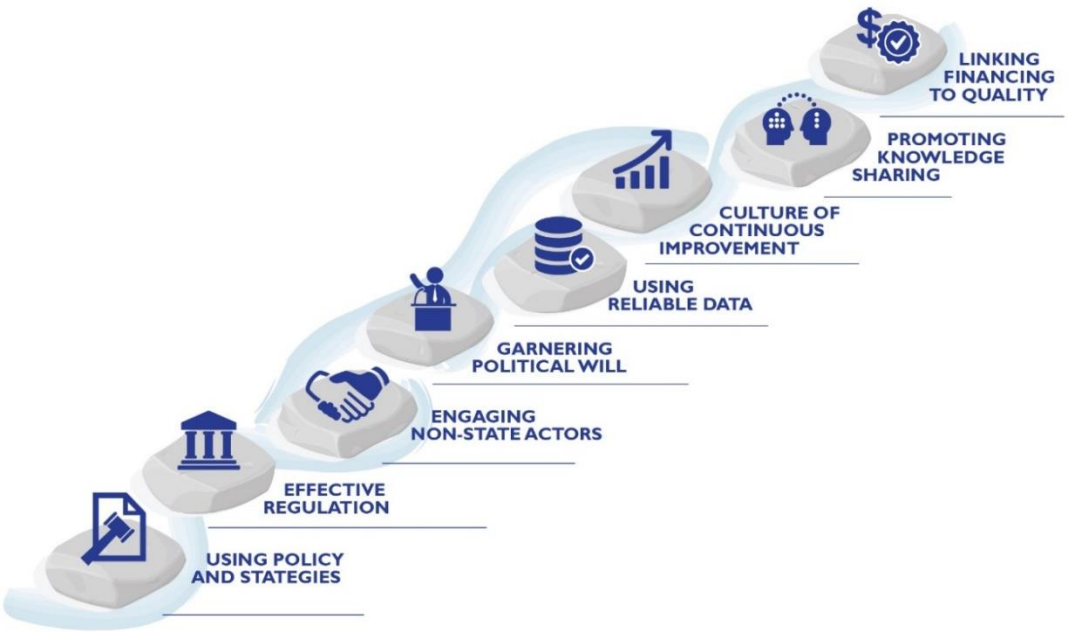
1. INTRODUCTION

As countries work towards achieving universal health coverage (UHC), expanding access to health services while maintaining and improving quality of care remains a major priority. Poor quality of care can prevent countries from achieving desired health outcomes. Furthermore, poor quality of care often leads to unnecessary costs, and limits the potential for expanding access. In low- and middle-income countries (LMICs), over 8 million deaths occur as a result of poor quality annually, translating into $6 trillion in economic losses (Kruk et al., 2018).

In this guide, the ***governance of quality in health care*** refers to the process of competently directing health system resources, performance, and stakeholder participation toward the goal of delivering health care that is effective, efficient, people-centered, equitable, integrated, and safe. (Cico et al., 2016; Health Systems 20/20, 2012; WHO, OECD, The World Bank, 2018). Ongoing strengthening of health governance structures is an essential component to ensure and improve the quality of care, particularly as the pursuit of UHC is often associated with changing institutional roles and the advent of new institutions that have the potential to impact quality.

Many stakeholders, including ministries of health, providers, professional associations, purchasers or payers, accrediting bodies, advocacy groups, and patients are involved in improving the quality of care, and require strong governance from policymakers who lead country strategy and priority setting in the health system. As policymakers pursue major health reforms to expand UHC, eight critical aspects, or *stones,* emerge for consideration to aptly govern for quality in health care, as illustrated in Figure 1 (Tarantino et al., 2016).

Figure 1: Eight Stones of Governance for Quality Health Care



This guide focuses on the ***Linking Financing to Quality*** stone as a potentially powerful lever to improve the quality of care, and explores the role of the payer(s) in improving quality of care. In this guide, the term "payer" refers to institutions or entities that pay or reimburse for health care services. These are typically entities such as social or private health insurance agencies, large employers, Ministries of Health, etc.

1.1 Purpose and Users of the Guide

The purpose of this guide is to support policymakers when they are defining the institutional roles, relationships, and capacities of payers in carrying out strategies for improving the quality of care. We intend government policymakers and institutional actors, including from ministries of health and payers, along with donors and implementing partners to use this guide as a diagnostic and planning tool. Specifically, the guide focuses on:

- identifying strategies whereby payers can leverage their power to enhance the quality of care,
- articulating possible institutional arrangements (among payers and other actors), and
- presenting a process to establish or improve those arrangements in a particular country.

When reshaping the institutional architecture of a health system to introduce or optimize the role of the payer(s), the guide can facilitate a reflection on what is working, where the gaps are, and where roles and responsibilities may be clarified and coordination improved.

The guide describes how payers can use various health financing levers, such as selective contracting, provider payments based on quality, etc. (see Section 2), to drive health sector performance. We assert that the road to UHC is path dependent, and each country will pursue different institutional configurations to provide health services. However, there are promising practices and key considerations for optimizing the role of the payer, whether that payer is a social health insurance scheme, national purchasing agency, private health insurance agency, large employer, or ministry of health (MOH). Importantly, there are promising practices for ensuring collaboration between the payer and other institutions working to ensure and improve quality.

The guide is designed to help countries systematically think through the institutional architecture and mechanisms currently used in a country to govern for quality, and to provide country policymakers with tactics for defining and clarifying institutional roles and responsibilities to ultimately optimize the role of the payer for improving quality of care. We have identified six strategies that payers can use to improve the quality of care. For each of the strategies, we provide key considerations and promising practices for structuring roles and responsibilities and clear coordination and collaboration procedures between the payer and other quality stakeholders.

1.2 How and When to Use this Guide

Policymakers could use this guide as a diagnostic tool routinely as part of strategic planning (aligned with the planning cycle in a given country) to reflect on improvements that can be made in health governance to strengthen the quality of care. The guide can help policymakers to develop a plan of action to effectively link finance to quality. The use of the guide could support the development and/or implementation of a country's national strategic direction on improving quality, e.g., the development and execution of national quality policy and strategy, an effort that many countries are carrying forward

(WHO, 2018). This guide could be a valuable resource while implementing major health reforms that involve payments and incentives for quality and the establishment or changing of health institutions and roles. When reshaping the institutional architecture of a health system to introduce or optimize the role of the payer(s), the guide can facilitate a reflection on what is working, where the gaps are, and where roles and responsibilities might be clarified and coordination improved. Ultimately, we hope this guide will be used in an iterative manner. Health system strengthening and quality of care improvement is a continuous process.

1.3 Process of Developing the Guide

This guide was developed through a collaborative process between the authors and health care quality and financing policymakers and experts from more than 10 countries and several international organizations. As a first step, a literature review was conducted to identify available resources on governing quality in health care, linking financing to quality, and defining institutional arrangements. The findings from the literature review led to the development of:

- the framework for the role of payers in governing quality in collaboration with other actors,
- interview guides used for virtual and in-person key informant interviews, and
- an initial outline of the guide.

Key informant interviews were conducted virtually with health administrators and quality experts from Ghana, Mexico, Nigeria, and the Philippines. Then, in August 2017, the authors and contributors convened for a three-day product development workshop in Jakarta, Indonesia. Participants from 10 countries[3] provided feedback on the framework and the outline, mapped out institutional arrangements for quality in their countries, and shared experiences on challenges and lessons learned to inform the content of the guide.

In addition, a qualitative research study was conducted on this topic in Indonesia, the Philippines, and Thailand, where approximately 20-30 stakeholders in each country were interviewed in person using an expanded version of the interview guide. The findings from this study were incorporated into the final version of the guide, which was reviewed by a panel of health finance and quality experts (see Acknowledgements for details).

Lastly, the Guide benefited from a pilot application in Ghana in 2018. With the support of the authors of this guide and other international specialists, the National Quality Technical Committee (NQTC) of Ghana used the guiding framework, the experiences of other countries, as well as the step-by-step process for establishing effective institutional arrangements presented in the guide to develop a detailed implementation plan for carrying out new or improved institutional arrangements.

[3] Ethiopia, Ghana, India, Indonesia, Malawi, Malaysia, Mexico, the Philippines, Tanzania, and Uganda.

2. INVOLVING PAYERS IN GOVERNING HEALTH CARE QUALITY

2.1 The Potential Roles of Payers in Quality

Before policymakers can make detailed decisions on the governance, powers, functions, roles and structures of the payer, they first need to clarify the vision for the payer (Hawkins, 2017). At one end of the spectrum, a payer can have a narrow role implementing the health financing policies designed by the ministry responsible for health, while at the other end, the payer has a large role actively using health financing levers to drive health sector performance. Countries seeking to define a larger role for the payer in driving health care quality need to ensure provider contracting and payment mechanisms are being used as effectively as possible to achieve objectives, including ensuring and improving quality of health care (Ibid, 2017)

Importantly, payers often move along the spectrum over time from a limited role as the financing operational arm of a ministry of health to a larger role with more autonomy and responsibility for using health financing levers. Evidence from LMICs suggests that political resistance to institutional reforms can be significant (Savedoff and Gottret, 2008), thereby underscoring the importance of step-wise approaches to strengthening the role of the independent payer(s).

Based on the research described above, we propose six strategies, or entry points, through which payers can engage with and leverage their influence on the health system and its stakeholders in order to govern quality:

1. Applying quality criteria to determine provider participation eligibility
2. Incorporating quality incentives or disincentives into provider payment mechanisms
3. Applying quality criteria to benefits package design
4. Generating demand for quality
5. Investing directly in quality improvement
6. Providing non-monetary incentives for quality

Figure 2 below maps these strategies to the mechanisms or processes that may be used to execute them, and identifies the roles and responsibilities needed for implementation. The framework builds upon a framework for insurance-driven improvement in health care quality developed by Mate et al. in 2013.

Many, if not most, of these roles and responsibilities would be fulfilled by actors other than the payer, including ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc. However, the payer can use its power and influence to (1) focus the health system and its stakeholders on these strategies, and (2) increase the likelihood that the strategies are effective in enhancing quality.

