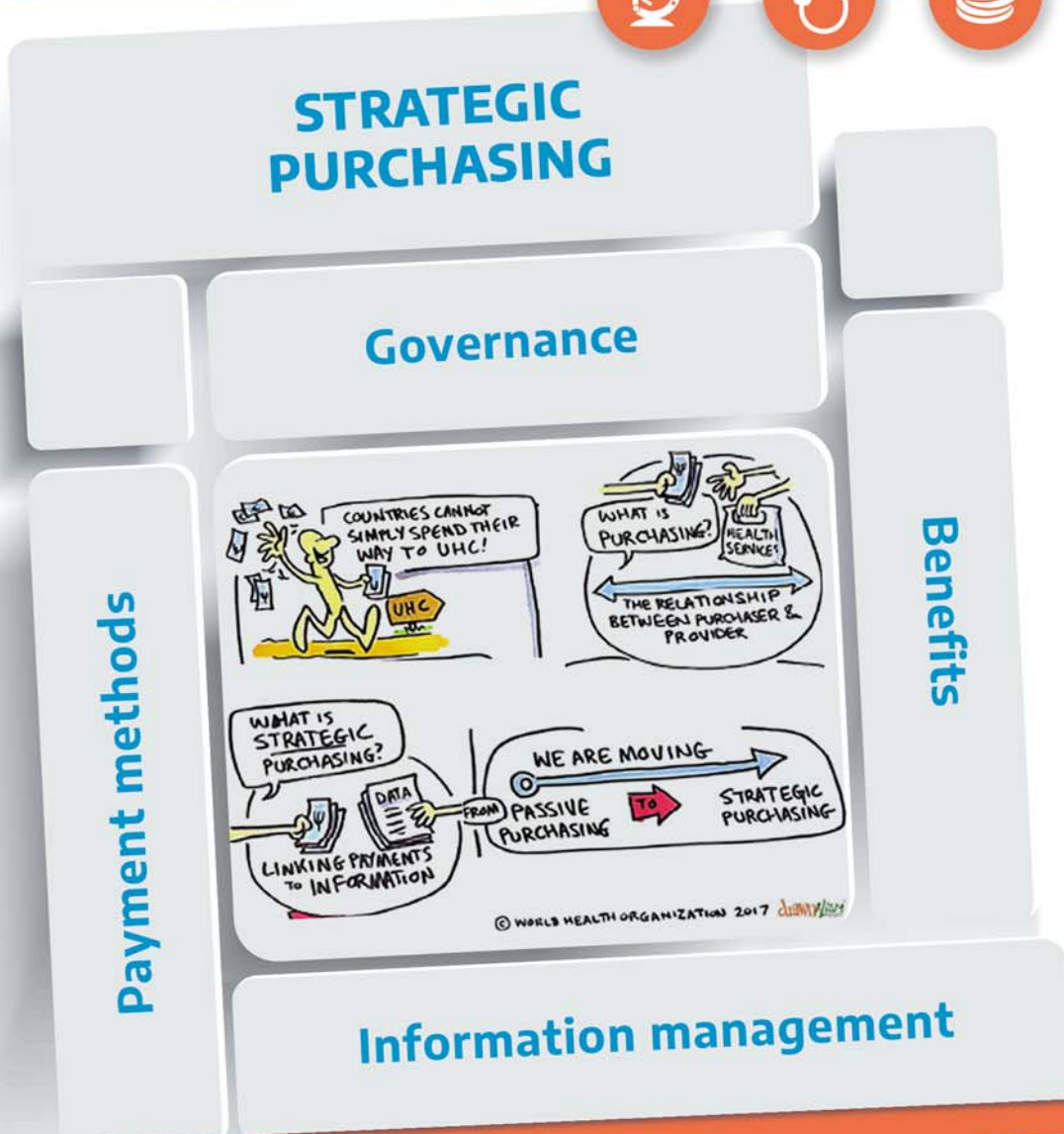


PURCHASING HEALTH SERVICES FOR UNIVERSAL HEALTH COVERAGE: HOW TO MAKE IT MORE STRATEGIC?



