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Managing Financing and Costing of Health Care: Policy levers of strategic purchasing

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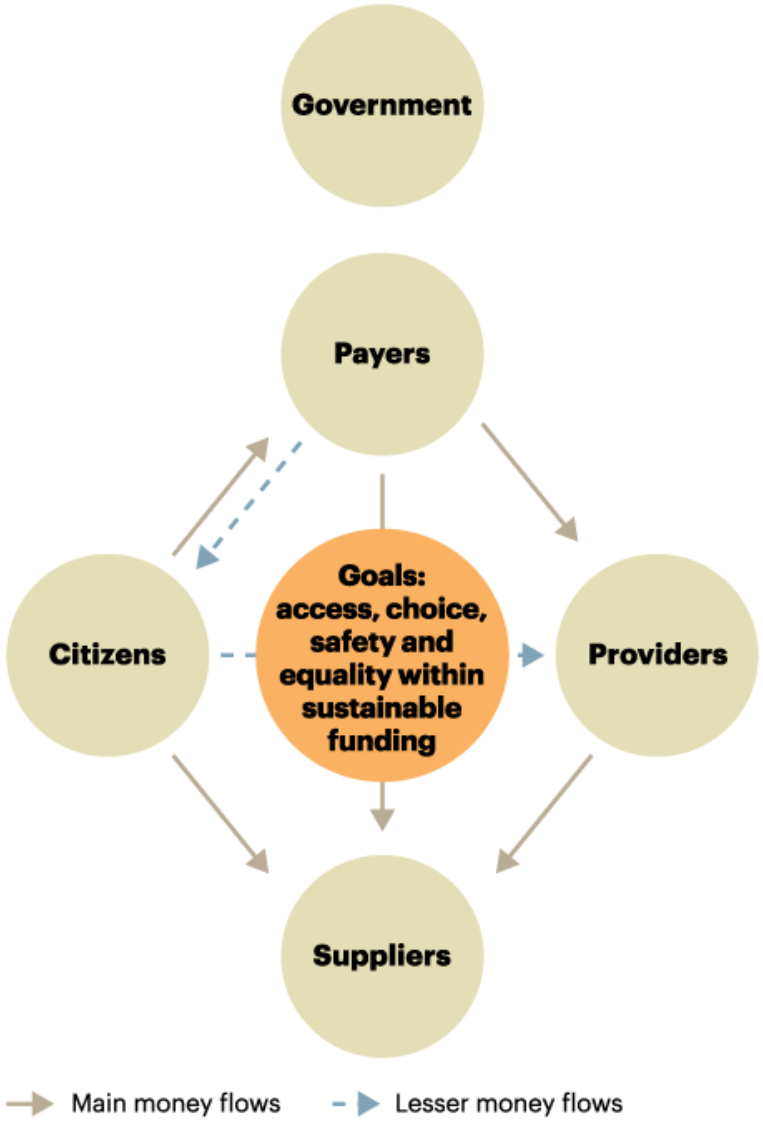
February 18 – 20, 2019
CEF, Ljubljana, Slovenia

Five basic types of healthcare systems



Free market

(unique to the United States)

- Maintains safety net through public payment of premiums
- Offers services and insurance through private sector

Bismarck

(instituted in Germany and France)

- Provides insurance through competing social funds
- Offers multiple sources of provision

Hybrid

(instituted in the Netherlands and Japan)

- Requires private insurance for high earners and social insurance for all others
- Provides services through public or private sector

Beveridge

(instituted in the United Kingdom, Spain, Italy, Scandinavia and Portugal)

- Funds system through general taxation
- Provides services through public sector; treatment is free at point of care