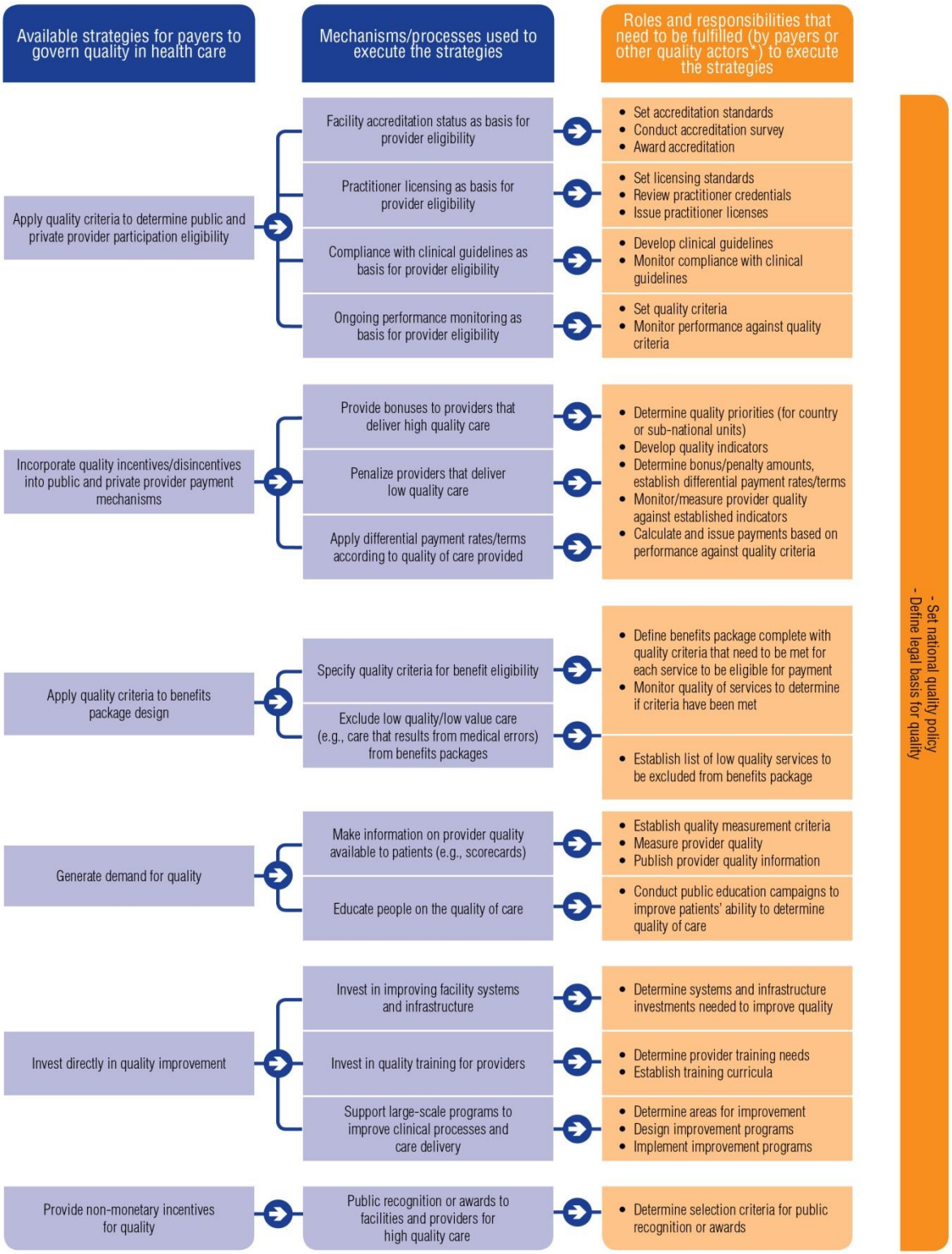
Detailed descriptions of each of the strategies as well as illustrative country examples are presented in sections 2.2-2.8. In Annex B, we present an extensive table outlining the roles and responsibilities of

payers and other stakeholders per strategy and execution mechanism across multiple countries reviewed in developing this guide.

Not all of the strategies described may be feasible in the context of a given country and period. Contextual factors (such as historical or political factors, the current institutional landscape, a country's economic situation, etc.) (Mate et al., 2013) should be taken into account when examining the relevance of available strategies, and only those strategies that are deemed feasible or relevant should be considered when roles and responsibilities in governing health care quality are defined.

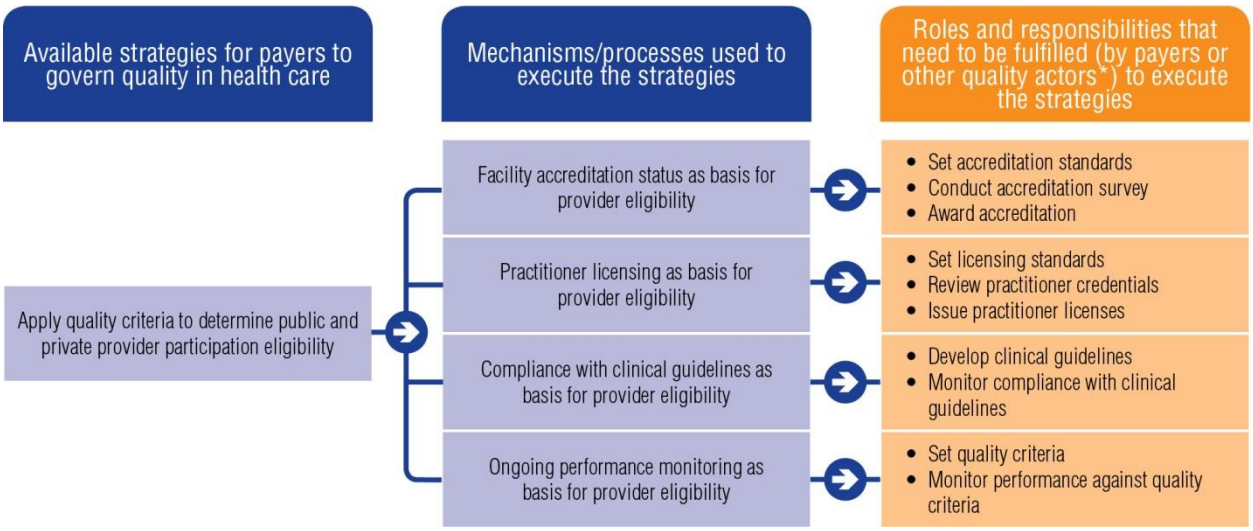
Working towards a long-term goal of implementing all the strategies, including sequencing of when to adopt each strategy, should be an objective. While the strategies often happen simultaneously and need continuous refinement and improvements, the first three are critical in fostering quality in the design of a payment system and the associated institutional architecture. In advanced health systems, most or all of these strategies are employed to strengthen the role of payers to positively influence and improve the quality of care. However, even in the most advanced health systems, strategies to improve quality -- including the roles and responsibilities for carrying them out -- must be continually reviewed for efficacy.

Figure 2: A conceptual framework for the role of payers in governing quality in collaboration with other actors*



*Other quality actors may include ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.

2.2 Applying Quality Criteria to Determine Provider Participation Eligibility



*Other quality actors may include ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.

The first and most common strategy through which payers can govern quality in health care involves linking the eligibility of providers to participate in health financing schemes to the quality of care provided by those providers. Selective contracting is often used, meaning the payer selectively enrolls in its scheme(s) providers that meet its quality criteria (Mate et al., 2013; McNamara, 2006). Several approaches for measuring or monitoring quality (which we refer to as "mechanisms" for executing this strategy) can be applied.

One of the more common ways a payer selectively contracts with providers is by using a facility's accreditation status to determine eligibility to participate in a scheme. In some countries, only accredited facilities are eligible to participate in national health insurance schemes.

While a payer may use a facility's accreditation status to determine eligibility, the process of accrediting facilities, involving standard setting, compliance monitoring, and issuing accreditation awards, is not necessarily a responsibility of the payer. In some countries, such as Malawi, Tanzania, and Uganda, accreditation is conducted by the MOH. In Tanzania, the MOH has recently introduced a stepwise certification towards accreditation system for quality in health care. However, it is envisioned that health sector stakeholders will ultimately establish an independent accreditation body. (United Republic of Tanzania Ministry of Health and Social Welfare, 2015) In other countries, like the Philippines, health insurance agencies jointly or solely conduct accreditation. In still others, such as India, Indonesia, Jordan, Malaysia, Moldova, and South Africa, it is the responsibility of an independent body. The last is considered a best practice, as it removes a potential conflict of interest from the accreditation process.

In the Philippines, the Philippine Health Insurance Corporation (PhilHealth) "employs a two-step process for facilities to contract with PhilHealth: certification (done by the Department of Health) and accreditation (done by PhilHealth). Both processes are roughly identical, and administratively and financially burdensome" (Kukla et al., 2016). A third-party accreditor could help to relieve the pressure of resource shortages (human and financial) within PhilHealth and could enhance accountability and transparency in the accreditation and certification process, strengthening institutional support for quality of care. However, if facility accreditation and certification is mostly subsidized by the government, as is

currently the case in the Philippines, an independent accreditation body may have difficulty establishing a sustainable revenue stream. In many countries, like Indonesia, initial subsidization by the government was required and important when establishing an independent body.

It should be noted that, regardless of which institution owns the accreditation process, accreditation usually requires collaboration among multiple stakeholders, i.e., the MOH, provider associations, and accreditation bodies, particularly in setting accreditation standards. In Indonesia, for example, the MOH works with Indonesia's Hospital Accreditation Committee (Komisi Akreditasi Rumah Sakit, KARS) to establish the accreditation standards, and the payer, the Social Security Agency for Health (Badan Penyelenggara Jaminan Sosial-Kesehatan, BPJS-K) supports district health offices in verifying accreditation records while credentialing public facilities.

In some countries, such as India and Malaysia, accreditation is voluntary and is not a prerequisite for participation in a scheme, but other incentives for accreditation, whether monetary (e.g., differential payment rates) or non-monetary (prestige), may exist. These are discussed in detail in 2.3 and 2.7, respectively.

The licensing of practitioners can also be used as a mechanism to determine eligibility for participation in a scheme. In this case, only facilities with licensed practitioners may be eligible. In most countries, practitioner licensing is the responsibility of professional associations, although health insurance agencies, the MOH, or other government agencies are often involved in setting standards for licensing. A close collaboration between professional associations and the MOH on the licensing of practitioners is usually needed, as differences may arise between the education standards and public health needs, as is the case in India.

INDONESIA

In Indonesia, accreditation is mandatory as part of the payer's credentialing process for hospitals to join the National Health Insurance Scheme (Jaminan Kesehatan Nasional). As a result, the Indonesia Hospital Accreditation Body (KARS) now receives a sustainable revenue stream from hospitals to continue to support them to reach higher levels of accreditation and provision of good quality health care.

The MOH is a member of the KARS Board of Directors.

In the Philippines, the Department of Health adopted the accreditation standards of PhilHealth, incorporating them into the licensing requirements for providers (Kwon S. et al., 2011), and increasing harmonization of requirements. In Indonesia, the Indonesian Hospital Association (Persatuan Rumah Sakit se-Indonesia) manages subnational authorities who are responsible for issuing two-year licenses, according to standards set by the MOH (Cashin et al., 2017). The payer (BPJS-K) selectively contracts with providers to participate in the health insurance scheme, and uses a credentialing process to check the status of both licensing and accreditation before a facility is credentialed. The technical criteria for the payer's credentialing process are set by the MOH.

Compliance with clinical guidelines is another factor that can be used to determine a facility's eligibility for participation in a health financing scheme. This would involve conducting a review of the facility's compliance with clinical guidelines to determine if that facility should be included or excluded from a scheme. While usually the role of the MOH, intentional collaboration with all stakeholders involved in delivering health services is useful, including involving stakeholders in clinical review and sharing results with providers, licensing or accrediting organizations, purchasers, and clients.

