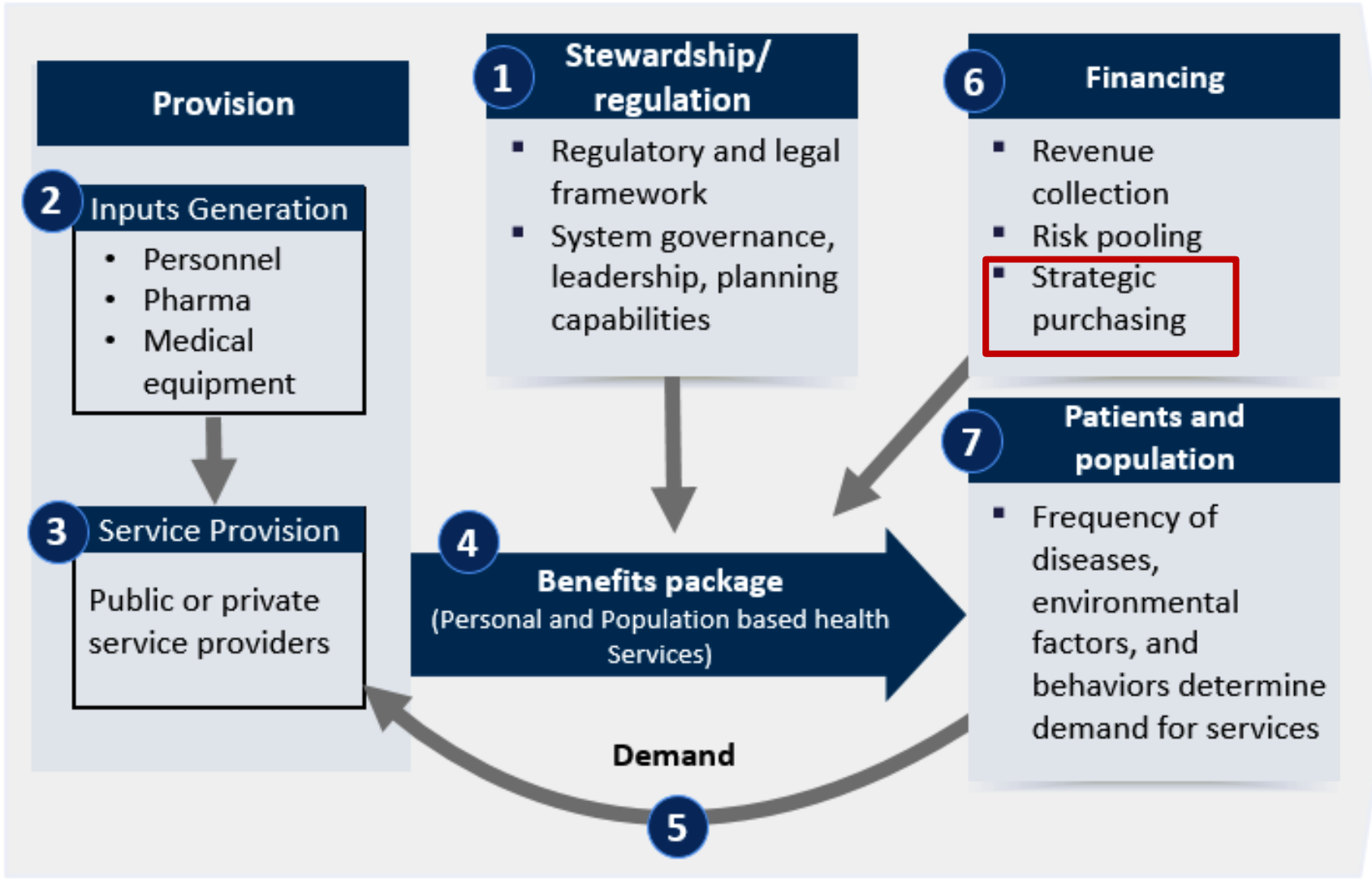
STRATEGIC PURCHASING: LEVERS AND MODELS GLOBALLY

PATHS FOR THE PHILIPPINES?

March 2018

Health Systems Functions and components



Health system objectives

- **Access to Services for Good health outcomes**
- **Financial protection**
- **Responsiveness** (patient satisfaction)
- **Sustainability and Country competitiveness**

OUTLINE

1. **Strategic Purchasing**
   - **Functions and Levers**

2. **Financing Providers ("Provider Payment") within Strategic Purchasing**
   - **a. Rationale**
   - **b. History and Models**
   - **c. "Enablers": Beyond Payment Design**
   - **d. More on Primary Care**
   - **e. More on Hospitals**

3. **Moving to Integrated Care Models?**

4. **What Does "Good" Look Like Overall?**

What is Strategic Purchasing?

At the Simplest Level it is "Spending Well" in the Health Sector

Fuller Definition (WHO)

Strategic health purchasers use information and policy levers to decide which interventions, services, and medicines to buy, from which providers, using which contracting and payment methods to encourage efficient behaviors and decisions among both providers and service users.