Ex-Semashko

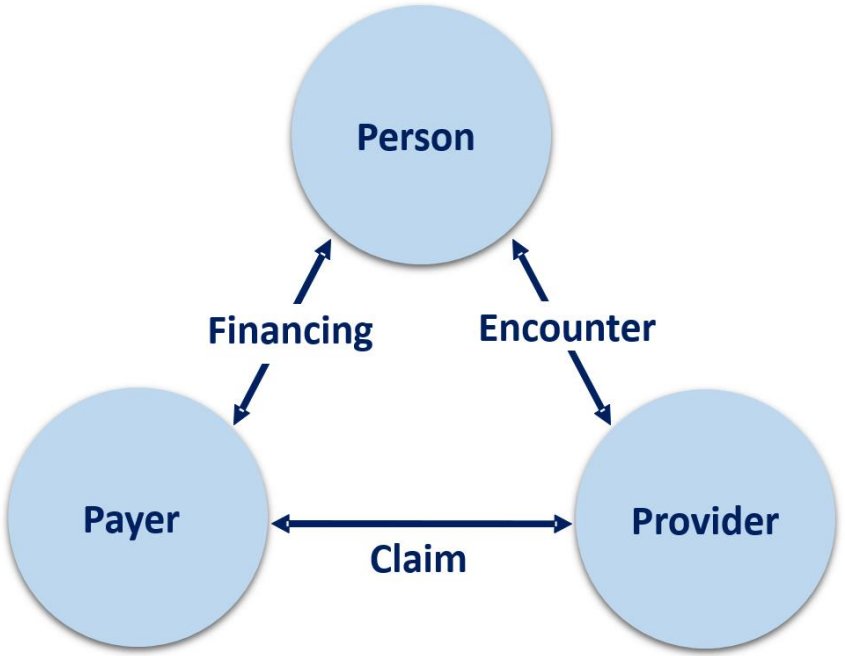
(instituted in Russia and former Eastern Bloc countries)

- Is decentralizing from Communist model and restructuring either to Beveridge or Bismarck system

Resource efficiency

The **2010 World Health Report** on **financing for universal coverage** noted that: “Raising sufficient money for health is imperative, but just having the money will not ensure universal coverage. Nor will removing financial barriers to access through prepayment and pooling. The final requirement is to **ensure resources are used efficiently**.”

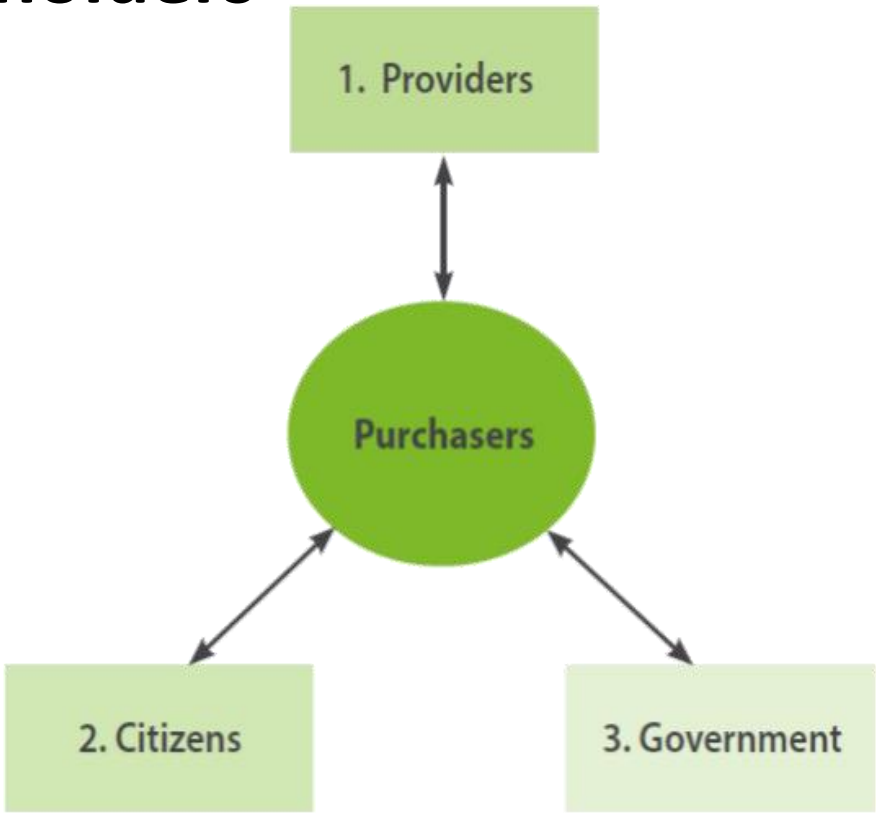
WHO World Health Report, 2010



Strategic purchasing requires the purchaser to engage actively in 3 main relationships between stakeholders

"**Passive purchasing** implies following a predetermined budget or simply paying bills when presented. **Strategic purchasing** involves a continuous search for the best ways to maximize health system **performance** by deciding which interventions should be purchased, how, and from whom."