Finally, ongoing performance monitoring against quality criteria can also be conducted to determine whether a facility should participate, or continue to participate, in a scheme. In many countries, this type of monitoring is conducted by the MOH, and results are not necessarily linked to the eligibility for

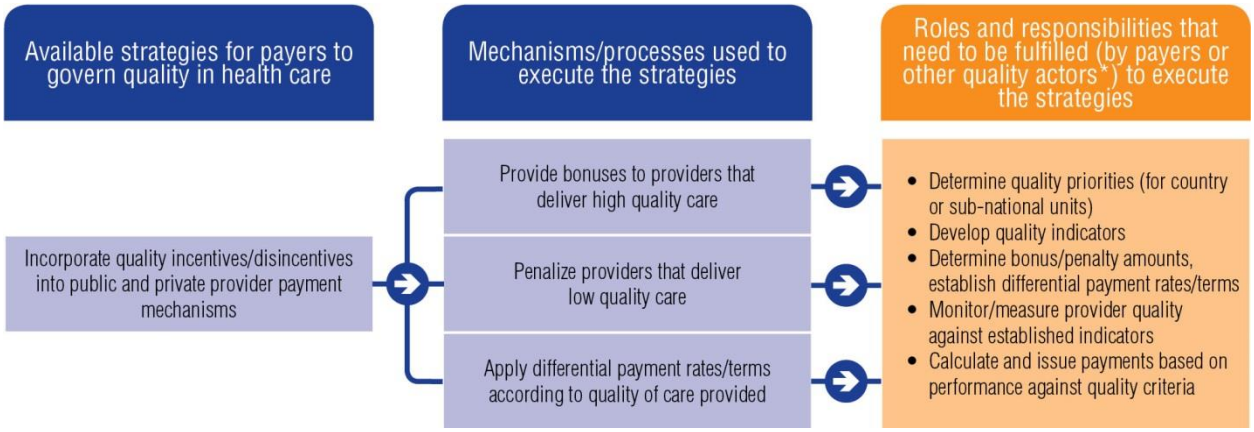
participation in a scheme. In Malaysia, for example, monitoring of performance against quality criteria is conducted at multiple levels, including at the national and subnational levels, within specific programs, and in health facilities. However, this monitoring is not tied to participation in a payment scheme. In contrast, in Estonia, the Estonia Health Insurance Fund (EHIF) since 2002 has been selectively entering into or renewing three-year contracts with providers by monitoring and assessing against predetermined criteria, including geographic accessibility (e.g., proximity to patients), prices of services, and quality (e.g., patient complaints recorded during the last contracting period) (Jesse et al., 2005). The criteria were redefined in 2014 to place more emphasis on quality, among other enhancements. While the current quality indicators are more focused on inputs, it is envisioned that outcome indicators will be used for selection in the future (Habicht et al., 2015).

In most countries, payers have not been significantly involved in setting the standards or conducting standards monitoring directly. Instead, they rely on other stakeholders (typically MOHs or independent agencies). Setting standards for accreditation and licensing, developing clinical guidelines, and monitoring performance are activities that involve multiple stakeholders, including payers and providers. In several countries, including Indonesia and the Philippines, multiple sets of standards exist, and are owned by different institutions, often creating confusion or conflict among institutions. Given this, stakeholders must have clear expectations for sharing information, collaborating, and communicating amongst one another.

Promising Practices & Key Considerations

- Selective contracting is a promising practice for payers, using credentialing criteria from accreditation, licensing, certification, and registration as eligibility criteria for participation in a health financing scheme. However, while linking participation eligibility to external evaluation programs, such as accreditation, is a good practice, in isolation it does not ensure the quality of care. While external evaluation programs are often early entry points for national improvement efforts, the evidence for their impact on quality is variable; it is important to recognize that these approaches should be embedded within a broader structured effort encompassing the required governance structures and a suite of effective interventions that is appropriate for the local context (WHO, 2018).
- An autonomous accrediting body is seen as a promising practice, removing a real or perceived conflict of interest if accreditation is led by the payer(s) or a MOH.
- When establishing a new institution, like an independent accrediting body, national subsidies may be necessary in the short term while establishing a sustainable revenue stream. Also, payers that require provider accreditation as part of selective contracting can help establish this revenue stream.
- Professional associations should be closely involved in developing the criteria for licensing of providers, working closely with MOH to ensure alignment of education standards and public health needs.
- Ongoing performance monitoring against standards should be more actively harmonized between institutions in countries to reduce the burden on providers of having to keep track of multiple sets of standards and criteria.
- The processes of setting standards setting, developing clinical guidelines, and monitoring performance involve multiple stakeholders. Multiple sets of standards or guidelines, owned by different institutions, may exist, creating confusion or conflict among institutions. The stakeholders involved must have clear expectations for sharing information, collaborating, and communicating among them.

2.3 Incorporating Quality Incentives or Penalties into Provider Payment Mechanisms



*Other quality actors may include ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.

A second strategy through which payers can govern quality involves linking the payment mechanism(s) to the quality of care provided. In this case, quality would be used as a basis for determining the terms under which a payment is made to a provider, and the amount of the payment. This is often referred to as "quality-based financing" or "quality-based payment." Several approaches for incentivizing high quality or penalizing low quality (which we refer to as "mechanisms" for executing this strategy) can be applied to achieve this strategy.

Quality criteria can be used to provide bonuses to providers that deliver high-quality care. These bonuses would serve to reward providers that deliver high-quality care, and would be provided in addition to the basic payment to which all providers are entitled. In Kenya, the National Health Insurance Fund offers rebates to the hospitals that receive the highest scores on their assessments (Cico et al., 2015; Lane et al., 2014). Similarly, in Moldova, health insurance contract terms include quality, and providers are positively rewarded based on results, such as the reduction of adverse events (Cico et al., 2015; Shaw, 2015).

Similarly, penalties may be issued to providers that deliver low-quality care. These penalties would serve to penalize providers that deliver substandard quality care, and would be deducted from the basic payment to which all providers are entitled. In Thailand, the National Health Security Office, which manages the Universal Coverage Scheme, assesses provider quality based on set standards, and penalizes providers that deliver below-standard care by deducting payments (Hanvoravongchai, 2013).

In Indonesia, at the primary care level, capitation is used to reimburse most primary care services, and performance incentives, Kapitasi Berbasis Komitmen (KBK), were jointly established by the national health insurance agency, the MOH, and other stakeholders to improve the efficiency and quality of capitated services. Under KBK, the final portion of the capitation payment is based on performance against three indicators that are self-reported through the P-Care data system: contact rate (target=15/1,000 members per month), referral rate, and the existence of a chronic disease management program (Cashin et al., 2017).

Differential payment rates and/or terms may also be applied according to the quality of care provided. If differential payment rates are applied, providers would receive payments at higher or lower rates for the same service, depending on the quality of care provided. Differential payment terms may be in the form of faster processing of claims for providers that deliver higher quality care. (See example on India

in text box right)

In Ethiopia, the health insurance agency is working to define indicators that will serve to monitor the quality of service for each facility. These indicators will be developed by taking into data that are already available, a process that will be part of the design of a payment scheme which is linked to the quality of care received (HFG, ASSIST, JLN, 2015a). Ghana uses comprehensive tools to assess facilities across 12 categories to determine the level of facility and the type of services to be reimbursed by the National Health Insurance Authority (NHIA). Grades are assigned to facilities based on their performance during the assessment. The rate of reimbursement is determined based on the level of the facility (HFG, ASSIST, JLN, 2015b).

Countries like Lebanon have health financing mechanisms that reimburse at higher rates for higher levels of accreditation attained. However, the evidence in Lebanon on this practice indicates that this alone is not enough to improve the quality of care, and that case mix and outcome indicators should also be used by the payer to ensure and improve quality, as this would incentivize facilities to improve quality beyond the purpose of meeting the accreditation requirements (Ammar et al., 2013).

The optimal governance arrangements for rate-setting and quality-based payment depend on the country context. However, regardless of which organization leads rate or tariff setting and the establishment of associated quality criteria -- i.e., the MOH or the payer(s) -- an intentional, multi-stakeholder, consultative engagement process with a clearly designated lead should be applied. Ghana's experience provides an example of engaging all stakeholders from the beginning to the end so that they have an understanding of what goes into tariff/rate setting.

Providers from both public and private facilities bring an important and unique perspective on care delivery, and should be involved in setting rates and determining quality metrics for purchasing. In the Philippines, for instance, PhilHealth relies on providers to set the case rate for reimbursement.

Ideally, rates and associated quality incentives or penalty structures will also take into account the geographic differences and disparities present in a country. The incentives process should be something that is designed nationally and accepted locally. Priorities may be different at different levels or with changing administrations, but there should be an institution responsible for keeping changing priorities on track. For instance, in Thailand, the Quality Outcomes Framework used by the National Health Security Office (NHSO), the largest payer of health services in the country, for purchasing health services can be adapted to reflect local needs, including both national and regional-level key performance indicators.

INDIA

In India, now that some coverage has been achieved, significant discussions about quality are beginning.

Accreditation is voluntary, but incentives to get accredited exist. For example, private facilities get "bragging rights" (e.g., the ability to display an accreditation award as recognition of the high quality of their services) and public facilities get financial incentives.

The health standards in India are set by national MOH and administered at the state level. If facilities are not rated at a certain star rate or above, their budgets are cut.

A state's health budget is also cut if a certain percentage of facilities do not achieve star levels. Accreditation surveys are conducted by external teams.

Patients are represented in health financing decision-making and they make decisions on what they do with the money for the health facility.

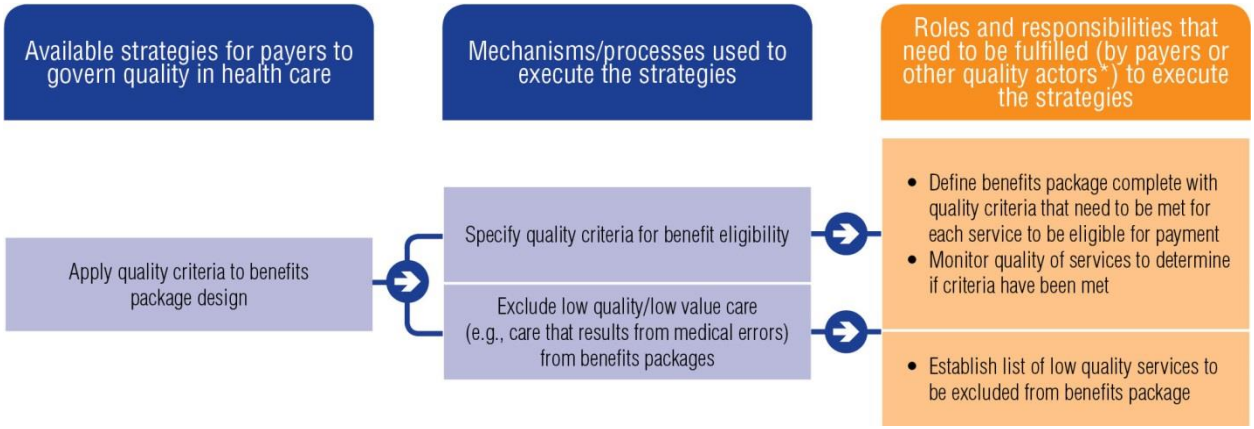
Patient satisfaction surveys are also conducted to get feedback on the quality of care, which then helps to determine how money is spent.

Quality monitoring to determine payment for incentives or penalties may be done by payers, providers, self-reporting, and/or independent trusted monitors. In Ethiopia, clusters of hospitals determine who should receive incentive payments, which are then provided to the selected facilities by the MOH. In Indonesia, primary care providers monitor and upload data on three "quality" indicators into a data system (P-Care) that is analyzed by the payer to determine capitated payments. Use of independent monitoring bodies should be considered as a means to separate implementation from validation.

PROMISING PRACTICES AND KEY CONSIDERATIONS

- An intentional, multi-stakeholder, consultative engagement process with a clearly designated lead should be applied in setting tariffs and explicitly including quality criteria in reimbursement rates.
- Providers from both public and private facilities should be involved in rate setting.
- Financial incentives are a necessary tool, but usually not sufficient on their own, for achieving quality goals. The structure and process for implementing the financial incentives matter a great deal, and should be monitored and refined often.
- Regardless of who establishes the quality criteria, those criteria are often not related to health outcomes, but instead related to outputs, i.e., number of contact rates, referrals, etc. Indicators on the efficiency and safety dimensions of health care are often lacking. Better data sharing practices among stakeholders and standardization of indicators are needed to track all dimensions of quality.
- Tariff setting and the quality criteria to determine incentives, penalties and/or differential payment terms should take into account the geographic differences and disparities present in a country.
- Patients and communities should be meaningfully engaged in determining quality priorities and standards that are aligned with the national strategic direction.