Strategic health purchasing requires an institutional authority (either within the Ministry of Health or an independent purchasing agency) to

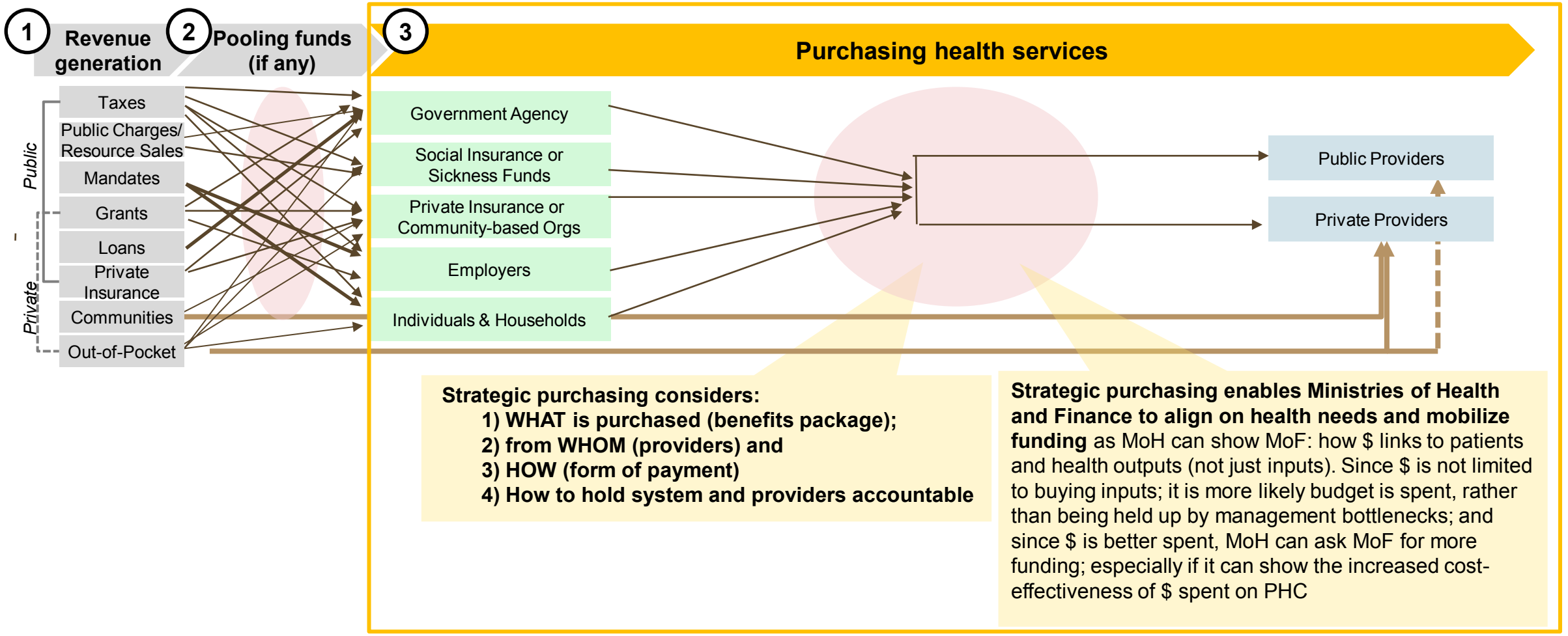
- make purchasing decisions;
- enter into contracts with providers;
- flexibility to allocate funds to pay for outputs and outcomes

If done well, can achieve improved efficiency, quality, and responsiveness of care

HEALTH FINANCING FUNCTIONS

HOW: 1) REVENUES ARE COLLECTED; 2) FUNDS ARE POOLED; 3) SERVICES ARE PURCHASED

Focus is purchasing health services



Strategic purchasing considers:

1) **WHAT is purchased (benefits package);**
2) **from WHOM (providers) and**
3) **HOW (form of payment)**
4) **How to hold system and providers accountable**

Strategic purchasing enables Ministries of Health and Finance to align on health needs and mobilize funding as MoH can show MoF: how $ links to patients and health outputs (not just inputs). Since $ is not limited to buying inputs; it is more likely budget is spent, rather than being held up by management bottlenecks; and since $ is better spent, MoH can ask MoF for more funding; especially if it can show the increased cost-effectiveness of $ spent on PHC

EVERYTHING MOF AND MOH DO TO ALLOCATE RESOURCES TO HEALTH IS A FORM OF "PURCHASING" …

INCREASINGLY, ALLOCATION OF FUNDS TO HEALTH IS MOVING FROM PASSIVE TO ACTIVE

Typical features

- "Passive"
  - resource allocation using norms
  - little/no selectivity of providers
  - little/no quality monitoring
  - price and quality taker
- "Strategic"
  - payment systems that create deliberate incentives
  - selective contracting
  - quality improvement and rewards
  - price and quality **maker**

STRATEGIC PURCHASING: FOUR (4) POLICY LEVERS TO DRIVE CHANGE

Health financing functions

Revenue generation	Pooling	Purchasing

Public financial management functions

Revenue projection *How public spend is determined*	Budget formulation *How spend priorities are decided*	Budget execution *How public spend is used*	Budget monitoring/reporting *How public spend is accounted for*