WHO World Health Report, 2000

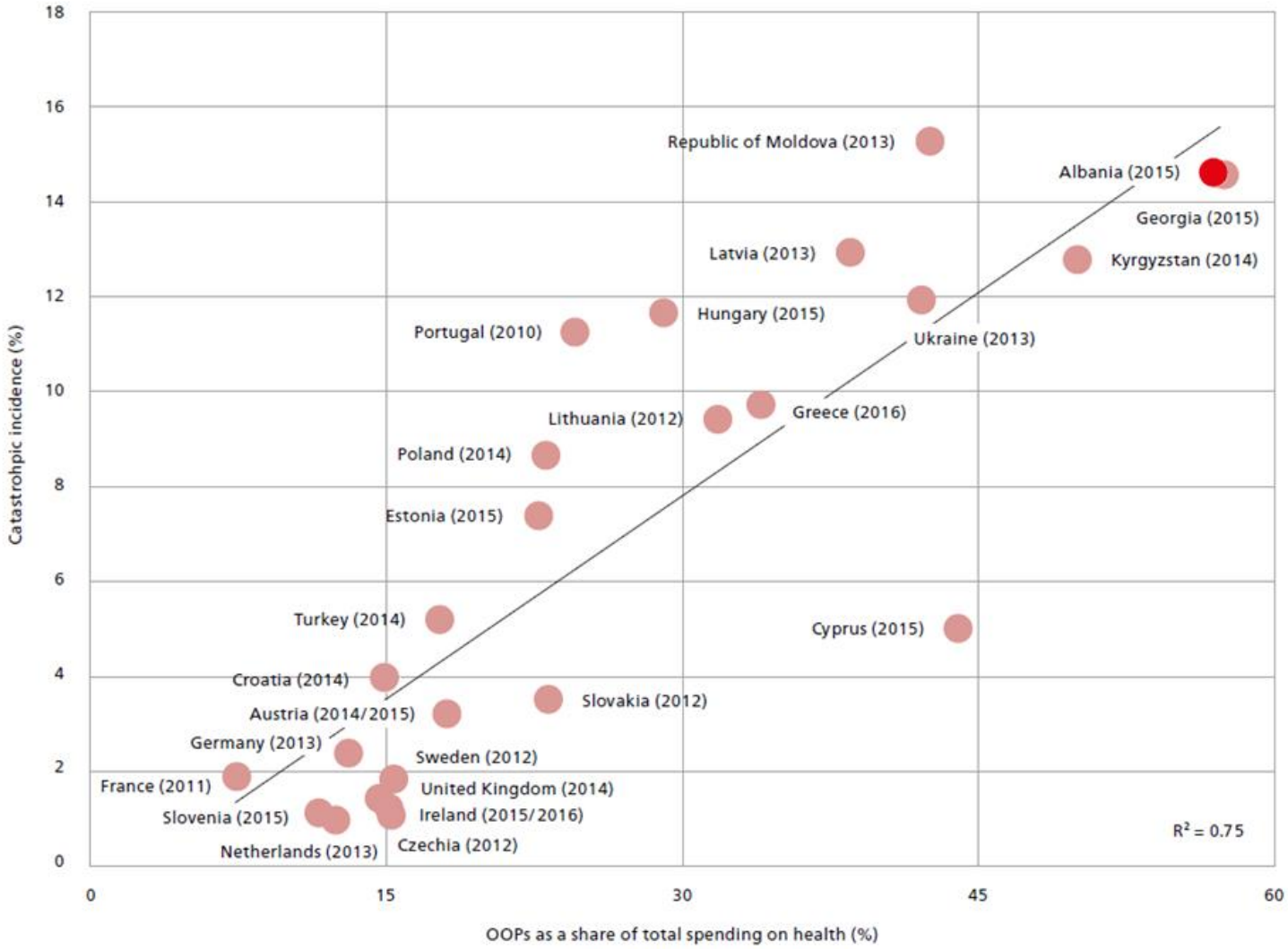


STRATEGIC PURCHASING INVOLVES THREE SETS OF DECISIONS:

1. **Identifying** the interventions or services to be **purchased**, taking into account population needs, national health priorities and cost-effectiveness.
2. Choosing service **providers**, giving consideration to service quality, efficiency and equity.
3. Determining **how** services will be purchased, including **contractual arrangements** and provider payment mechanisms

World Health Organisation 2000; Figueras, Robinson et al. 2005

INCIDENCE OF CATASTROPHIC SPENDING ON HEALTH AND THE OUT-OF-POCKET SHARE OF TOTAL SPENDING ON HEALTH IN SELECTED EUROPEAN COUNTRIES