HEALTH FINANCING POLICY BRIEF NO. 6

PURCHASING HEALTH SERVICES FOR UNIVERSAL HEALTH COVERAGE: HOW TO MAKE IT MORE STRATEGIC?

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Organization**

Purchasing health services for universal health coverage: How to make it more strategic? / Inke Mathauer, Elina Dale, Matthew Jowett and Joe Kutzin

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Key Messages

- Purchasing refers to the allocation of pooled funds to healthcare providers for the delivery of health services on behalf of certain groups or entire population. Purchasing of health services is to be distinguished from the procurement of medicines and other medical supplies in bulk.
- Purchasing is considered to be strategic when these allocations are linked, at least in part, to *information* on aspects of provider performance and the health needs of the population they serve, while managing expenditure growth.
- Strategic purchasing involves several core areas that should be aligned and addressed jointly, namely:
 - specification of services and interventions (“what to buy”);
 - choice of providers (“from whom to buy”); and
 - design of financial and non-financial incentives (“how to buy”) – this refers to provider payment mechanisms and contractual arrangements.
- Information is intrinsic to strategic purchasing and needed for the above questions and a key enabler for effective governance of strategic purchasing to enable progress towards UHC objectives.
- For the purchasing function to contribute to progress towards UHC, it must be strategic. Strategic purchasing transforms budgets into benefits, with the aim of distributing resources equitably, realizing gains in efficiency and managing expenditure growth and improving quality.
- Reforms which enhance the strategic nature of purchasing can be incremental and packaged rather than radical or big-bang. Many of these reforms are within the realm of the health sector and can often be guided by the Ministry of Health. Nonetheless, it is important not to ignore the political economy behind strategic purchasing reforms.

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1. WHAT IS PURCHASING AND WHEN IS IT STRATEGIC?

This policy brief aims to show how strategic purchasing contributes to progress towards universal health coverage (UHC)¹ and how countries can make their purchasing more strategic.

Purchasing is a core health financing function that refers to the allocation of pooled funds to public and private health care providers for the health services they provide. Medicines and other medical supplies included in the provision of care or as part of inpatient or outpatient benefits are included in this definition. Importantly, purchasing of health services must be distinguished from procurement of medicines

and medical supplies. Procurement refers to the process of selecting vendors, establishing payment terms and negotiating contracts for obtaining commodities in bulk [1]. Similarly, whilst investment, infrastructure and human resources are important for the provision of health services, human resource management and the planning of investments and infrastructure are not part of this paper on purchasing.

The purchasing landscape is often complex due to the existence of multiple purchasers and an ever-growing and diverse private sector of health care providers, including for-profit and not-for-profit providers.

What is a purchasing agency?

Purchasing agencies can take many forms, such as the Ministry of Health, subnational authorities (e.g. at provincial or district levels), a mandatory or voluntary health insurance agency (or multiple insurance agencies), a community-based health insurance organisation, a non-governmental organization, etc.

There is a growing consensus that purchasing of health services must be more active or strategic if countries are to make progress towards UHC. However, purchasing of health services is often rather passive – i.e. resources are allocated to any providers without distinction, without consideration of their performance, and for a package of benefits that is poorly defined. There are hence few if any financial incentives for providers to do better.