Passive purchasing

- Coverage is low or non-existent, because user fees too often exist, quality is poor, or provider/drugs not available
- Benefit package ad hoc (implicit)
- Input based financing for commodities / provider salaries etc
- Line Items tend to bias towards urban tertiary facilities

Strategic purchasing policy levers

1. **BENEFITS PACKAGE: what to buy**, in **which form**, what's excluded?
2. **CONTRACTING: from whom**, at what price and how much to buy?
3. **PROVIDER PAYMENT: at what price and how to pay?**
4. **ACCOUNTABILITY of providers and system for performance**

Enabling functions

Monitoring	Provider autonomy	ICT / data systems	Quality accreditation & assurance

Purchasing Outcomes

Quality	Efficiency	Access

WHICH COUNTRIES? 19 / 27 COUNTRIES IN THE JOINT LEARNING NETWORK ARE MOVING TOWARDS STRATEGIC PURCHASING

Passive purchasing → ***Increasingly strategic purchasing***

	Line-item budgets; no defined benefits package/essential services package	*Defined benefits package/essential services package; some contracting; and small-scale use of output-based payment*	*Defined benefits package/essential services package, contracting; large-scale use of output-based payment; other purchasing strategies (e.g. use of data, quality management, etc.)*
Lower income	Liberia	Ethiopia Mali Senegal	
Lower middle income	Egypt Kosovo Yemen	Bangladesh India Morocco Sudan	Ghana Indonesia Kenya Moldova Mongolia Nigeria Philippines Vietnam
Higher-middle income	Malaysia Namibia	Bahrain Mexico	Colombia Peru

The Joint Learning Network is a peer learning network of Ministries of Health and Finance including 27 countries (2 countries not shown are high income countries). Sub-Saharan African countries include Ghana, Kenya, and Nigeria. See Appendix for details

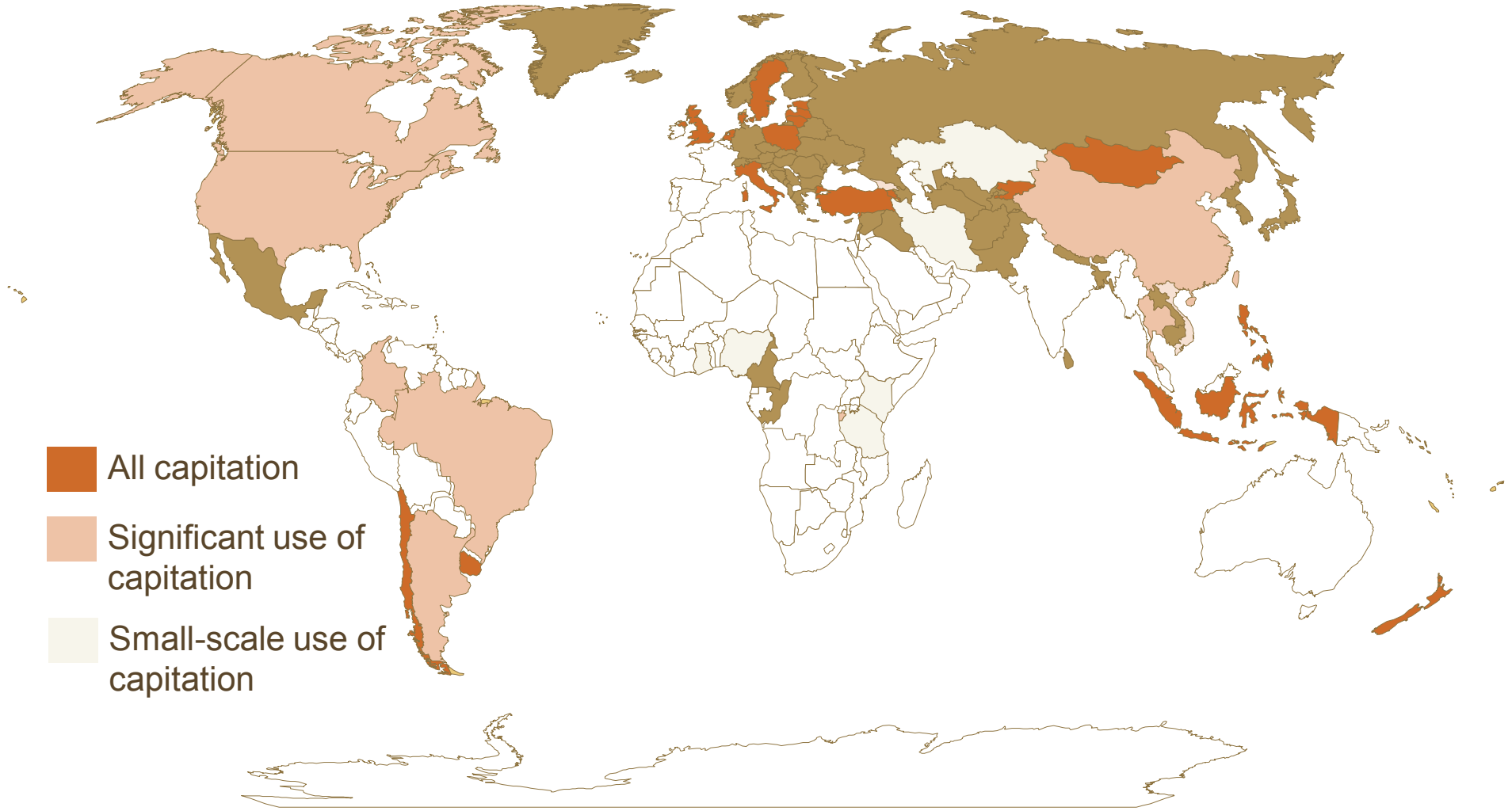
Source: Landscape of JLN country financing models, prepared by R4D (2016) – *See appendix for further details*