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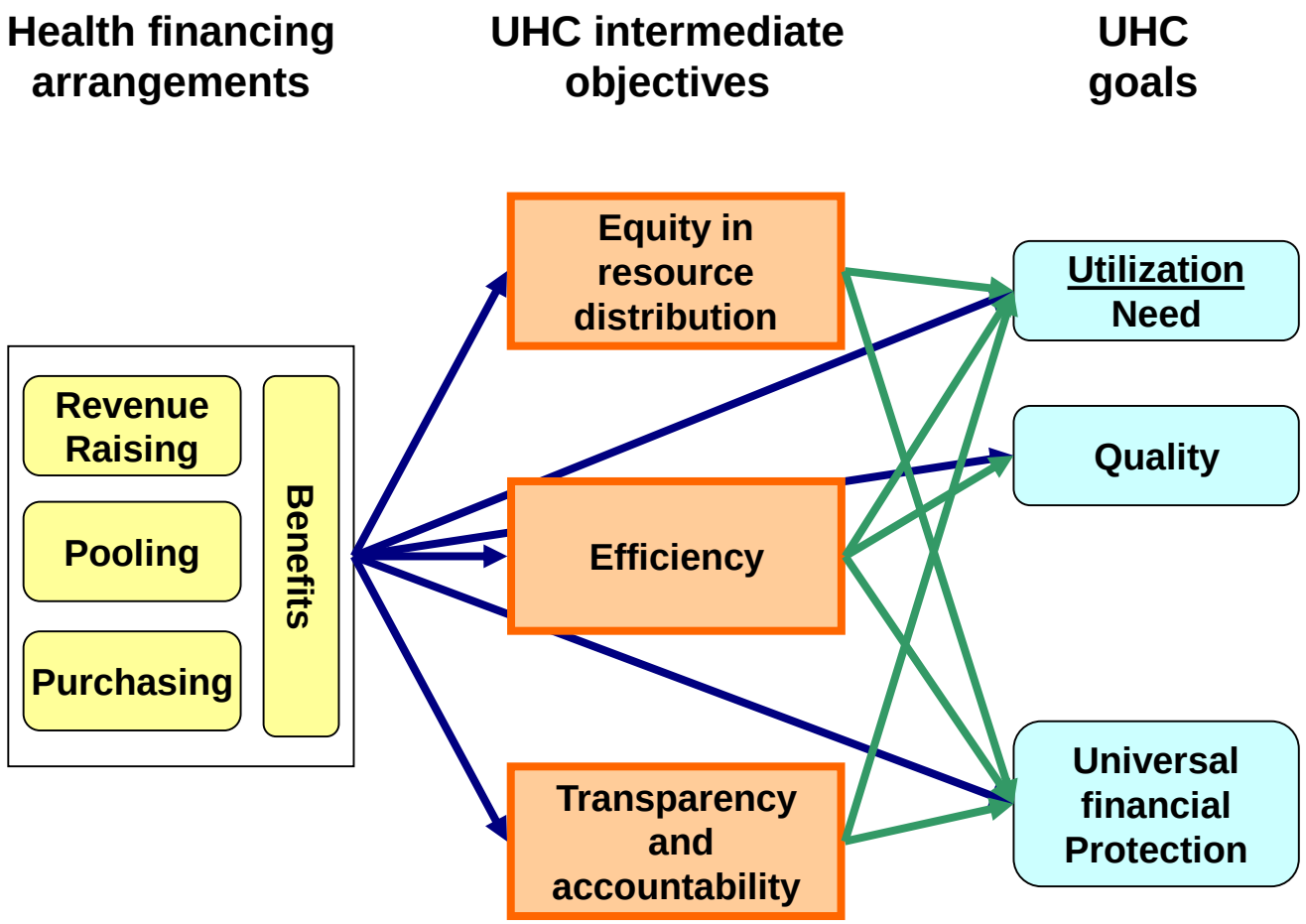