2.4 Applying Quality Criteria to Benefits Package Design



*Other quality actors may include ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.

A third strategy through which payers can govern quality involves applying quality criteria to the process of designing and defining benefits packages. Two main approaches for executing this strategy include specifying quality criteria for benefits eligibility and explicitly excluding low-quality care within the benefits package.

Specifying quality criteria for benefits eligibility involves not only defining the list of services included in a benefits package, but also defining how those services must be provided to be eligible for payment (e.g., in alignment with evidence-based care and stated national clinical guidelines). For instance, clinical practice guidelines or protocols (e.g., national standard treatment guidelines) may accompany the list of services, outlining how care must be provided to be considered of acceptable quality and thus eligible for payment. In France, for instance, mandatory medical guidelines (*références médicales opposables*) have been used since 1993 to set coverage policy (Woolf et al., 1999; Allemand and Jourdan, 2000). Guidelines are also associated with benefits packages in Estonia and the Philippines, where quality standards are included in contracts with providers (Cashin et al., 2017).

As is the case with the two previous strategies, compliance with guidelines or protocols would need to be monitored. Services that are not compliant would be considered ineligible and payment for those services would be denied. For instance, in Ghana, claims processing is based on the MOH Standard Treatment Guidelines. Deviations from policy are not reimbursed. If a provider does not follow the malaria treatment protocol, for example, part of the claim will not be reimbursed. This ensures that providers adhere to protocols, thereby encouraging quality service delivery (HFG, ASSIST, JLN, 2015b). In Colombia, health plans compete for enrollees based on the service and quality features of their benefits packages (Cico et al., 2015; Hsiao and Shaw, 2007). In Indonesia, the national health insurance agency is not supposed to reimburse for inappropriate referrals, although it is not clear if this policy is enforced (Cashin et al., 2017).

In many countries, payers determine the lists of services to be included in benefits packages in collaboration with other stakeholders, who, in turn, establish the standards and guidelines. Usually, the MOH leads the standards and guidelines development process, working closely with professional associations, patient advocacy groups, accrediting bodies, etc., and the MOH, the payer(s), or an independent group may monitor compliance with those guidelines. In some countries (e.g., Ghana and Indonesia), roles and responsibilities are established through a legislative framework. In Ghana, the NHIA sets and implements benefits package policy. For instance, guidelines associated with the benefits package are set by the MOH, but the NHIA incorporates those guidelines into the benefits package, assigning them to different insurance coverage levels.

These roles have often evolved over time. In Ghana, there was a realization that if the same institution was both making and implementing policy, there would be no "referee." Therefore, parliament created the Ghana Health Service (GHS) to become the implementing, or service delivery, body, and the MOH devolved some of its functions related to service delivery implementation to the GHS while retaining the policymaking functions. Meanwhile, the NHIA is the purchasing body, and it also has a large role in monitoring and accreditation.

In Tanzania, stakeholders conducted study-tours in different countries and learned from their experiences before establishing roles, with the result that the MOH and payer functions were separated from the beginning. However, the insurance body has evolved over time to take on a more prominent role in quality.

In Indonesia, the primary health benefit package provided by the health insurance program and paid by BPJS-K currently includes minimum service standards for 144 competencies outlined by the MOH. As described by Cashin et al. (2017), "A new MOH program makes local governments accountable for 12 new minimum service standards for promotion and prevention programs related to conditions such as

mental health, hypertension, diabetes, tuberculosis and HIV. These services are intended to be complementary to health insurance benefit package, and help reduce the need for curative services."

Excluding low-quality or low-value care from benefits packages is another approach for ensuring that the packages take quality into account. Stakeholders who are involved in developing the benefits packages would be responsible for identifying the types of services to be excluded. In the United States, for instance, the Centers for Medicare & Medicaid Services (CMS) has a growing list of hospital-acquired conditions specifying many preventable errors that CMS will not reimburse, including surgical site infections, falls and trauma, and foreign objects retained after surgery (CMS, 2018).

It is important to ensure that the benefits package spans the continuum of services for specific conditions (e.g., diagnosis, inpatient care, outpatient care), and that the reimbursement mechanism mandates provider communication across levels of care to share information on client cases. This, in turn, can spur providers to provide timely, clinically appropriate, and unduplicated care (Kukla et al., 2016).

Promising Practices and Key Considerations

- In many countries, payers determine the lists of services to be included in the benefits package(s), working with the MOH (leading), providers, and professional associations who, in turn, establish the standards and guidelines to ensure quality health service delivery across all services.
- Specifying quality criteria for benefits eligibility involves not only defining the list of services that are included in a benefits package, but also defining how those services must be provided to be eligible for payment.
- Guidelines are adhered to when the appropriate structures, functions, and agreement frameworks are in place and roles are clearly assigned. Unclear roles and responsibilities often lead to tension and less than optimal collaboration among payers, the MOH, providers, patients, etc.
- It is important to ensure that the benefit package spans the continuum of services for specific priority conditions and the reimbursement mechanism mandates provider communication across levels of care to share information on client cases.
- Participatory approaches involving all relevant actors should be used for identifying and defining benefits packages.
- Learning from other countries' experiences is a helpful capacity-building tool that country stakeholders should employ strategically. Furthermore, learning from within the country plays a key role in developing implementation-informed policies aimed at improving quality (WHO, 2018).

2.5 Generating Demand for Quality

*Other quality actors may include ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.

A fourth strategy through which payers can govern quality involves generating demand for quality health services. Demand can be generated by:

- Making information on provider quality publically available, or
- Educating people on the quality of care.

Data collection on provider and service delivery quality is often led by the MOH, with support from accrediting bodies, empaneling bodies, district health offices, and providers (through self-assessments). Payers sometimes collect data on quality indicators, like in Indonesia and the Philippines. Often through the purchasing mechanisms, payers have useful data to analyze to provide insights into provider quality (e.g., claims data, data collected for the purpose of calculating provider payments that are adjusted for quality, etc.). Payers also have the potential to use selective contracting to ensure providers share information on quality. For example, when assessing providers during its selective contracting process, EHIF in Estonia awards extra points to providers using national e-health (Habicht et al., 2015).

Currently, in the majority of countries, provider quality data are not yet public. In several countries, especially in those with advancing and advanced health systems, payers publish high-level information (e.g., facility accreditation status) on their websites and/or encourage facilities to display it to foster competition among providers for improved service delivery quality. There is evidence that publicizing provider quality has had a positive effect on quality improvement initiatives (Jung et al., 2015; Hibbard et al., 2003). In Scotland, the National Health Services' eHealth strategy encourages patient reviews of provider quality and the dissemination of other information on providers to help patients engage in their own health care decision making processes and demand provider quality (The Scottish Government 2018). In Malaysia, hospitals pursue accreditation by the Malaysian Society for Quality in Health on a voluntary basis, and publicly display their accreditation status to create demand for their services. In Ghana and India, the MOHs display A+ facility ratings on their websites. However, general consensus exists across countries that information on provider quality needs to be disseminated more widely.

Summarized and standardized information on provider quality, for instance in the form of scorecards, may help patients make better decisions when choosing providers. Scorecards should be carefully designed to help people think about the factors that are most important to them in the choice of a provider, and to nudge them to improve their choices (Boyce et al., 2010). Decisions on the appropriate quantitative and qualitative data to share publicly should be made through a national multi-stakeholder engagement process, including patient advocacy groups. Regulations for publicizing data should be clearly communicated and protected by law. The institutional roles and responsibilities for sharing data should be clearly established, along with the avenues for disseminating data on provider quality, e.g., via civil society organizations, the media, public administrative offices, specific websites or data repositories,

or directly from providers. Capacity for data analysis should be built within all the key institutions, i.e., the MOH, the payer, public health research institutions, etc. Ideally, there would be a coordinated and transparent system for making the appropriate data public. Payers would work closely with the MOH, civil society organizations, and other actors to regularly disseminate data on provider quality, and require providers to share types of data with clients as part of selective contracting provisions.

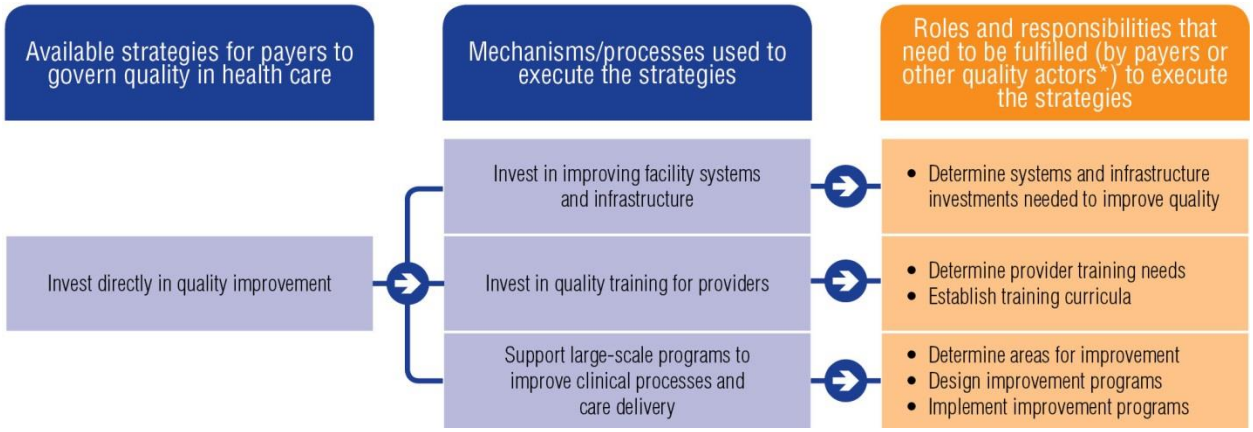
Additionally, payers have the ability to educate citizens on the quality of care and engage them in influencing provider quality through education campaigns as well as through patient feedback. Payers can use selective contracting to require providers to share information on standards and guidelines, and to collect patient feedback and provide a forum for complaints. In Indonesia, BPJS-K requires hospitals to have a process for collecting patient complaints, and to use patient satisfaction surveys to collect patient perceptions of service delivery quality; if the feedback is negative, hospitals must implement a plan for improving the quality of their service delivery. If a hospital continues to fail to improve perceptions of quality, it risks not being contracted to participate in national health insurance.

Payers can also directly share information with patients and collect patient feedback or complaints. For example, the NHSO in Thailand directly manages a hotline that fields patient complaints. Additionally, payers can run educational campaigns on the benefit package and quality standards -- disseminating materials and campaign messaging through print, digital, social media and other channels -- and conduct other social and behavior change activities. In the Philippines, patient advocacy groups are one segment of civil society that is frequently overlooked in service quality improvements, and yet they frequently lobby providers to improve the quality of care. PhilHealth has acknowledged that it could also benefit from more interaction with civil society to strengthen its image and enhance the voice of beneficiaries. However, it has yet to decide on types of forums, the degree of formalization, and the frequency of such interactions. Thus, institutional arrangements for incorporating civil society are in need of further development. In contrast, civil society organizations in Thailand have a strong voice and take a leading role in elevating debate around provider quality issues that are frequently publicized through the media.