PAYING PROVIDERS: THERE ARE A NUMBER OF DIFFERENT OUTPUT-BASED OPTIONS TO PAY PROVIDERS, EACH CREATES CERTAIN RISKS AND INCENTIVES

	Risk Borne by		Provider Incentive to			
Payment mechanism	**Payer**	**Provider**	**Increase No of Patients**	**Decrease number of Services per payment units**	**Increase reported Illness severity**	**Select healthier patients**
Fee for service	All risk borne by payer	No risk borne by provider	✓	✗	✓	✗
Case Mix Adjusted per Admission(e.g., DRG)	Risk of Number of Cases and Case Severity Classification	Risk of Cost of treatment for a given case	✗	✓	✓	✓
Per admission	Risk of number of Admission	Risk of number of services per admission	✓	✓	✗	✓
Per-Diem	Risk of number of days to stay	Risk of cost of services within a given day	✓	✓	✗	✗
Capitation	Amount above "Stop Loss" ceiling	All risk borne by provider up to a given ceiling (stop loss)	✓	✓	N/A	✓
Global Budget	No risk borne by payer	All risk borne by provider	✗	N/A	N/A	✓

Sources: Hsiao et al.1999,Modifying data from WHO 1993,Bodenhiemer and Grumbach 1994

Capitation is Widely Used in OECD and LMICs



Source: Cashin 2017

NO ONE MODEL PERFECT…SO…

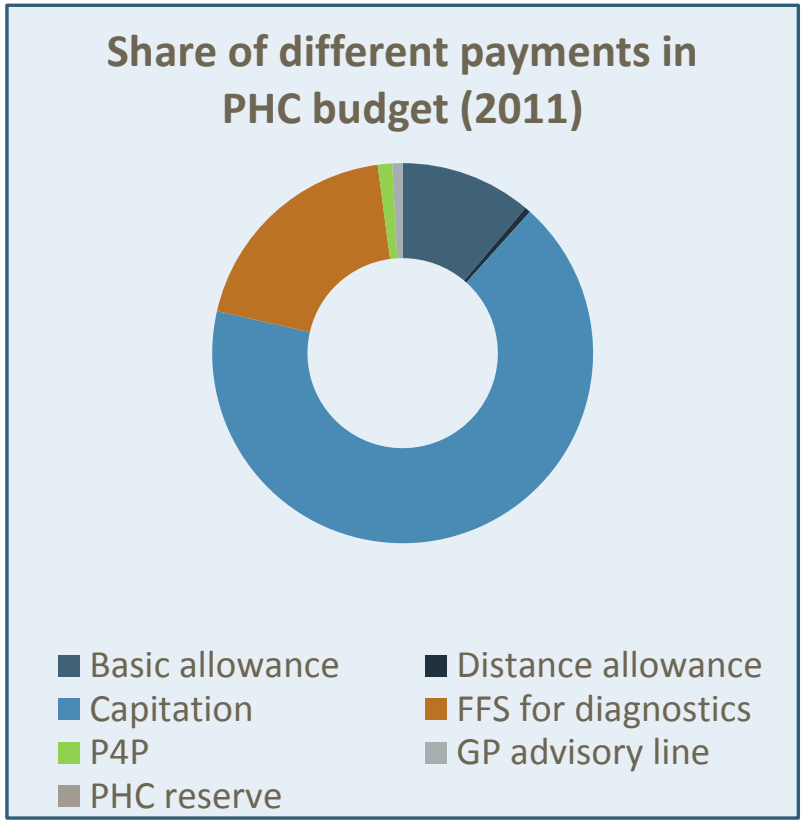