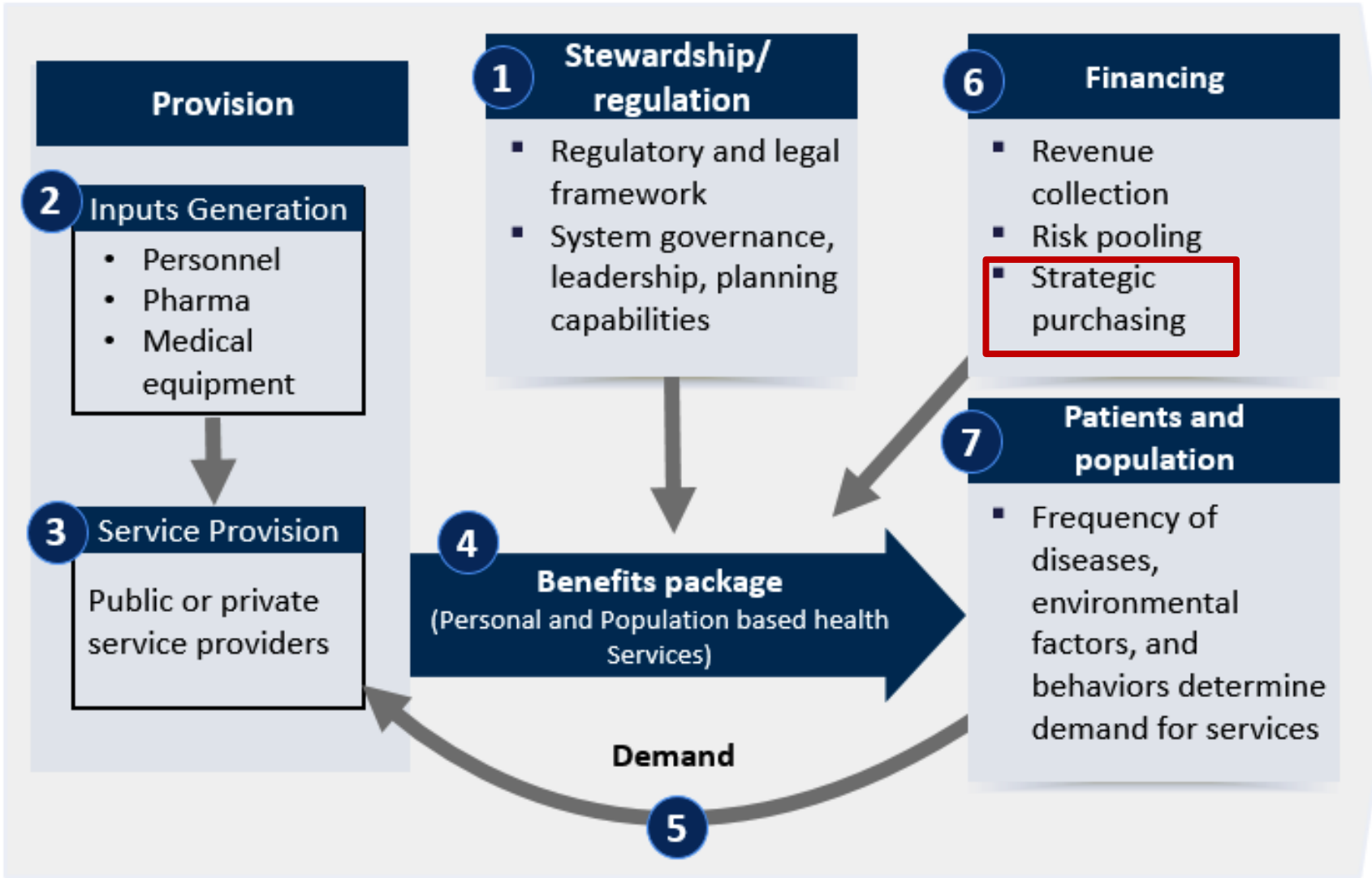
REAL-LIFE SITUATION