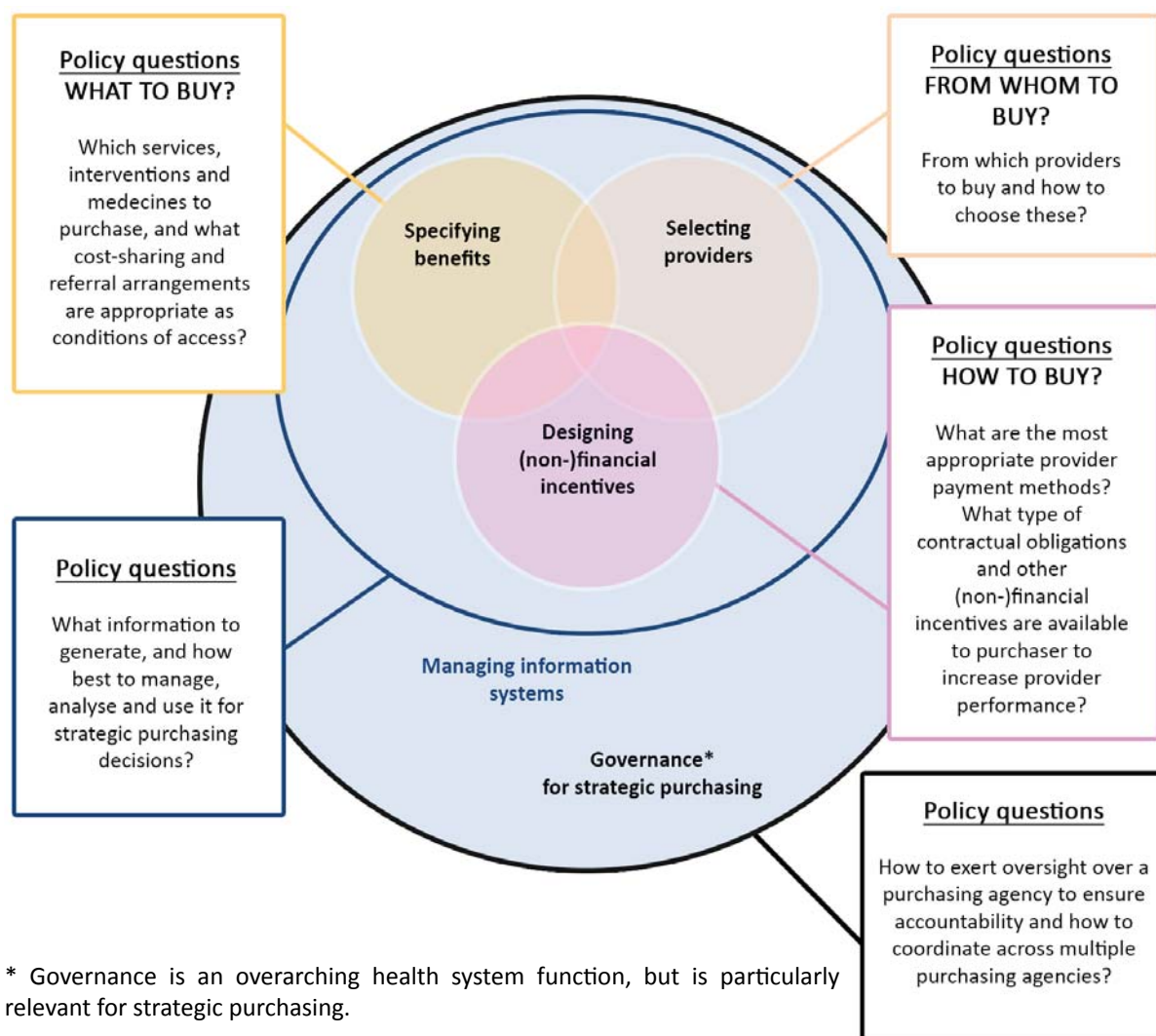
Strategic purchasing means aligning funding and incentives with legal entitlements to health services and must therefore be guided by detailed information on the performance of providers and the health needs of the population served [2]. Strategic purchasing aims to maximize health system objectives through an active, evidence-based process that defines which specific health services should be bought from which providers, how the services should be paid for and at what

¹ Universal health coverage (UHC) means that all people can access health services of good quality without experiencing financial hardship [2].

rate they should be paid. Strategic purchasing is not only relevant to dedicated purchasing agencies, e.g. health insurance funds. While strategic purchasing may be easier when the functions of purchasing and provision are separated, it does not necessarily require an institutional purchaser-provider split [3].

Strategic purchasing involves several interrelated areas, which need to be aligned and addressed jointly. These are presented together with their respective policy questions in Figure 1 below and are further outlined in Section 4.

Figure 1: Core areas of strategic purchasing and policy questions



Source: Authors compilation²

A country’s purchasing arrangements are usually neither completely passive, nor fully strategic. Countries at all income levels are seeking to progress on this continuum

towards more strategic purchasing [4]. Improvements in any of the areas outlined above contribute to making purchasing more strategic.