PROMISING PRACTICES AND KEY CONSIDERATIONS

- Data collection on provider and service delivery quality is often led by MOH, with support from accrediting bodies, empaneling bodies, district health offices, and providers (through self-assessments).
- There is evidence from advanced health systems that publicizing provider quality has positive effects on quality.
- Often through purchasing mechanisms, payers have useful data to analyze to provide insights into quality.
- Capacity for data analysis should be built in all actors, i.e. the MOH, the payer, research institutions.
- Emerging lessons on quality from the frontline should be captured and information should be shared nationally to transform governance arrangements.
- A national multi-stakeholder engagement process, including patient advocacy groups, should be used to determine in policy and regulation the provider information to be provided to patients, the types of questions to answer, and feedback to collect. A need for widely disseminating data on quality exists.
- The institutional roles and responsibilities for sharing data should be clearly established, along with the avenues for disseminating data on provider quality, i.e. civil society organizations, the media, public administrative officers, websites, providers, etc.
- Payers can use selective contracting to require providers to share information on quality standards and guidelines, collect patient feedback, and provide a forum for complaints.

2.6 Investing Directly in Quality Improvement



*Other quality actors may include ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.

A fifth strategy through which payers can govern quality involves making direct investments in quality improvement. These can be in the form of:

- Investments in the improvement of facility systems and infrastructure,
- Investments in training providers on quality concepts and quality improvement, and/or
- Support for large-scale programs to improve clinical processes and care delivery.

While financial incentives and other strategies to improve quality described in this guide can be effective, direct investments on the supply-side are also necessary for those strategies to achieve the desired goals (Lagomarsino et al., 2012). The MOH or other agencies typically invest directly in infrastructure or systems, and MOHs or ministries of education are generally responsible for training providers. However, payers may also have a role in such investments, as provider payment mechanisms can build infrastructure or staff investment needs into rate calculations. In Kerala, India, the payer invested in instituting electronic transfers to make payments quicker; as a result, facilities had reliable access to income, corruption was reduced, and quality in many facilities improved (Tarantino et al., 2016). Also, through selective contracting, payers can require providers to maintain certain training and human resource standards and undertake infrastructure improvements.

In contexts where multiple payers, including commercial payers, may exist, government may require payers to contribute part of their funds to infrastructure and system investments. Such examples exist in several states of the United States, including Massachusetts, Michigan, Pennsylvania, Washington, and Rhode Island, where payers fund investments in primary health care infrastructure and systems, including investments in human resources and training (Center for Health Care Strategies & State Health Access Data Assistance Center, 2014). Furthermore, in Vermont, Ohio, Iowa, and Colorado, payers invest in health information systems, including electronic health records, health information exchanges, and others (Center for Health Care Strategies & State Health Access Data Assistance Center, 2014).

Programs designed to improve clinical processes and care delivery, such as improvement collaboratives[4], have been shown to produce significant improvements in the quality of care provided in LMICs (Miller Franco and Marquez, 2011). While quality- or performance-based payment systems alone may not be sufficient to improve quality, aligning the design of such systems with improvement collaboratives has been shown to result in significant improvement (Mandel and Kotagal, 2007).

In Mexico, one important challenge is that a clear definition of what is considered an investment in quality does not exist, leaving it up to each state to make that determination. An important lesson is the need to specify what types of investments are needed to bring up the level of provider quality, and to establish prioritization criteria to help subnational governments make investment determinations.

PROMISING PRACTICES AND KEY CONSIDERATIONS

- Direct investments on the supply side are a necessary complement to other strategies to improve or incentivize quality.
- Provider payment mechanisms can build infrastructure or staff investment needs into rate calculations.
- Through selective contracting, payers can require that providers maintain certain training and human resources standards and undertake certain infrastructure improvements per MOH or other actors' recommendations.
- Aligning the design of performance-based payment systems with improvement collaboratives has been shown to result in significant improvement.
- Clarifying the types of investments that are needed to bring up the level of provider quality can help providers and other stakeholders and actors understand where to invest.

2.7 Providing Non-Monetary Incentives for Quality

Available strategies for payers to govern quality in health care	Mechanisms/processes used to execute the strategies	Roles and responsibilities that need to be fulfilled (by payers or other quality actors*) to execute the strategies
Provide non-monetary incentives for quality	Public recognition or awards to facilities and providers for high quality care	• Determine selection criteria for public recognition or awards

*Other quality actors may include ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.

Lastly, a sixth strategy through which payers can govern the quality of care involves providing non-monetary incentives for quality. These can be in the form of public recognition or awards for facilities and providers that provide high-quality care. Such recognition can be a powerful incentive for improving quality (Committee on Quality of Health Care in America, Institute of Medicine, 2001).

[4] Improvement collaboratives refer to "coordinated efforts of teams to accelerate improvement in a single area of care through iterative changes and peer-to-peer learning about successful changes" (Miller Franco and Marquez, 2011).

Awards or recognitions are typically provided by the MOH, subnational government officials, other agencies, or associations. In Chile, Mexico, Mozambique and Uganda, various forms of non-monetary incentives for quality, including awards for staff or facilities, exist (Cico et al., 2015). In Indonesia, local government units recognize top performing facilities each year through a ceremony and in the media, and the MOH recognizes the country's top facilities every year in the same way. In Thailand, accreditation awards are offered during an annual ceremony held by the independent Healthcare Accreditation Institute. Thailand also offers the prestigious Thai Quality Award spanning multiple sectors through the Ministry of Industrial Affairs under the Foundation of Productivity Improvement. Voluntary accreditation, which is not tied to eligibility for participation in a financing scheme or to provider payment rates, can also be a form of non-monetary incentive. Accreditation may be seen as a sign of prestige and recognition that a provider offers high-quality services. This is particularly true in countries where medical tourism is well developed. For instance, in Malaysia, where accreditation is voluntary and not tied to payments, facilities seeking to attract medical tourists have a strong incentive to pursue accreditation. Similarly, in Thailand, facilities seeking to attract medical tourists pursue accreditation by the Joint Commission International (JCI), regarding it as a more prestigious and internationally-recognized award than accreditation by the HAI.

In some countries, payers recognize certain facilities as centers of excellence. In the Philippines, PhilHealth and the Department of Health have developed award initiatives, such as Centers of Excellence, to further incentivize providers. There is some discussion in PhilHealth about developing special administrative licensing privileges for facilities that pursue International Organization for Standardization (ISO)-certified facilities, using differential payment terms. Payers have an opportunity to build in differential payment terms to encourage facilities to achieve recognition for high-quality care.

PROMISING PRACTICES AND KEY CONSIDERATIONS

- Non-monetary awards or recognitions are typically provided by the MOH, other government agencies, or professional associations.
- Payers do have an opportunity to build in criteria for differential payment terms in selective contracting to reward providers that receive quality awards from other institutions and/or pursue quality recognition.

2.8 Payers' Roles in Policy Development and Regulatory Reforms

In addition to the roles that must be fulfilled for the implementation of the six strategies discussed above, payers, as key actors in governing the quality of care, may have other overarching roles in setting national policies or drafting and defining laws related to quality. Policy reform or development processes typically require collaborative efforts among multiple stakeholders, including payers. As countries consider national quality policy and strategies (WHO, 2018), involving payers from the beginning provides an opportunity to optimize their role across the strategies described in sections 2.2-2.7 through multi-stakeholder engagement.

If payers are to take an active role in policy development or reform to improve the quality of care, they should also be held externally accountable by policymakers. Policymakers should determine, though participatory, meaningful engagement, the quality indicators and reporting mechanisms for payer accountability, and payers should establish appropriate internal monitoring strategies to report on

indicators. For example, in Estonia, EHIF has a monitoring framework that includes quality indicators related to access (waiting times for services, beneficiary satisfaction, household survey of living conditions and income) and financial protection (level of out-of-pocket payment, coverage), among others, and the EHIF is annually accountable to the Supervisory Board (Jesse, 2008). The EHIF Supervisory Board is chaired by the minister of social affairs for political accountability and is comprised of 15 members representing patient, employer, and government-nominated members including from the Ministry of Social Affairs (Hsiao and Done, 2009).

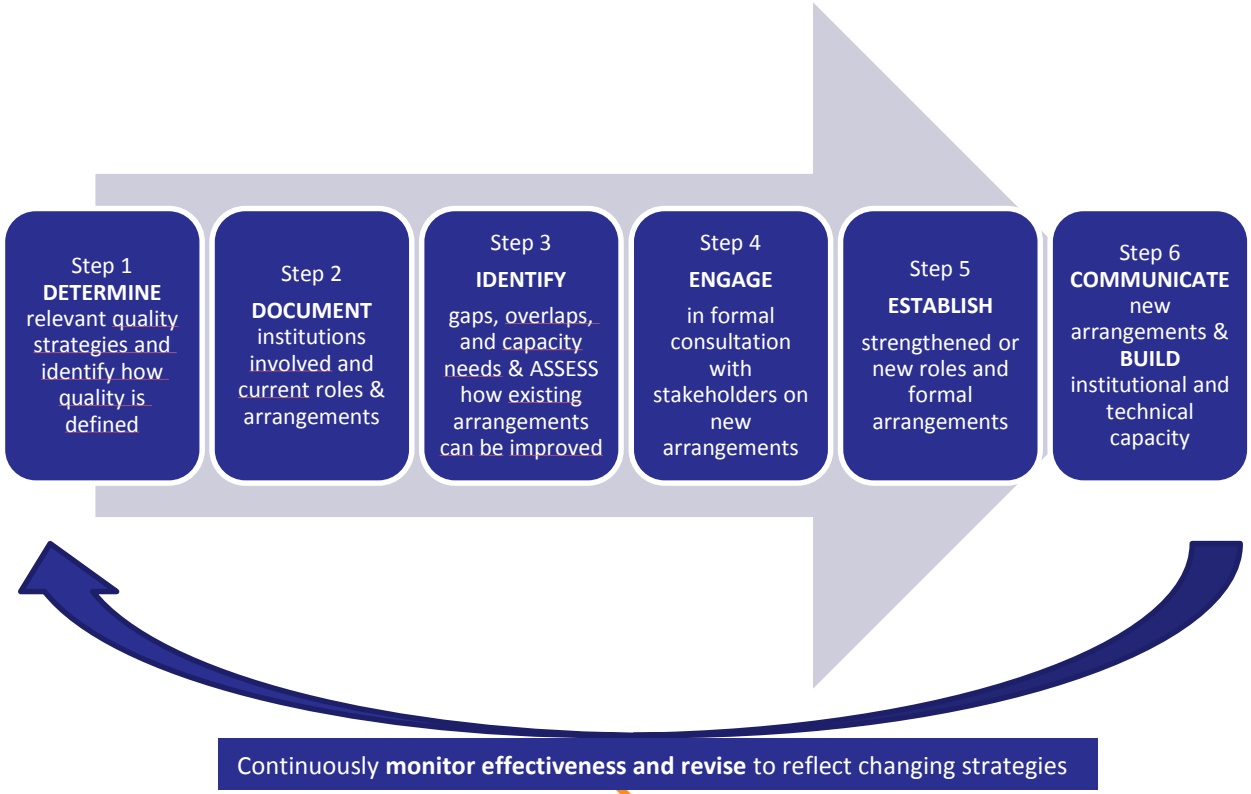
PROMISING PRACTICES AND KEY CONSIDERATIONS

- As countries consider national quality policy and strategies, involving stakeholders such as payers across the design, implementation, and evaluation process provides an opportunity to optimize their role and ownership.
- Working closely with actors, policymakers should determine the quality indicators, interventions, and reporting mechanisms for payer accountability and payers should establish appropriate internal monitoring strategies to report on indicators.

3. ESTABLISHING INSTITUTIONAL ARRANGEMENTS

We propose a six-step process for establishing effective institutional arrangements linking health financing to quality in a given country. This process is illustrated in Figure 3. Each step is described in detail in sections 3.2-3.7.