Universal Health Coverage



Health Systems Functions and components



Health system objectives

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

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:

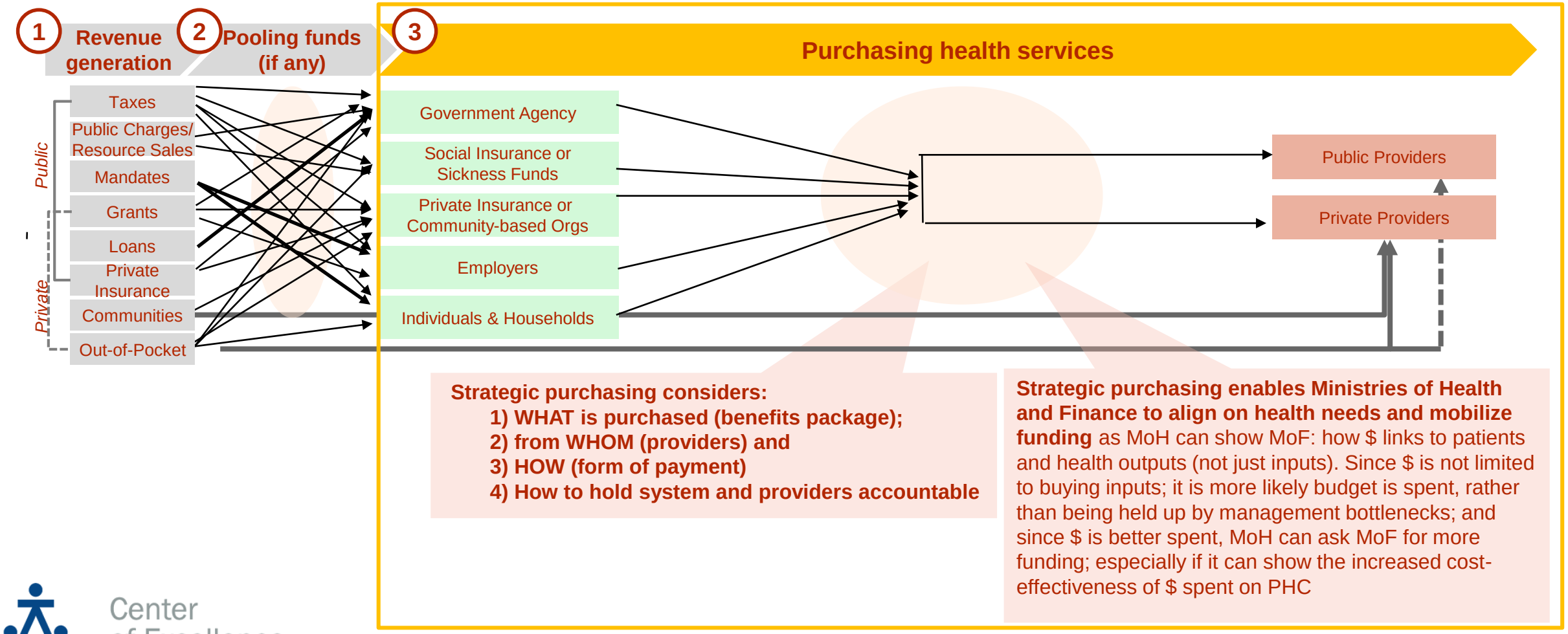
- make purchasing decisions;
- enter into contracts with providers;
- flexibility to allocate funds to pay for outputs and outcomes