² The three core questions “what to buy”, “from whom to buy” and “how to buy” are based on the World Health Report 2000.

2. WHY IS STRATEGIC PURCHASING IMPORTANT FOR UNIVERSAL HEALTH COVERAGE AND HOW FEASIBLE IS IT?

Revenue raising and effective pooling of funds for health are important, but strategic purchasing is vital for countries to be able to progress towards UHC. Strategic purchasing transforms budgets into effective coverage, with the aim of realizing gains in efficiency and managing expenditure growth. This frees up resources and, as such, is an important revenue source for expanding service or cost coverage. It also seeks to improve quality by giving signals to health providers. Strategic purchasing can also improve financial protection through reduced out-of-pocket expenditure, make the distribution of resources more equitable and enhance the transparency and accountability of providers and purchasers [5].

Numerous countries have made progress towards UHC through improvements in strategic purchasing in the past two decades [2]. Examples include Argentina, Ghana, Kyrgyzstan, Philippines, Thailand and Turkey [6-11]. Yet, many low- and middle-income countries face political, institutional and technical challenges to improving the way they purchase health services. Moreover, new

developments (e.g., new health technologies, new priorities, changes in provider behaviour or greater availability of data) continually emerge, requiring the adaptation of purchasing arrangements. Because of its significance, strategic purchasing for UHC needs to receive much more attention [1].

Strategic purchasing reforms do not have to be big-bang changes but can be gradual and in several packages. Reforms aimed at making purchasing more strategic are not always easy but, importantly, they can be introduced step-by-step: building the information management system, specifying benefits to align with payment methods and vice versa, modifying payment methods and rates to improve service provision, and putting in place an accreditation system, etc. These measures can drive system change and, being within the realm of the health sector, can often be steered by the Ministry of Health. These steps can be undertaken before tackling broader issues such as pooling or increased revenue raising to finance expansion of coverage to the informal sector [12].

3. STRATEGIC PURCHASING POLICY OPTIONS: WHAT DO WE KNOW FROM THEORY AND PRACTICE?

The most widely used framework for understanding purchasing arrangements is based on the principal-agent theory. The agent (i.e. the health care provider) undertakes to perform various tasks (i.e., service provision) for the principal (the purchaser who is in turn an agent for the people), in exchange for a mutually agreed award (i.e., primarily the provider payment), because the principal needs the efforts and expertise of the agent [13]. However, the interests of the agent (provider) may differ from those of the principal (purchaser). Moreover, the principal cannot always observe the agent, resulting in information asymmetry between the two parties. The central problem for the principal is how to ensure that the agent acts in the way that is desired by the principal [13]. Thus, the key tasks for strategic purchasing include specifying the interventions to purchase, whilst setting the right incentives through provider payment methods plus accompanying information systems for monitoring performance and decisions on resource allocation. All this also depends

upon effective governance arrangements that need to be improved concurrently.

Policy makers need to carefully think through the sequencing of strategic purchasing reforms for successful implementation. Such reforms must be designed and implemented with a system perspective, rather than trying to optimise the purchasing function of a specific scheme only. For instance, many performance-based financing initiatives have been designed and implemented as isolated projects, often without adequate consideration of the rest of the health system and, more specifically, of how it can link to existing provider payment systems [14, 15]. Moreover, as the key areas of strategic purchasing are interrelated, they must be aligned and addressed jointly not only for a specific health financing scheme but, more importantly, across the entire health financing system and all purchasers and providers. The following sections outline in detail the respective strategic purchasing policy options.

SPECIFYING BENEFITS

The agencies responsible for purchasing play a pivotal role in further operationalising the stated benefits within a given budget, by further specifying which health services or interventions to purchase. However, decisions on the benefit design,³ i.e. those benefits to be covered by public funds, are in many cases made by higher levels of

government. This brief does not go further in the criteria and process used to define benefits, as this is described elsewhere.⁴ This operationalisation of the stated benefits involves choices for example on specific treatment options for a specific health condition (e.g., peritoneal dialysis or hemodialysis for renal replacement therapy)

³ Benefits may be defined along level of care (e.g. primary health care, secondary and tertiary care), types of care (outpatient, specialized outpatient care, inpatient care), and/or along diseases and health conditions or interventions.