Figure 3: Process for establishing effective institutional arrangements



How and by whom this process will be carried out may differ in each country. In some countries, this may not be a prescriptive one-dimensional stepped approach. Regardless, it is recommended that a working group, task force, or committee with representation from various health care quality stakeholders be established, or an appropriate existing mechanism be identified (refer to section 3.4 for further detail on health care quality stakeholders). In countries where a national quality policy or strategy has recently been developed, a national quality working group or committee may already exist, and may be an appropriate mechanism for carrying out this work (WHO 2018). In other countries, quality management directorates, units, or boards may exist. If a new working group or other mechanism is to be established, this would typically be done through a formal decree that describes how the group relates to its titular head, its members, terms of reference, deliverables, and period of existence.

Whether newly established or previously existing, this working group would be tasked with leading and coordinating the process of establishing institutional arrangements for quality. The members of the working group would be senior leaders of their organizations, and their role on the working group would be to attend the group's meetings and develop and approve the group's recommendations. Specific tasks would be carried out by technicians outside the working group, such as mid-level technical staff within the member organizations, consultants, consulting firms, local universities, etc. These individuals would carry out the necessary reviews and analyze and present them to the working group for review and approval.

In order to be effective, the working group needs to have a sufficient budget to cover its operations. It also needs to have clearly defined terms of reference, strong leadership, a clear decision-making process, an effective operational plan, and oversight authority over the persons/organization implementing its plan. Because the process of establishing, reviewing, and monitoring institutional arrangements for quality should be ongoing, ideally aligned with planning cycles, it is envisioned that the working group would serve an ongoing function of monitoring and course correction.

3.1 Step 1: Determining Relevant Quality Strategies and Definitions

The first step in defining roles and responsibilities for quality would be to determine the quality strategies that are relevant in the given country. The working group should review the six strategies described in section 2 and determine the relevance of each. The working group can accomplish this by:

- *Conducting a desk review of current strategies that address quality.* Examples of such strategies may include stand-alone strategies for quality in health care (e.g., national quality strategies), strategies for health financing or universal health coverage, broader health sector strategies (e.g., health sector development plans), etc. (Cico et al., 2016) The desk review should also attempt to identify the definition(s) of quality that are relevant in the specific country's context.
- *Conducting stakeholder interviews to identify any additional strategies or definitions that are not yet documented.* The working group should identify 5-10 key stakeholders to interview. To identify relevant quality strategies and definitions, the following questions should be addressed:
    - How quality is generally defined within the country/local context?

- To what extent do payers apply quality criteria to determine which health care providers can receive payments?
- Payers use various payment mechanisms (e.g., salaries, capitation, and diagnosis-related groups (DRGs)) to reimburse providers. Are these payments adjusted for quality?
- Are there standard benefits packages in place that specify which services are eligible for reimbursement? Are these packages adjusted for quality?
- Do payers play a role in assisting or encouraging patients to select higher quality providers (e.g., by publicizing provider quality data, educating patients)?
- Do payers make direct investments in quality improvement (e.g., facility infrastructure or systems, quality training for providers, large-scale programs to improve clinical processes and care delivery)?
- Do payers provide non-financial incentives to encourage quality improvement (e.g., public recognition or awards to providers or facilities for high quality of care)?

In addition to identifying quality strategies, the two methods described above should also be used to inform the following two steps along the process of establishing institutional arrangements for quality: documenting current arrangements (described in section 3.2), and identifying gaps, capacity needs and areas for improvement (described in section 3.3). Annex A includes a list of sample stakeholder interview questions. These questions should be revised based on information already known by members of the working group, and tailored to the stakeholder being interviewed.

3.2 Step 2: Documenting Current Arrangements

A starting point in documenting current institutional arrangements is for the working group to identify all the institutions involved in executing each of the quality strategies identified in section 3.1, and to map out current roles. This information can be summarized in a table format as follows, to facilitate subsequent analysis.

Table 1: Documentation of current institutional arrangements

Role/Responsibility	Currently Fulfilled (Yes/No)	Leading Institution / Actor	Additional Institutions / Actors Involved	Existing Formal or Informal Mechanisms for Interaction Among Leading and Additional Actors	Laws or Regulations that Mandate Current Arrangements
Set accreditation standards*	Yes*	Health Facilities Regulatory Agency*	Pharmacy Council, National Health Insurance Authority*	Technical Working Group*	Health Institutions and Facilities Act 2011 (Act 829)*

*The information included in the table is an example of one role/responsibility from Ghana, intended to illustrate how the table may be completed with the relevant information.

Based on the relevant strategies identified for regulating and incentivizing quality by involving payers, only the appropriate roles and responsibilities associated with those strategies (refer to Figure 2) should be listed in Table 1. The next step is to identify leading and additional or secondary actors involved in carrying out those roles and responsibilities, and to describe existing mechanisms, whether formal or informal, for interaction among those actors. To collect this information, a desk review as well as stakeholder interviews may be conducted, as described in section 3.1. In addition to reviewing strategies that address quality, the desk review should also involve reviewing relevant legislation, including but not limited to legislation that addresses health reform, health financing, health care quality, patient rights or safety, provider or facility registration, certification, accreditation, or licensing. (Cico et al., 2016)

The following questions should be addressed about each role or responsibility:

- Is the role or responsibility currently fulfilled?
- Which institution or actor has the primary responsibility for carrying it out?
- Which other institutions or actors are involved?
- How do these institutions or actors interact with regard to the fulfillment of this role or responsibility?
- Which laws or regulations, if any, mandate the current arrangements?

3.3 Step 3: Identifying Gaps, Capacity Needs, and Areas for Improvement

Challenges may result from the absence of clearly defined roles, conflicting roles, weak enforcement, weak organizational capacity, or weak collaboration among various institutions. After current arrangements have been documented and are well understood, a second step would be to analyze that information for the purpose of:

- Identifying gaps, ineffectiveness, or overlap in current arrangements. These could include, among other issues, roles or responsibilities that are not currently being fulfilled because no institution or actor has been designated to fulfill them; because roles or responsibilities are not optimally assigned and/or are not effective in achieving the desired outcomes; or because multiple actors are responsible for fulfilling the roles and responsibilities without a clear delineation of tasks.
- Identifying institutional and technical capacity needs. This could include identifying both the capacity-building needs of institutions and their staff to fulfill current roles and responsibilities, as well as the capacity building required for new arrangements to be implemented.

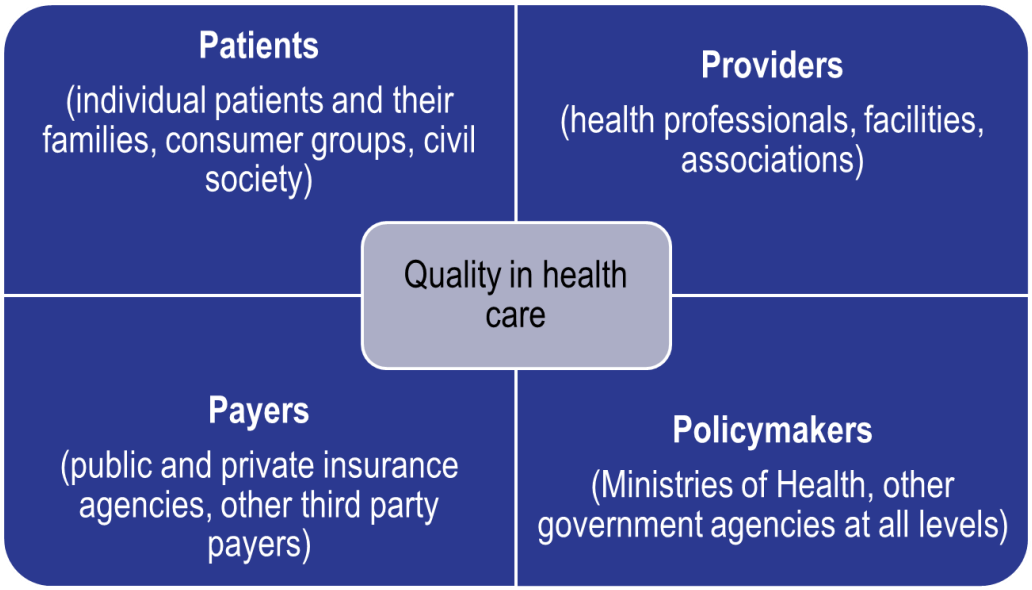
Examples and best practices/advantages and disadvantages of institutional arrangements from other countries (described in section 2) should be considered here.

The outcome of this step would be a set of options for improved arrangements, to be reviewed with stakeholders.

3.4 Step 4: Engaging Stakeholders

The options for improved arrangements identified in step 3 should be reviewed through a participatory process, in a consultation with quality stakeholders. A workshop format with 20-30 stakeholders is recommended. All stakeholders currently fulfilling specific roles in quality, or envisioned to do so in the future, should be represented, as illustrated in Figure 4.

Figure 4: Health care quality stakeholders



The objective of the workshop would be to identify and agree on new or improved arrangements for governing the quality of health care, and to develop a plan for institutionalizing these new arrangements. Agenda items should include:

- Presenting and validating findings from the documentation of current arrangements and the analysis of gaps and capacity needs;
- Reviewing options for improving arrangements, including examples from other countries, and agreeing on the most feasible options;
- Developing a timeline and plan (including a capacity-building plan) for implementing the new arrangements.

An example of a workshop agenda from the Ghana pilot application of this guide is included in Annex C. The working group could be tasked with coordinating the workshop, including developing the list of participants and finalizing the agenda. To ensure neutrality in a context where conflict among various institutions may exist, it is recommended that the workshop be facilitated by an independent facilitator who does not represent any of the main institutions involved. If budget allows, this facilitator could be an independent local consultant with knowledge of the topic and of the country's health sector. Alternatively, members of the working group could serve as co-facilitators.

3.5 Step 5: Establishing Formal Arrangements

Once the stakeholder validation has taken place, the most feasible way forward for defining or redefining institutional arrangements should be identified and an implementation plan should be drafted, as described in section 3.4. The plan can be presented in a table format, as illustrated in Table 2.

Table 2: Implementation plan for establishing institutional arrangements to link health financing to the quality of care

Mechanism / option for improvement	Tasks or actions to be taken to achieve the desired improvement*	Responsible institution / actor	Supporting institutions / actors	Timeline for completion

* Tasks or actions may address the following categories: building institutional and technical capacity; communicating strategically to build support for the change; engaging in advocacy for decision makers; drafting legislation or legislative amendments; obtaining formal approvals; communicating new/revised arrangements to stakeholders; and any other actions deemed necessary for the improvements to be achieved.

The plan should address all the steps required to formalize the new arrangements, including but not limited to:

- drafting legislation or legislative amendments to reflect the new arrangements;
- obtaining formal governmental approvals for the new arrangements to take effect;
- communicating strategically with providers or the population to support any changes in behaviors or relationships needed to implement the new arrangements (especially when changing health benefits policy and provider payment mechanisms); and
- engaging in advocacy for decision makers to adopt the recommended arrangements (e.g., developing advocacy materials, including policy briefs, etc.).

The process of establishing formal arrangements would involve completing the relevant steps outlined in the implementation plan. These steps will enable the new arrangements to take effect.

Ultimately, optimal institutional arrangements must:

- balance power among the institutions involved,
- avoid conflict of interest,
- consider contextual factors, and
- be clearly defined.