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

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

Passive → Strategic

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

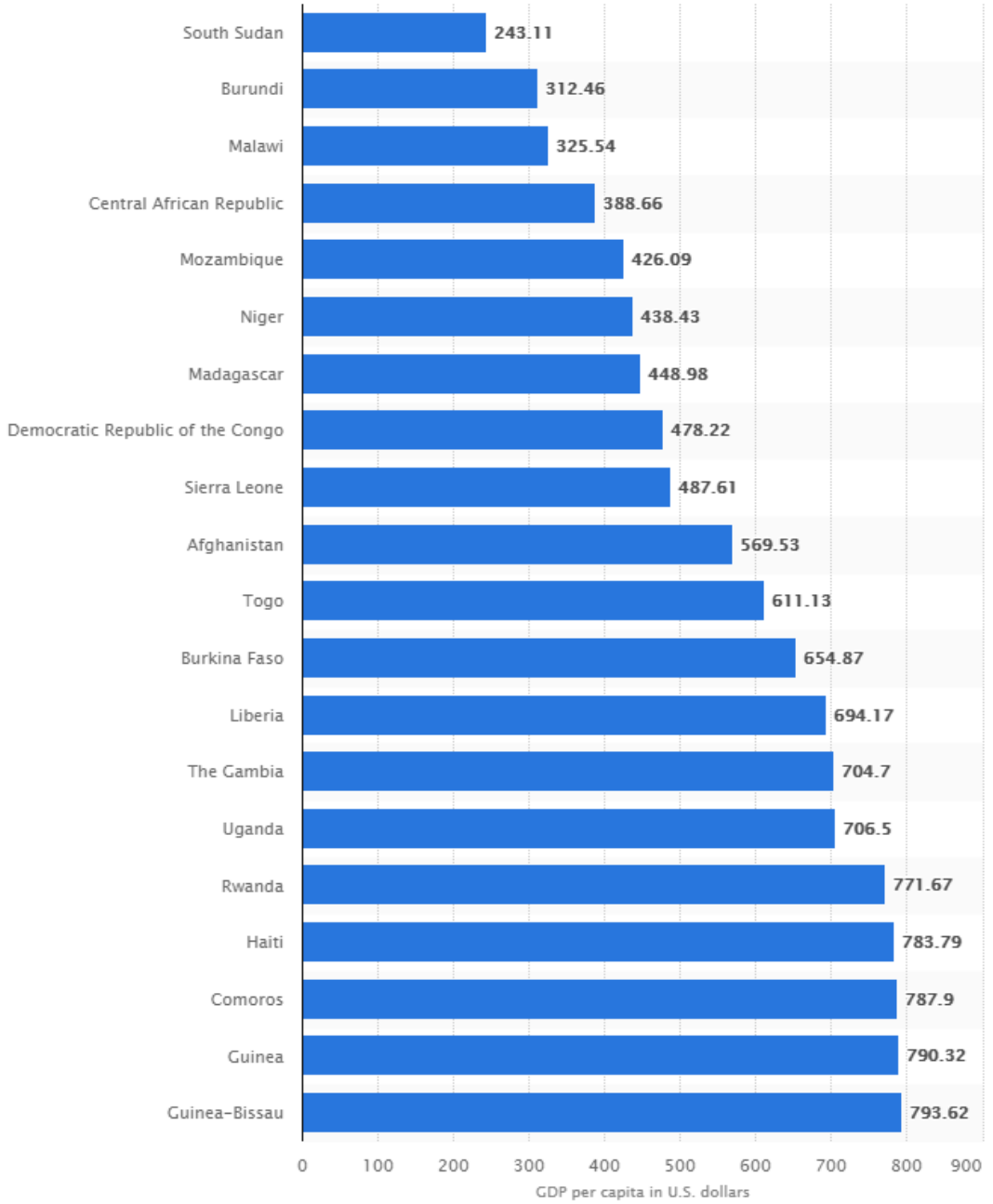
Purchasing Outcomes

Quality	Efficiency	Access

GDP

5% of GDP per capita allocated for health

Country	GDP	GDP Health
South Sudan	243.11	$12.16
Burundi	312.46	$15.62
Malawi	325.54	$16.28
Central African R.	388.66	$19.43
Mozambique	426.09	$21.30