WORLD MOVING TO BLENDED PAYMENT MODELS: EXAMPLE FROM ESTONIA

Reduce financial risk of providers

Main payment method—efficiency and prevention incentives

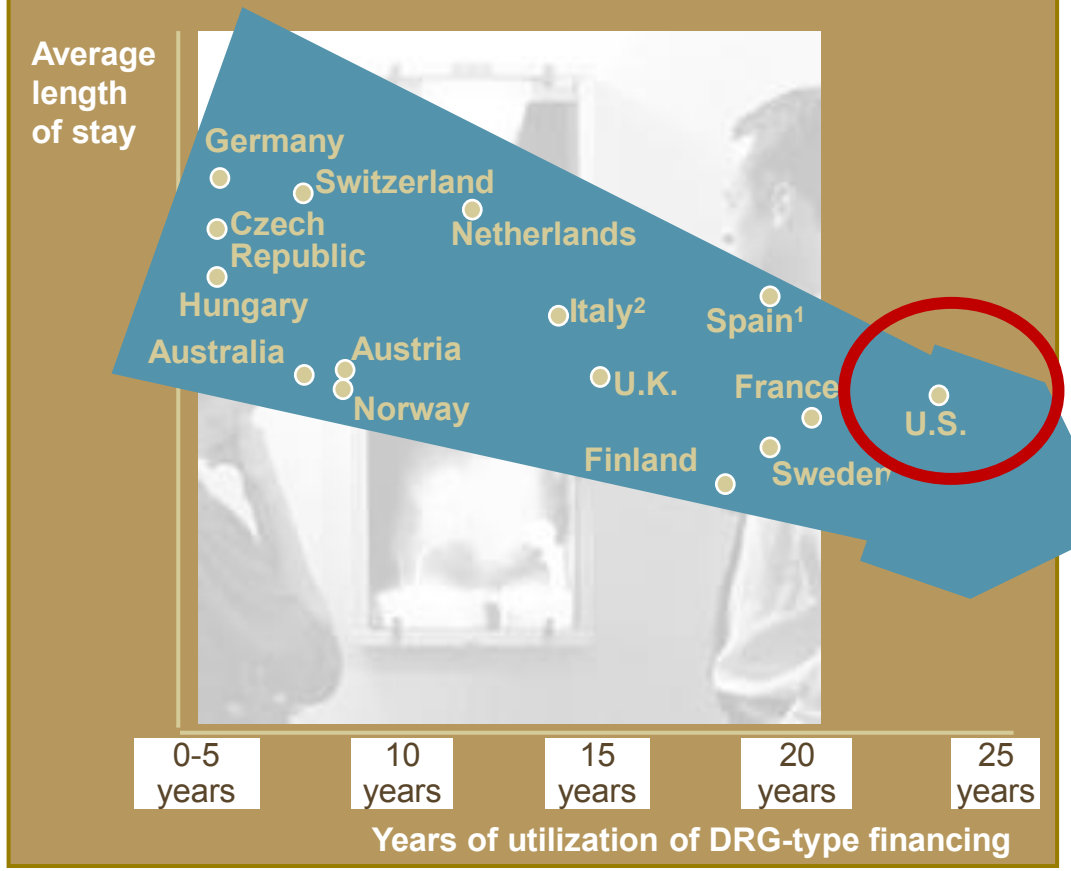
Counteract adverse incentives of capitation to under-provide services

- Basic allowance
- Capitation
- FFS
- Performance payment



Diagnosis-Related-Groups (DRGs) is the payment mechanism towards which most develop systems are converging, having also positive implications in terms of efficiency

Case mix/activity-based payment systems have been introduced in many countries, including Eastern Europe



1 Length of stay in 1997 2 Length of stay in 1998

Benefits and drawbacks for implementing activity-based reimbursements

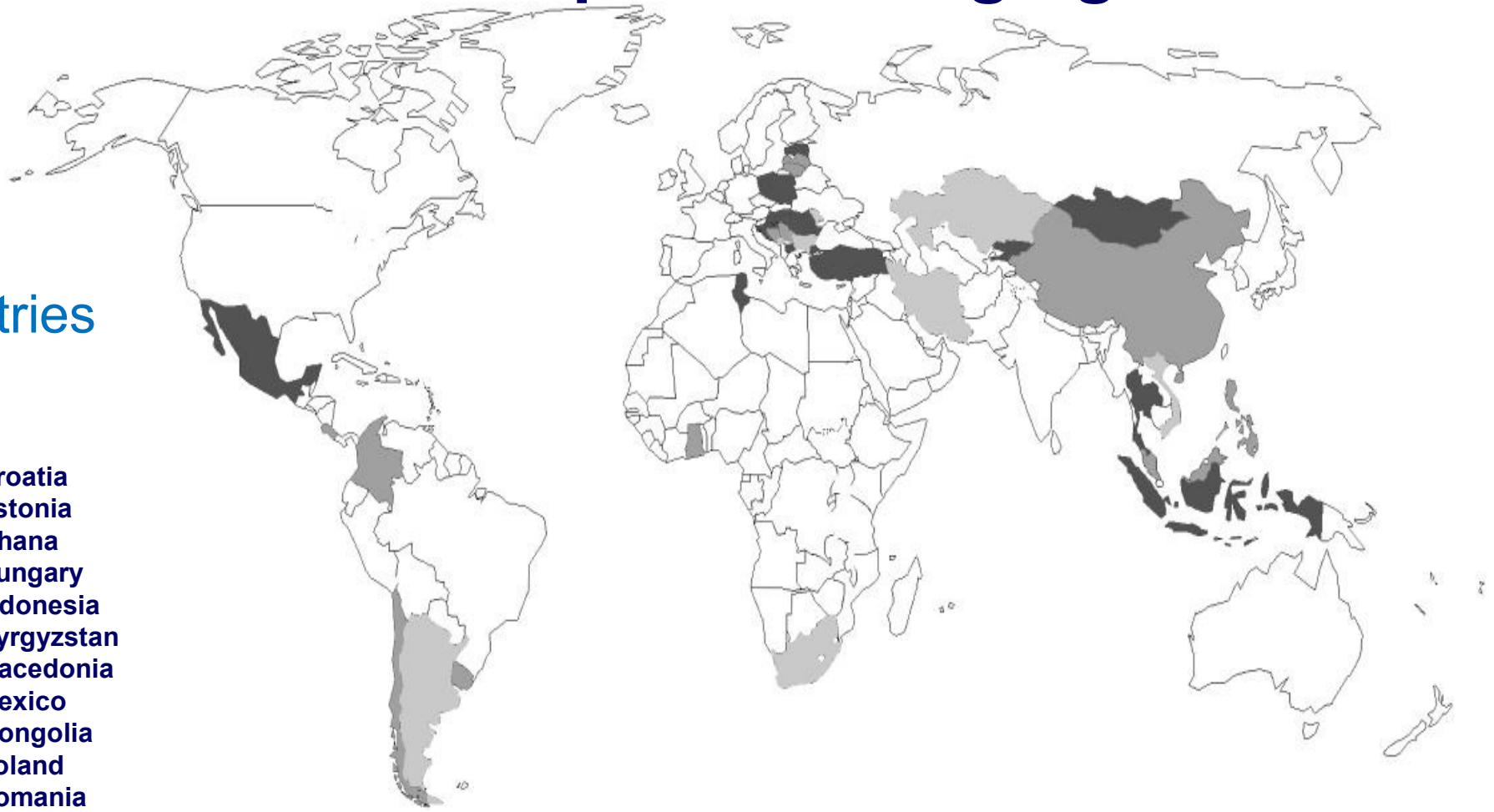
Benefits	▪ Facilitates competition between providers ▪ Improve responsiveness to patient needs ▪ Improves cost transparency and increase efficiency within providers
Draw-backs	▪ Increases complexity in financial flows and data recording ▪ Faces risk of significant increase in costs (due to increase in volume of activities) if not properly implemented and controlled ▪ Leaves space for frauds (e.g., up-coding)