⁴ The topic is addressed in greater detail in a forthcoming WHO Health Financing Policy Brief.

or which medicines are covered (e.g. generics only). Another important element is to specify the conditions of access to these services, i.e. patient cost-sharing and referral rules. As such, purchasers can choose for example to give greater priority to primary health care, focus on cost-effective services or on the disease burden of vulnerable population groups, and set higher cost-sharing rates for higher levels of care to reduce self-referral to hospitals and specialists. Operationalising benefits requires a regular revision and updating process,

with utilisation reviews inter alia being an important tool. It also entails the specification of service and medicines standards, although this may in some cases be undertaken by the Ministry of Health.

Beneficiaries need to be aware of their entitlements and related access conditions.

A common challenge is that benefits may not be clearly defined in terms of either entitlements or conditions of access. This is where the purchaser plays an important role in further specifying and clarifying these.

SELECTING PROVIDERS

Purchasers need to further define and specify from which levels of providers and provider types covered services, interventions and medicines will be available and whether and how these can be accessed from the public sector and/or the private sector. Again, in some cases, such decisions may have been taken by higher government levels, but nonetheless purchasers need to concretise and align this with the access conditions referred to above.

Selective contracting as well as accreditation are key instruments in strategic purchasing to select from which providers to buy. Accreditation is a process of review that allows healthcare providers to demonstrate their ability to meet defined quality related standards (e.g., related to structure, process and/or outcomes), and as such the accreditation results provide relevant

information to the purchaser about provider performance [16]. Selective contracting⁵ means that a purchaser can select among (competing) providers, i.e. it has hence a right not to contract with all available providers. This selection can be based on predefined criteria or a provider's accreditation results in order to further incentivise quality and good performance [17].

The use of selective contracting is however limited practice for various reasons. On the one hand, especially in rural and remote areas, there may only be one provider for people to access health services in a given catchment area. On the other hand, including certain providers, but not contracting with other providers may be politically challenging. In many LMIC, it is found that all licensed providers are contracted by a national health insurance programme.

COHERENT INCENTIVES IN MIXED PROVIDER PAYMENT SYSTEMS AND CONTRACTUAL ARRANGEMENTS

The appropriateness of each payment method depends on the health system's objectives, identified challenges, the type of services to be paid for and contextual factors, such as the level of provider autonomy.

Payment methods and the set of incentives may thus have a slightly different effect on private for-profit providers. The main provider payment methods are line-item budgets, per diem payments, case-based payments,

⁵ A contract involves a prospective and explicit agreement between the purchaser and an individual provider regarding the terms and conditions of payments. A contract would specify the provision of the type and volume of services over a defined period, with specified objectives and indicators to measure contract fulfilment (e.g. on quality) [24].

global budgets, fee-for-service and capitation payments. Each provider payment method has advantages and disadvantages; as such, each creates its own (financial) incentives. Annex 1 explains these payment methods and outlines their respective incentives. For example, when the objective is to increase utilization of specific services, fee-for-service payment can be useful to incentivize providers to provide more of those services, as it was a case in Ghana and Indonesia [18]. However, open-ended fee-for-service payments may easily lead to over-provision of health services and result in accelerated expenditure growth. Purchasers must manage dynamically and anticipate changes (e.g. in cost structures, technology, provider behaviour) while regularly adjusting and optimizing payment methods [19].

As payment methods and rates send signals to providers, purchasers can use them to influence provider behaviour and their resource use. For example, purchasers can pay relatively high amounts for primary health care services to reflect their priority and incentivise providers to put greater focus on these, and pay relatively lower prices for high-cost but low-priority services as an incentive to limit the provision of these services [20].