3.6 Step 6: Communicating Arrangements and Building Capacity

The implementation plan should also outline steps that need to be taken beyond the formal establishment of the new institutional arrangements. These additional steps, which would address the successful implementation and effectiveness of the arrangements, include:

- *Communicating the new arrangements to all institutions and stakeholders involved.* This may require targeted communication efforts, including issuing written guidance and conducting information

sessions to ensure an understanding of the implications of the new arrangements for the roles and responsibilities of each institution.

- *Building institutional and technical capacity to implement the new arrangements.* The implementation plan should also outline steps to build both institutional and technical capacity, based on the gaps and needs identified through the review. Once the new arrangements are approved, the capacity-building plan should be implemented and monitored to ensure that each institution involved is able to effectively implement them. This will ensure that the new arrangements work as intended.

3.7 Monitoring Effectiveness and Revising Arrangements

Recognizing that needs may evolve over time, and quality strategies will likely be updated to reflect emerging needs, the process outlined above may need to be repeated periodically (possibly to coincide with the development of new quality strategies or health sector plans) to ensure that the institutional arrangements that have been put in place are adequate and appropriate. At a minimum, steps 1-3 would need to be repeated to determine whether institutional arrangements for quality are effective and will allow for the successful implementation of new strategies.

ANNEX A: SAMPLE STAKEHOLDER INTERVIEW QUESTIONS

1. What does quality improvement in health care mean to you?
    a. Where did you first hear this concept?
    b. Who uses this concept?
2. To what extent do payers in [COUNTRY] apply quality criteria to determine which health care providers can receive payments from them?
    a. What are the criteria (e.g. accreditation, licensing, compliance with clinical guidelines, ongoing performance monitoring, etc.)?
    b. Who established them?
    c. Who monitors whether they are met?
3. Payers use various payment mechanisms (e.g., salaries, capitation, and DRGs) to reimburse providers. Now we want to better understand how these payments may or may not be adjusted for quality in [COUNTRY].
    a. What quality incentives/disincentives are incorporated into these mechanisms, if any (e.g., bonuses, penalties, differential payment rates/terms, etc.)?
    b. Who develops and selects the quality indicators associated with these mechanisms? How does this work? What is the process?
    c. Who determines bonus/penalty amounts, or establishes differential payment rates/terms?
    d. Who monitors provider quality against the established indicators?
4. Are there standard benefits packages in place in [COUNTRY] that specify which services are eligible for reimbursement?
    a. To what extent were quality considerations taken into account in their design (e.g., do they exclude low quality or low value care)?
    b. Are any quality criteria in place that determine benefit eligibility? If so, what are they?
    c. Who established these quality criteria?
    d. Who monitors whether these criteria are being met?
5. Do payers in [COUNTRY] play a role in assisting or encouraging patients to select higher quality providers (e.g., by publicizing provider quality data, educating patients)?
    a. Are data on provider quality publicly available (if so, ask about frequency and perceived accuracy)? What kinds of indicators are available?
    b. Who developed the quality measurement criteria/indicators?
    c. Who measures these indicators?
    d. Are payers directly conducting or collaborating with other actors to conduct public education campaigns on the quality of care?
6. Do payers in [COUNTRY] make direct investments in quality improvement (e.g., facility infrastructure or systems, quality training for providers, and/or large-scale programs to improve clinical processes and care delivery)?

    a. If so, who determines investment needs, training needs, and/or areas for improvement?
7. Do payers in [COUNTRY] provide non-financial incentives to encourage quality improvement (e.g., public recognition or awards to providers or facilities for high quality of care)?
    a. If so, who sets the criteria and who selects the providers of facilities that will receive the incentives?
8. In your opinion, to what extent do you feel that payers have clear roles and responsibilities in promoting the quality of care in [COUNTRY]?
    a. Do these conflict or overlap with roles of any other actors? How so?
    b. What could be done to more clearly define these roles and responsibilities?

ANNEX B: COUNTRY EXAMPLES OF ROLES AND RESPONSIBILITIES FOR EXECUTING QUALITY STRATEGIES

Roles and Resp.	Ethiopia	Ghana	India	Indonesia	Malawi	Malaysia	Mexico	The Philippines	Tanzania	Uganda
1. Applying quality criteria to determine provider eligibility										
Set accreditation standards		Health insurance agencies Other government agencies	MOH departments or units	MOH departments or units Independent bodies	MOH departments or units	Independent bodies	Other government agencies	Health insurance agencies	MOH departments or units	MOH departments or units
Conduct accreditation survey		Health insurance agencies Other government agencies	Subnational government entities	MOH departments or units Independent bodies	MOH departments or units	Independent bodies		Health insurance agencies	MOH departments or units	MOH departments or units
Award accreditation		Health insurance agencies Other government agencies	Subnational government entities	Independent bodies	MOH departments or units	Independent bodies		Health insurance agencies	MOH departments or units	MOH departments or units
Set licensing standards		MOH departments or units		MOH departments or units	Professional associations	Professional associations	Other government agencies			
Review practitioner credentials		Professional associations	Subnational government entities	Professional associations	Professional associations	Professional associations		Health insurance agencies Professional associations		

Roles and Resp.	Ethiopia	Ghana	India	Indonesia	Malawi	Malaysia	Mexico	The Philippines	Tanzania	Uganda
Award licenses		Professional associations	Subnational government entities	Subnational government entities	Professional associations	MOH departments or units		Professional associations	Professional associations	Professional associations
Develop clinical guidelines		MOH departments or units	MOH departments or units Subnational government entities	Professional associations		MOH departments or units Other government agencies		Professional associations	MOH departments or units	MOH departments or units
Monitor compliance with clinical guidelines		MOH departments or units Health insurance agencies Other government agencies	Subnational government entities	Facilities or individual providers	MOH departments or units	Facilities or individual providers		MOH departments or units Health insurance agencies Professional associations	MOH departments or units	
Set quality criteria for ongoing performance monitoring		Health insurance agencies Other government agencies	Subnational government entities	MOH departments or units	MOH departments or units	Independent bodies		Health insurance agencies	MOH departments or units	
Monitor performance against quality criteria	MOH departments or units Subnational government entities	Other government agencies	Subnational government entities		MOH departments or units		Other government agencies	MOH departments or units Health insurance agencies Professional associations		
2. *Incorporating quality incentives or disincentives into provider payment mechanisms*										

Roles and Resp.	Ethiopia	Ghana	India	Indonesia	Malawi	Malaysia	Mexico	The Philippines	Tanzania	Uganda
Determine quality priorities		MOH departments or units		MOH departments or units	MOH departments or units		MOH departments or units	MOH departments or units Health insurance agencies	MOH departments or units	MOH departments or units
Develop quality indicators	MOH departments or units	Health insurance agencies Other government agencies		MOH departments or units Health insurance agencies	MOH departments or units		Other government agencies	MOH departments or units Health insurance agencies	MOH departments or units	
Determine bonus/penalty amounts or establish differential payment rates/terms		Health insurance agencies	Subnational government entities	MOH departments or units Health insurance agencies	MOH departments or units			MOH departments or units Health insurance agencies Other government agencies Subnational government entities	MOH departments or units	MOH departments or units
Monitor/measure provider quality against established indicators		Health insurance agencies	Subnational government entities	Health insurance agencies	MOH departments or units			MOH departments or units Health insurance agencies Other government agencies Subnational government entities	MOH departments or units	MOH departments or units
Calculate and issue payments based on		Health insurance agencies	Subnational government entities	MOH departments or units			MOH departments or units	Health insurance agencies	MOH departments or units	MOH departments or units

Roles and Resp.	Ethiopia	Ghana	India	Indonesia	Malawi	Malaysia	Mexico	The Philippines	Tanzania	Uganda
performance against quality criteria				Health insurance agencies				Other government agencies Subnational government entities		
3. Applying quality criteria to benefits package design										
Define benefits package	Health insurance agencies	MOH departments or units	Subnational government entities	MOH departments or units	MOH departments or units			Health insurance agencies	Health insurance agencies	MOH departments or units
Develop clinical guidelines to be associated with benefits package		MOH departments or units Health insurance agencies	Subnational government entities	Professional associations	MOH departments or units		MOH departments or units		MOH departments or units	MOH departments or units Professional associations
Monitor compliance with guidelines		Health insurance agencies Other government agencies	Subnational government entities	MOH departments or units	MOH departments or units			Subnational government entities	Health insurance agencies	
4. Generating demand for quality										
Establish quality measurement criteria/indicators	MOH departments or units		Subnational government entitites	MOH departments or units				Health insurance agencies	Health insurance agencies	
Measure provider quality			Subnational government entities	MOH departments or units	MOH departments or units			MOH departments or units Health insurance agencies Subnational government entities	Health insurance agencies	

Roles and Resp.	Ethiopia	Ghana	India	Indonesia	Malawi	Malaysia	Mexico	The Philippines	Tanzania	Uganda
Publish provider quality information		Health insurance agencies	Subnational government entities	MOH departments or units	MOH departments or units		MOH departments or units	Health insurance agencies		MOH departments or units
Conduct public education campaigns to raise patient awareness of quality of care			Subnational government entities	MOH departments or units Health insurance agencies	Subnational government entities Professional associations					Civil society
Determine systems and infrastructure invesments needed to improve quality	Subnational government entities	MOH departments or units	MOH departments or units Subnational government entities		MOH departments or units Subnational government entities Private sector	MOH departments or units Private sector	MOH departments or units	MOH departments or units Subnational government entitites Facilities or individual providers Private sector	MOH departments or units	
5. Investing directly in quality improvement										
Determine provider training needs	Subnational government entities	MOH departments or units Other government entities			MOH departments or units			Other government entities		
Establish traning curricula		MOH departments or units			Other government entities			Private sector		
Determine areas for improvement										
Design improvement programs										

Roles and Resp.	Ethiopia	Ghana	India	Indonesia	Malawi	Malaysia	Mexico	The Philippines	Tanzania	Uganda
Implement improvement programs										
6. Providing non-monetary incentives for quality										
Determine selection criteria for public recognition or awards	MOH departments or units		Subnational government entities	MOH departments or units Health insurance agencies Professional associations	MOH departments or units	MOH departments or units Other government agencies Professional associations	MOH departments or units	Health insurance agencies	MOH departments or units Subnational government entities	MOH departments or units

ANNEX C: GHANA'S EXPERIENCE USING THIS GUIDE

In May and June 2018, a team of four health governance specialists from the HFG project provided assistance to the Government of Ghana to complete steps 1-4 of the process for establishing and strengthening institutional arrangements for governing the quality of health care. This support served as a practical application of *Defining Institutional Arrangements when Linking Financing to Quality Health Care: A Practical Guide*. The expected outcomes from the pilot were:

- A mapping of new or strengthened institutional roles and relationships, to address current priorities and challenges, and
- A detailed implementation plan with timelines and tasks that involve advocating for, formalizing, communicating, and building capacity to successfully carry out the new arrangements.

Ghana in 2018: Governing health care quality and UHC[5]

Ghana's National Health Insurance Scheme (NHIS) was established by an Act of Parliament in 2003 (Act 650) to provide financial risk protection against the cost of health care services for all residents of Ghana. In 2012, the law was revised to address some of the operational challenges in management of the scheme. The object of the Scheme is to attain universal health insurance coverage for residents and those visiting the country. The National Health Insurance Authority (NHIA) is the corporate body mandated to implement the NHIS and is governed by a Board of Directors. The new NHIS Act of 2012 (Act 852) establishes a unitary scheme with offices across the country – Head Office, Regional Offices, and District Offices. In recent years, UHC and the NHIS functioning has been marred by underfunding of the NHIS resulting in late payments to providers for care.