SOURCE: OECD report, 2002

“DRGs”
OECD countries …plus…Emerging Economies

OECD countries not marked

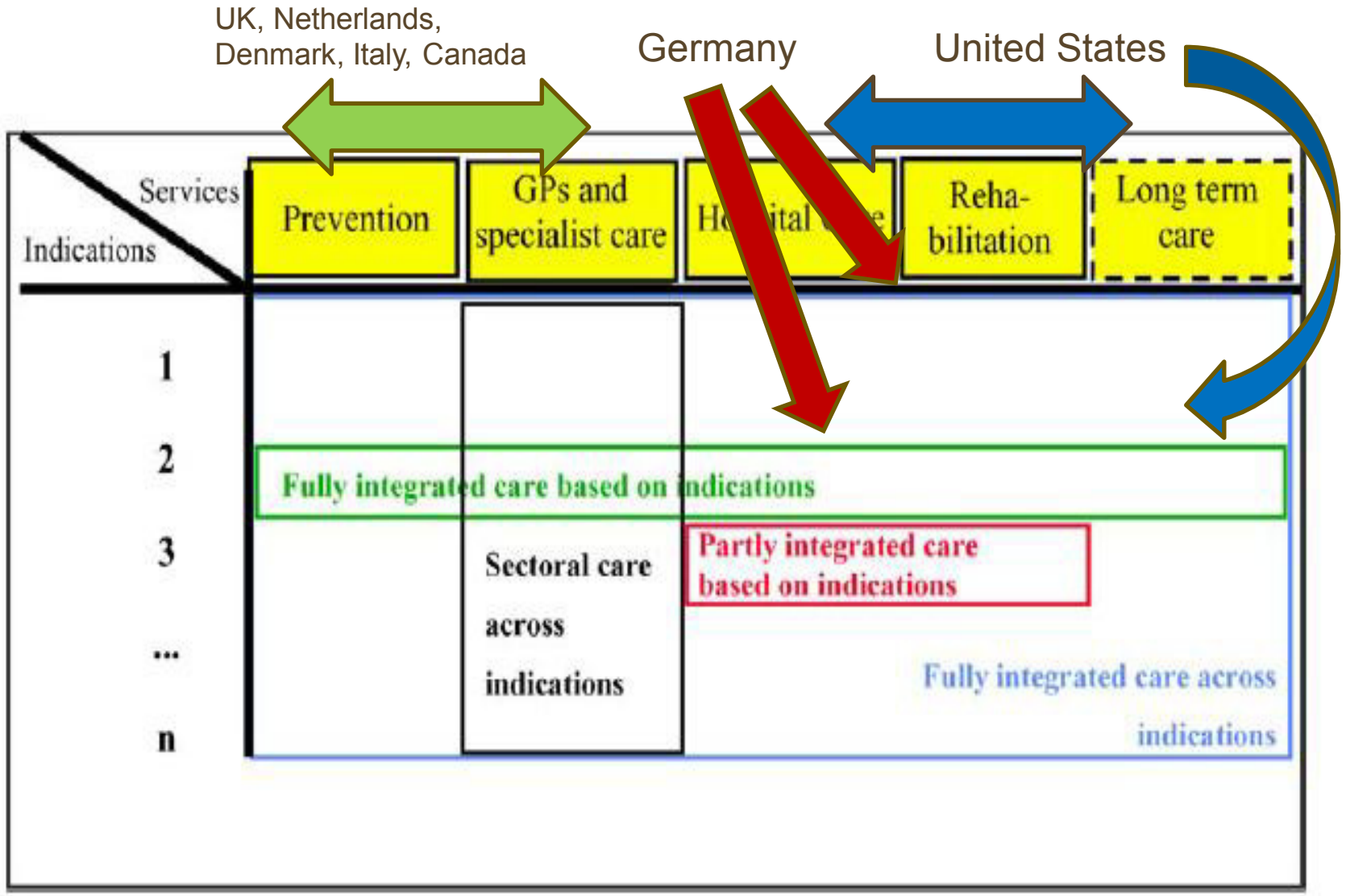
1. Croatia
2. Estonia
3. Ghana
4. Hungary
5. Indonesia
6. Kyrgyzstan
7. Macedonia
8. Mexico
9. Mongolia
10. Poland
11. Romania
12. Thailand
13. Tunisia
14. Turkey