There is growing evidence and increased consensus that purposive alignment of payment methods – balancing the undesirable incentives of a single payment method and harmonizing the range of incentives – is the optimal approach to improving the payment system [21]. Blended payment methods are one way. Blending means two or more payment methods are combined purposively. For example, case-based payment is combined with a global budget as a way of controlling overall spending, or a base payment (e.g. salaries, fee-for-service, capitation) is blended with a pay-for-performance mechanism [22]. This latter option is a way to link some part of the payment to the performance of

providers, measured in terms of quantity or quality. Estonia provides a good example of a blended payment system [23]. Another option of purposively aligned payment is bundled pay, whereby several components of health care for a specific intervention are put together and paid for together, based on the expected costs of patient cases, episodes or care over a specified time-period. Depending on its design, bundled payment can provide incentives for integration of care [22].

Pay-for-coordination arrangements are also gaining importance. The idea is to incentivise continued care and care coordination across providers and care levels (from primary to specialist and hospital care), while incentivizing the use of primary health care [22, 24]. This must also be geared to establishing an effective provider network.

Even in a well aligned mixed payment system, there is need for complementary administrative mechanisms to ensure that payments over time continue setting the right incentives to providers. Utilisation reviews are important not only to revise and update what services and medicines to cover, but also to have information to adjust payment methods and rates. Administrative controls include for example audit, claims review and fraud control measures. Moreover, regular revisions of payment methods and rates serves to respond to provider behaviour caused by a provider payment method itself (e.g., the tendency of “upcoding” in a Diagnosis Related Groups (DRG) payment system) [19].

Contracting is a key policy instrument for strategic purchasing and effective payment systems by putting greater focus on the achievement of measurable results. While there are sector-wide agreements and accords on payment methods and rates for a whole group of providers reimbursed by a purchaser, e.g. a health insurance agency, the idea behind contracting is to provide clear specifications to an individual provider.

A growing number of countries across all income levels set up payment methods in combination with explicit contracting arrangements to address concerns about health care quality and pursue performance targets [25]. Contracting may also include non-financial incentives, e.g. reputational benefits or support supervision.

For providers to be able to respond to any incentives they need sufficient managerial and financial autonomy and capacity. If providers are supposed to receive case-based payments but the public financial management (PFM) rules do not allow them to change the mix of inputs, the expected efficiency gains will not be realized and the quality of care will suffer [26].

INTEGRATED OR INTEROPERABLE INFORMATION MANAGEMENT SYSTEMS

Detailed and up-to-date information is critical for a purchaser to be able to allocate funds according to population needs and provider performance, to design payment methods as well as to monitor provider behaviour.

The needed information includes both clinical and financial data as well as data on quality and service-delivery outputs, all of which will require harmonized or interlinked data systems. However, such detailed information is not readily available or accessible in many low- and middle-income countries, making it difficult to use evidence as the basis for strategic purchasing decisions (e.g. in contract design). One decisive challenge is that several information subsystems operate in isolation. Although these subsystems may contain information relevant to the design of provider payments and the monitoring of providers' behavioural responses, they are not interoperable [19].

Countries can and should move towards strategic purchasing, even when their information management system is not yet comprehensive or integrated [21].

For instance, in several countries, as in Kyrgyzstan, diagnosis-related group (DRG) payment systems started simply, were organized for example by clinical departments, and then were progressively differentiated as data allowed for further refinement [27]. Finally, as countries gradually improve their capacity to generate, analyse and translate data into policy decisions about purchasing, they will face increased challenges to safeguard patient privacy and guarantee the system's accountability. These two considerations should be addressed from the start and should remain constant concerns throughout the process.

EFFECTIVE GOVERNANCE ARRANGEMENTS FOR STRATEGIC PURCHASING

Governance as an overarching health system function is equally critical for strategic purchasing. Governance arrangements, including regulatory frameworks, need to be improved in a complementary way to support the shift to strategic purchasing through the above policy options.

First, effective governance arrangements are needed to coordinate a multiple healthcare purchasing market and to manage different interests of the involved stakeholders. In many countries, governance is constrained by lack of clarity about roles and responsibilities across different ministries, government levels

and purchasing agencies [19]. Streamlining accountability and reporting lines, as well as strengthening the capacity of both the Ministry of Health and the purchasing agencies, are ways to support a system's ability to perform strategic purchasing [21].