Improving quality of health care is the responsibility of the Ministry of Health, its agencies, health NGOs, the communities and patients/clients. Various structures and systems are in place to ensure quality in health care. These include systems for regulation, accreditation and credentialing, medical audits, development of clinical protocols, guidelines and standards, peer reviews, quality improvement, monitoring and supervision. The Health Facilities Regulatory Agency (HeFRA) was established as an agency of the MOH by the Health Insurance Facilities Act of 2011 to license facilities for the provision of public and private health care services, among other roles. Since that time, however, HeFRA has been unable to fulfill that role completely due to underfinancing and a lack of capacity.

In December 2016, the Government of Ghana, under the leadership of the Ministry of Health, developed the National Healthcare Quality Strategy (NHQS) 2017-2021 which established the National Quality Technical Committee (NQTC) as the governing body responsible for implementation, monitoring and oversight of the strategy. As a result, in 2017, a push began to increase HeFRA's capacity, which as of 2018 included the accreditation of a limited number of private sector facilities. In recent years, partnership

[5] Adapted from "*Ghana:* Governing for Quality Improvement in the Context of UHC," HFG project with ASSIST project and the JLN. 2016.

with an international NGO has contributed to the implementation of large scale quality improvement initiatives in the country.

How the guide was used

HFG collaborated closely with the MOH and the NHIA - on behalf of the NQTC - in the planning and implementation of the entire activity.

Step 1: Determining Relevant Quality Strategies and Definitions

The HFG team conducted a desk review of current strategies in Ghana that address quality in health care and conducted stakeholder interviews to identify any additional strategies or developments in the governance of quality that are not yet documented. With this research, the team used the template in the guide "Table 1: Documentation of current institutional arrangements" to track preliminary findings including:

- which of the six strategies for governing quality proposed in the framework are relevant to Ghana's context,
- institutions involved in implementing the relevant strategies and current institutional arrangements, and
- gaps or challenges arising from existing arrangements to be addressed.

Step 2: Documenting Current Arrangements

The HFG team met with Vivian Addo-Cobbiah, Acting Director of Quality Assurance for the National Health Insurance Agency, and Dr. Ernest Asiedu, Head of Quality Management Unit in the Ministry of Health, prior to the workshop to discuss its objectives. This was to be the second quarterly meeting of the National Quality Technical Committee, which would facilitate institutionalization of the implementation plan. As such, the HFG team worked with local government partners to ensure that adequate space was dedicated to working through the business and structure of subsequent meetings in addition to fulfilling the workshop's objectives. In addition to this, the HFG team conducted a preliminary mapping of the roles and relationships for linking financing to quality in healthcare, so that workshop participants had something to build upon during the exercise on the first day.

Step 3: Identifying Gaps, Capacity Needs, and Areas for Improvement

The team then co-facilitated with the Ministry of Health a stakeholder engagement workshop. In this case, the workshop was comprised of members of the NQTC, which includes members of a broad cross-sectoral group of stakeholders. At the workshop, the team presented and validated the findings of the landscape analysis. The HFG team spent a significant amount of time reviewing in detail potential strategies that are described in the guide, and sharing international examples of each.

The NQTC identified areas of weakness in the implementation of the NHQS related to the capacities, roles and relationships of the various organizations engaged in quality improvement and assurance. The group reviewed options for improving institutional arrangements and examples from other countries and agreed on priorities for strengthening governance of quality through institutional role and relationship improvements.

Through this workshop pilot, the NQTC identified the following governance challenges to be the most pressing:

A. Incorporating quality incentives when linking financing to quality

B. Linking eligibility to provider payment

C. Generating demand for quality

D. Investing directly in quality improvement

Step 4: Engaging Stakeholders

Stakeholders were engaged throughout the pilot to various degrees. When discussing the workshop aims with Ghanaian government partners, it became clear that there was a need to slightly adapt the HFG workshop objectives to fit the needs of the NQTC. This committee is responsible for carrying out the National Healthcare Quality Strategy and they had already begun to develop some tools to support an implementation plan. For this reason, the HFG team allotted time and space in the two-day agenda for the Quality Management Unit of the MOH to coordinate its program of work with the NQTC. This involved introductions with the assembled stakeholders at the outset of the workshop and a business meeting of sorts embedded into the second day of the workshop. The June 2018 two-day workshop was an effective forum to validate and discuss the mapping of existing institutional roles and relationships, as the meeting spawned a great deal of discussion and some surprising debate. Through group exercises, discussion, report-outs and feedback sessions, a number of challenges and weaknesses in the existing governance of health care quality regime emerged. The benefit of this long meeting was that it allowed for debate and consensus, thus increasing the validity and usability of the resulting conclusions.

By the end of the second day, the NQTC had identified the most feasible options – five priority interventions - for addressing the most pressing challenges including new or enhanced institutional roles and relationships and drafted an implementation plan for the first of the priority interventions to more effectively link finance to quality.

Step 5: Establishing formal arrangements

Through group work and a facilitated prioritization process, the stakeholders agreed on the following five strategies to prioritize in addressing the challenges identified:

Challenge	Strategies (in order of priority)
Incorporating quality incentives when linking financing to quality	1. **Separate the role of the payer and the regulator for quality assurance** *In practice the functions are both fulfilled by NHIA but it is proposed that HeFRA be empowered to fulfill the regulator function*
Linking eligibility to provider payment	2. **Build the capacity of HeFRA** *With capital investment, technical assistance, human resources, and establish regional HeFRA offices.*

Generating demand for quality	**3. Educate patients to demand quality services** *Through a number of strategies using media, provider communication techniques and other means.*
Investing directly in quality improvement	**4. Establish a system for knowledge sharing**
	5. Empower the MOH's Quality Management Unit to enforce quality standards

The group developed a first draft of a detailed implementation plan for the first strategy above, with activities, timelines, responsible organizations and measureable milestones. An outline of a complete implementation plan was drafted to align with the National Healthcare Quality Strategy and to be executed in subsequent quarterly meetings by the NQTC.

As a result of this activity, the use of the guide facilitated the NQTC in moving further along its path towards strengthening the quality of care, while identifying strategic entry points for the payer to more fully realize its role in quality assurance and quality improvement.

Lessons learned

One of the challenges HFG faced when conducting this workshop was aligning the objectives of the guide with the objectives laid out in Ghana's new National Healthcare Quality Strategy. In the time that had passed since the strategy was developed, some new challenges had emerged which were articulated in the workshop. Surprisingly, a significant number of individuals on the NQTC were not well-informed about what exactly various agencies are doing in this space, which suggests that there was significant scope for this activity. Occasionally, HFG helped to mediate conversations when confusion led to frustration. Ghana is quite far along in thinking through some of the issues related to quality and at times suggestions provided by the HFG team would have been intractable given the number of compromises and level of consensus for key issues among the assembled stakeholders if it weren't for the progress made to date on aligning priorities and developing a unified vision for achieving improved quality of care.

In the future, a facilitated workshop as this one would benefit from 1) longer time spent in country (2-3 weeks) consulting stakeholders and completing a more thorough mapping and assessment prior to the workshop, 2) a longer workshop, but with more space for discussion among the sessions, as well as deliberation about the current National Healthcare Quality Strategy, which some participants were less familiar with than others, 3) clearer ways for HFG or another project to support implementation of the plan with technical assistance where needed after the workshop has ended.

The team concluded that the guide may be difficult for country participants to use "off the shelf" without expert facilitation. If policy-makers do want to use the guide without specialized technical support, then it is recommended that they spend a significant amount of time before meeting to review the guide, and to map their understandings of current roles and responsibilities. With signification preparation, a group discussion of stakeholders and policymakers using the framework and templates in the guide could be well-structured and productive. The team has made some adjustments to one of the templates in the guide, based on the experience of the workshop.

Workshop Agenda

DEFINING INSTITUTIONAL ARRANGEMENTS WHEN LINKING FINANCING TO QUALITY IN HEALTH CARE IN GHANA

STAKEHOLDER ENGAGEMENT WORKSHOP
Date: June 20th-21st, 2018
Location: Food and Drug Administration Building, Accra

OBJECTIVES:

The Stakeholder Engagement Workshop aims to:

1. Increase understanding of how linking health financing to the quality of care is impacted by institutional roles and relationships in Ghana,
2. Identify where and how the roles and relationships of institutions can be strengthened to improve the link between health financing and quality,
3. Agree on the most feasible options for improving institutional arrangements to effectively link health financing to quality, and
4. Develop an implementation plan for strengthening existing roles and relationships and/or establishing new arrangements.

DAY 1: June 20th, 2018

8:30-9:00	**Registration**
9:00-9:30	**Session 1: Welcome Remarks, Introductions, and Objectives**
9:30-10:15	**Session 2: Presentation of the Baseline Assessment on the Implementation of the National Healthcare Quality Strategy (NHQS) and Discussion of the Guidelines for Implementing the NHQS at the Sub-National Level** **Objectives:** • Present the results of the baseline assessment on the implementation of the NHQS • Discuss the guidelines on supporting Regional Quality Management Units (RQMUs) to implement the strategy at their level and subsequently support the District Quality Management Units (DQMUs) and the facility Quality Management Teams (QMTs).
10:15-10:45	**COFFEE BREAK**
10:45-11:30	**Session 3: Overview of the Practical Guide for Defining Institutional Arrangements When Linking Financing to Quality in Health Care** **Objectives:** • Provide brief background on the guide, its purpose, and development process • Present the framework to highlight all the possible links between health financing and quality of care • Present the proposed process for strengthening institutional arrangements for quality
11:30-12:30	**Session 4a: Mapping of the Institutional Roles and Relationships Linking Health Financing to Quality in Ghana**

	Objectives: • Present landscape analysis findings • Group work to corroborate, clarify, and supplement the findings
12:30-1:30	LUNCH BREAK
1:30-2:00	**Session 4b: Mapping of the Institutional Roles and Relationships Linking Health Financing to Quality in Ghana** **Objectives:** • Continuation of group work to corroborate, clarify, and supplement the findings • Group report-outs
2:00-3:30	**Session 5a. Review Options for Strengthening Institutional Arrangements to Link Health Financing to the Quality of Care** **Objectives:** • Present promising practices and experiences from other counties • Identify and agree on the gaps, ineffectiveness, or overlap in current arrangements • Identify options for strengthening institutional roles and relationships to link health financing to quality of care in Ghana
3:30-3:45	COFFEE BREAK
3:45-4:45	**Session 5b: Group Report-out of Options for Strengthening Institutional Arrangements to Link Health Financing to the Quality of Care** **Objective:** Document the options for strengthening institutional arrangements to link health financing to the quality of care
4:45-5:00	**Summary and Preview of Day 2**

DAY 2: June 21st, 2018

8:30-9:00	Registration
9:00-9:30	**Session 6: Recap and Review of the Agenda for the Day**
9:30-10:30	**Session 7: Prioritization of Options for Strengthening Institutional Roles & Relationships** **Objectives**: Prioritize options to strengthen institutional arrangements to link health financing to the quality of care
10:30-11:00	COFFEE BREAK
11:00-12:30	**Session 8: Develop an Implementation Plan** **Objectives**: Using the practical guide presented in session 3 and the options for improvement agreed upon during session 7, develop a plan with specific tasks for strengthening arrangements.

12:30-1:30	**LUNCH BREAK**
1:30-4:30	**Session 9: Discussion on Other Quality Healthcare Issues** **Objectives**: Discuss other issues related to quality healthcare, focusing on: 1. Emergency management 2. Referral challenges 3. "No bed" syndrome
4:30-4:45	**Next Steps and Closing Remarks**

ANNEX D: BIBLIOGRAPHY

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