AGAIN: BLENDED PAYMENT MODELS FOR HOSPITAL CARE: INTERNATIONAL TRENDS GO BEYOND PAYING HOSPITALS WITH DRGS

Country	DRG	Global Budget	Global Budget with DRG case-mix adjustment
Australia	X		X
Belgium			X
Denmark	X	X	
England			X
Finland	X		
France			X
Germany			X
Ireland			X
Italy			X
Norway			X
Portugal			X
Spain			X
Hungary			X
Thailand			X
Taiwan (China)	X (with FFS)	X	

THE FRONTIER: Bundling Payments ACROSS Levels of Care



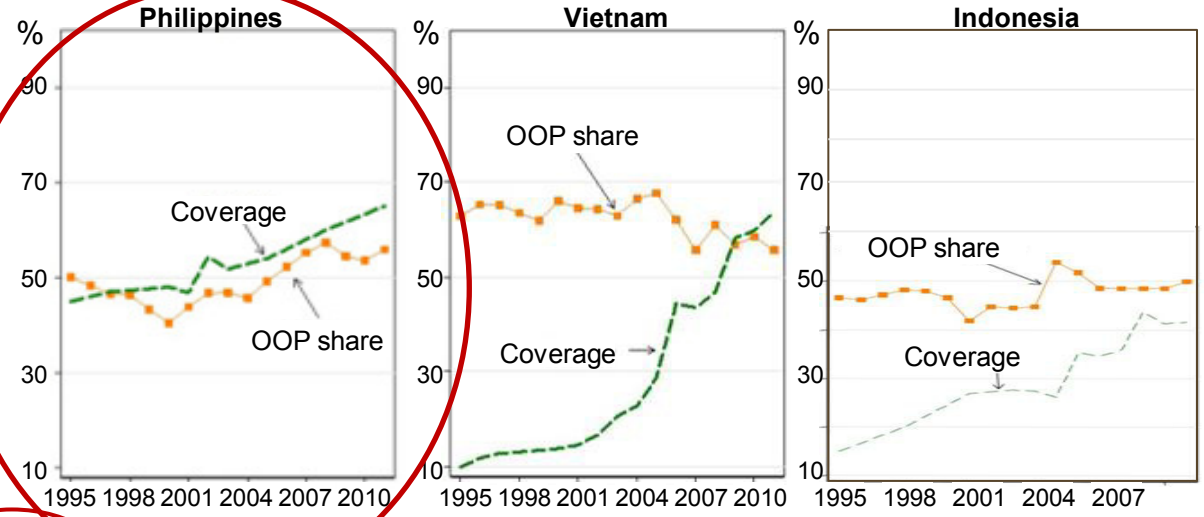
+ New initiatives: Ex: Poland, China, Mongolia, India to move to integrated care models.

Are HMOs in Philippines the start?

MANY COUNTRIES EXHIBIT UNSTRATEGIC PURCHASING

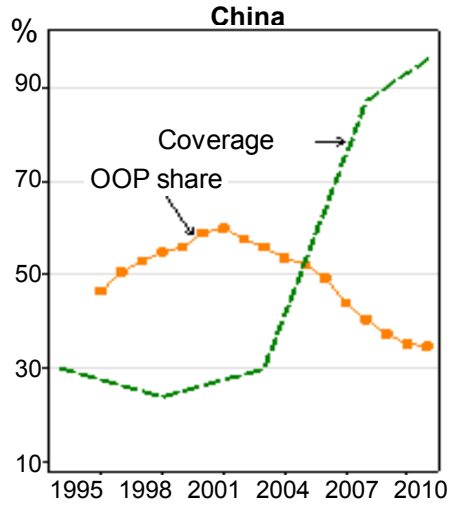
COVERAGE WITHOUT FINANCIAL PROTECTION

Philippines, Vietnam and Indonesia have all seen increases in population coverage but no decrease in OOP payments