There have been debates on the theoretical merits of competition between multiple health care purchasers, yet the outcome depends on how well the healthcare purchasing market is regulated. This could result, for example, in a drive for higher quality and responsiveness to citizens' preferences. However, there are also strong disadvantages of competing purchasers – including an increase in managerial costs, loss of market power of a single purchaser, and fragmentation in the health care system – that could potentially lead to inequities in resource distribution and access to health services [28]. Coordination and regulation of a healthcare purchasing market is even more challenging when health services are purchased with both public and voluntary prepaid funds.

Second, effective governance at the level of a purchaser agency is needed to ensure that a purchaser acts strategically. This includes having effective oversight mechanisms, stakeholder participation, clear accountability and reporting lines, and a clear legal mandate for strategic purchasing. In many countries, the oversight body of the purchasing agency is weak and puts insufficient focus on the actual performance by the purchaser [29]. On the other hand, various countries (e.g. Chile, Moldova, Thailand) have managed to strengthen purchasers' accountability both to the government and to the population. This has been achieved, for example, by widening representation, allowing for public participation, conducting internal and external audits, careful selection of the Board Chair, and satisfaction surveys [1, 30-32]. Governance actors must also empower citizens and patients through information on their entitlements and rights, functional feedback channels and complaints mechanisms. Finally, purchasers need to have the autonomy commensurate with their capacity to act strategically [33] and to address and respond to the external environment and context factors [34].

4. HOW DOES STRATEGIC PURCHASING LINK WITH OTHER ISSUES RELATED TO HEALTH FINANCING?

There are important issues regarding the alignment of purchasing policy with other health financing policies and health system functions. Table 1 outlines these alignment issues relating to strategic purchasing and suggests how these can be addressed.

Table 1. Alignment issues between strategic purchasing and other health (financing) system-related elements and ways to address them

Alignment issues in relation to:	Ways to address alignment issues
<p>Revenue raising:</p> <ul style="list-style-type: none"> • Paying for promised benefits must not exceed revenues raised, so as to avoid implicit rationing and informal payments, persistent deficits in health insurance funds, or non-payment of providers, which ultimately erode coverage. 	<ul style="list-style-type: none"> • Align the specifications of benefits with available funding and/or adjust the funding and priority given to health to bring it in line with benefits that should be covered.
<p>Pooling:</p> <ul style="list-style-type: none"> • A good pooling architecture creates the potential for an equitable distribution of resources according to needs. The purchasing arrangements need to ensure that this potential is maintained and is further enhanced by creating the right incentives for efficiency, equity and financial protection. 	<p>In a single pool:</p> <ul style="list-style-type: none"> • Introduce allocation formulas with the purpose of risk adjustment to reflect health needs/risks, independent of the revenue-raising capacity of the catchment area populations. <p>In a system with multiple pools:</p> <ul style="list-style-type: none"> • Harmonize benefits, payment methods and rates.
<p>Public financing management (PFM):</p> <ul style="list-style-type: none"> • The budget may not reflect the service package when presented on the basis of inputs (e.g. salaries, utilities, medical supplies) and/or by facility (health centres, district hospitals, university hospitals). • More active purchasing is constrained where input-based line-item budgets capped at facility level do not allow for full implementation of output-based payment methods. • There may be different purchasing arrangements and accounting procedures for different revenue streams. • PFM rules may not allow the use of public funds to pay private providers. 	<ul style="list-style-type: none"> • Shift away from detailed input-based budget formulation, appropriation and expenditure management to programme-based budgeting to allow for clear identification of purchased services. • Use the same accounting and reporting procedures regardless of the revenue stream. • Adjust PFM rules to enable contracting with private providers.

Table 1 (cont.)