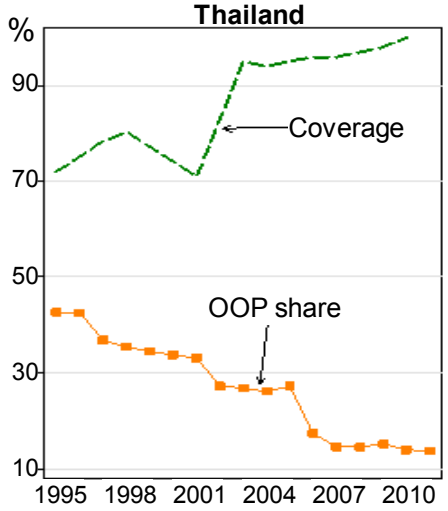
14.7%

China's benefit package cap and fee for service payment meant greater coverage, but no change in financial protection



- No change in % households facing catastrophic expenses (12% in 2003, 13% in 2011)
- No change in % spent on health out of total household spending (11% in 2003, 13% in 2011).

Thailand has had greater success



Strategic purchasing can have unintended consequences if not implemented effectively across a network of functions and institutions

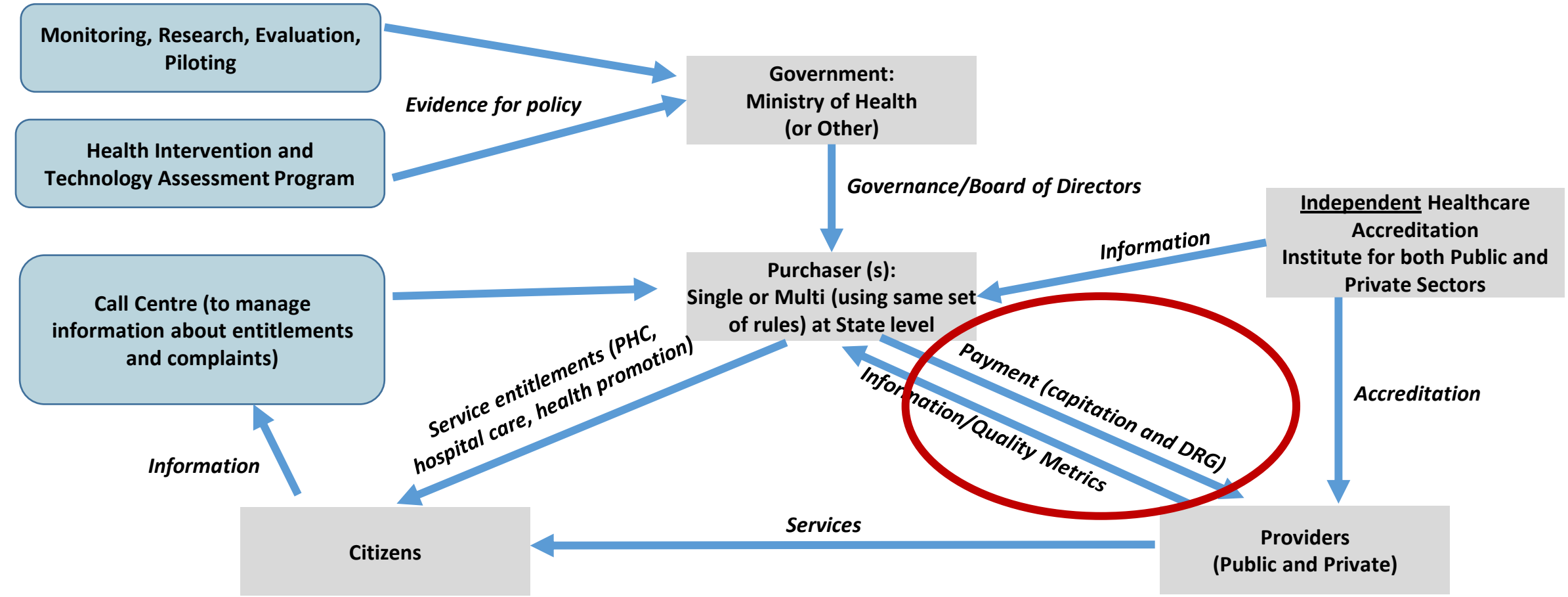
- Many countries are working hard at expanding scheme coverage (effectively addressing revenue generation and revenue pooling functions), but in some settings this is leading to no improvements in financial protection (as represented by reductions in the OOP share of THE)
- It is likely that this is because of a lack of attention to issues of purchasing – the services covered are not the ones that people want; insufficient attention being devoted to quality of care; purchaser is not limiting extra billing or people are continuing to use "out of plan" providers or services.
- In these countries, the purchasing actions concerning the "what services" and "purchasing arrangements" are not being addressed.

Source: WHO country reports; SUSENAS; WHO China Health Services Report; Tandon, iHEA 2015

THE ROAD AHEAD: WHAT DOES "GOOD" LOOK LIKE?

FUNCTIONS MUST FORM COHERENT TASK NETWORKS ACROSS ACTORS AND INSTITUTIONS

Thailand: Purchasing functions and sub-functions form a system or network



Source: K. Hanson, 2017

THANK YOU

QUESTIONS?

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