Alignment issues in relation to:	Ways to address alignment issues
<p>Service delivery:</p> <ul style="list-style-type: none"> ● Purchasing arrangements, and particularly payment methods, may not be aligned with service delivery objectives (e.g., care coordination and integration, focus on primary health care) or defined benefits and may contribute to fragmentation of service provision. ● Payment methods may favour health service provision in urban over rural areas, or secondary care over primary care. 	<ul style="list-style-type: none"> ● Clearly define benefits in terms of priority services and related conditions of access; allocate resources towards these priorities, with payment mechanisms that incentivize better quality, equity and efficiency. ● Introduce bundled payment or add-on performance incentives for care integration and coordination.
<p>Devolution⁶</p> <ul style="list-style-type: none"> ● The division of expenditure authority and purchasing responsibilities between central and local levels is often unclear. ● Purchasing at subnational levels may not be in line with economies of scale, externalities and capacity in PFM and purchasing, and may thus be inefficient. ● Resource allocation to health is not always a local political priority, and there may be less focus on health prevention. Conditional fund allocations may not be in line with needs either. 	<ul style="list-style-type: none"> ● Adjust the division of responsibilities between the central and local levels. ● Organize bulk purchasing at central level based on local needs. ● Use conditional funding for core health priorities, coupled with block grants to allow for local resource allocation decisions in line with needs and preferences.

⁶ Devolution is understood as the transfer of decision-making powers and resources to subnational governments [35].

5. THE PERSPECTIVE OF WHO

There is a range of measures and policy options that a country can apply to move more towards strategic purchasing, as outlined in Section 3. Capacity to carry out strategic purchasing tasks and to introduce these measures must be developed if governance actors and purchasers are to be effective. First, this involves the operationalisation of benefits to specify entitlements and obligations and to select providers to deliver these, while making sure that people are aware of their entitlements. Secondly, payment methods need to be adjusted and aligned on a regular basis to create a coherent set of incentives in line with the health system objectives and the country text [36]. Thirdly, an integrated or interoperable information management system is required to have appropriate data to take purchasing decisions. Finally, effective governance arrangements for purchasing are decisive for purchasers to act strategically and for managing the dynamics in purchasing.

The multitude of issues calling for change and reform also raise the question of sequencing health financing reforms. Experience suggests that getting the incentives right for provider payment and service provision is essential before pulling in more money through revenue-raising reforms. Hence, countries can start health financing reforms

for UHC with strategic purchasing. This is a “technical” issue in that not all changes may need to be approved by parliament or by high-level legislation. The reforms do not have to be sudden major changes but can be gradual. Many of these reforms are within the realm of the health sector and can often be guided by the Ministry of Health. It is argued that, particularly in countries with a large informal economy and limited fiscal capacity, it makes sense from a technical and political perspective to start with purchasing reforms to progress towards UHC.

But it is important to consider the political economy that lies behind “technical” issues such as payment methods and rates, and political and institutional feasibility challenges need to be understood and addressed. The move towards strategic purchasing thus needs to be supported by effective governance arrangements [37]. Moreover, strategic purchasing policies must be carefully considered in the light of other health system and health financing policies and should be aligned with them. Finally, it is important that health financing strategies provide detailed orientation for the various areas of strategic purchasing reform to ensure that budgets translate into promised benefits that are effectively delivered.

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ANNEX 1: MAIN PAYMENT METHODS USED IN HEALTH SYSTEMS AND EXPECTED INCENTIVES

Payment method	Definition	Incentives
Prospective:		
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g. staff, medicines), with limited flexibility to move funds across these budget lines	Under-provision, no focus on quality or outputs unless specified and held accountable
Global budget	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. The budget is flexible and is not tied to line items.	Under-provision, also in terms of quality or outputs unless specified and held accountable; more potential for efficiency due to budget flexibility
Capitation	Providers are paid a fixed amount in advance to provide a defined set of services for each person enrolled for a fixed period of time.	Under-provision, over-referral (if unit of payment does not include some referral services)
Retrospective:		
Fee-for-service	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.	Over-provision
Pay for performance	Providers are paid for each individual service or case, or defined target (output or outcome). The payment is fixed in advance. Alternative terms: Performance-based financing or results-based financing.	Over-provision, focus on those services under Pay for Performance, possibly at the detriment of other services
Case-based (“DRG”)	Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics.	Increase of volume, reduction of costs per case, avoidance of severe cases
Per diem	Hospitals are paid a fixed amount per day so that an admitted patient is treated in the hospital.	Extended length of stay, reduced cost per day; cream-skimming

Source: Adapted from [20].



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