Per capita health expenditure

$1100

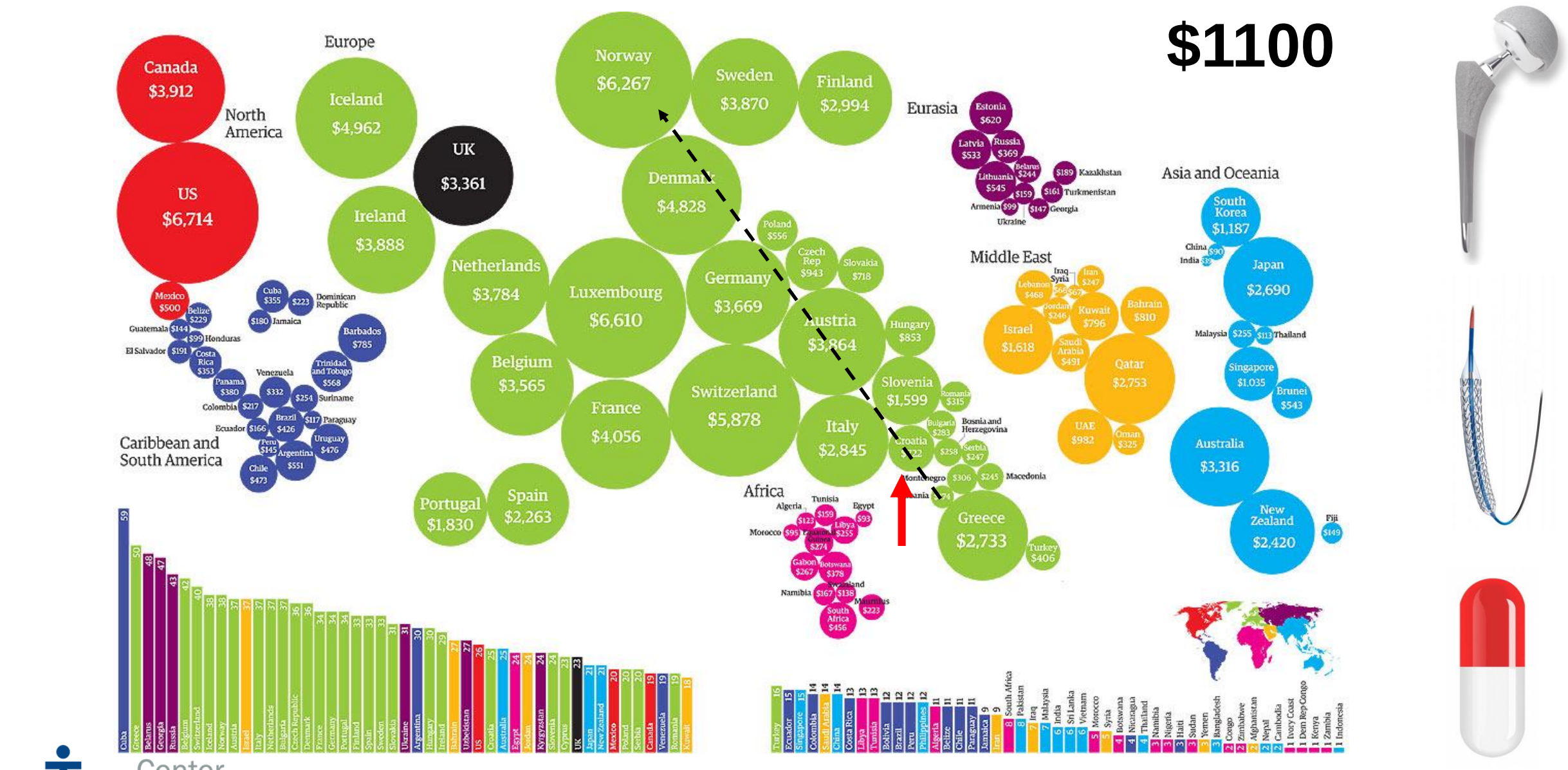
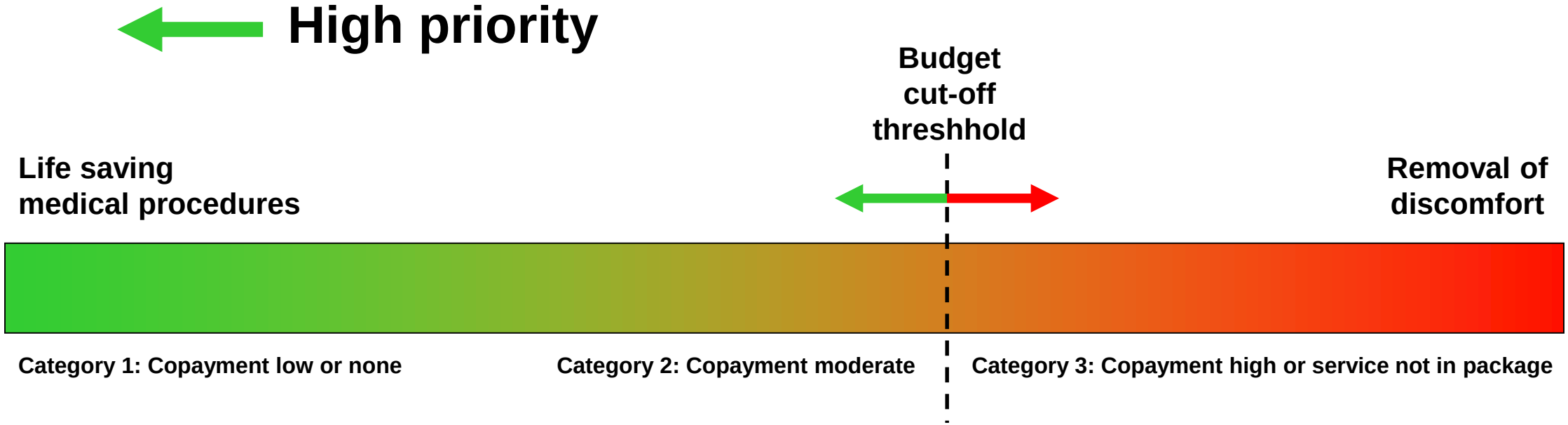


Table 1: Comparison of fiscal context in health expenditure in surrounding countries in the region

Country	GDP per capita, current prices	GDP per capita, purchasing power parity	Total expenditure on health as % of GDP	General government expenditure on health as % of GDP
Albania	$4,583	$11,821	7.1%	3.0%
Bosnia and Herzegovina	$4,540	$11,404	9.6%	6.4%
FYR Macedonia	$5,500	$15,203	6.5%	3.9%
Kosovo	$4,140	$12,003	3.3%	2.5%
Montenegro	$7,071	$17,439	6.4%	4.0%
Serbia	$5,600	$15,164	10.4%	5.4%

Source: International Monetary Fund, World Economic Outlook Database (2017), World Health Organization, Global Health Expenditure Database (2015), Albanian Ministry of Health and Social Protection (2018)

BENEFITS PACKAGE **what to buy**, in **which form**, what's excluded?



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

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

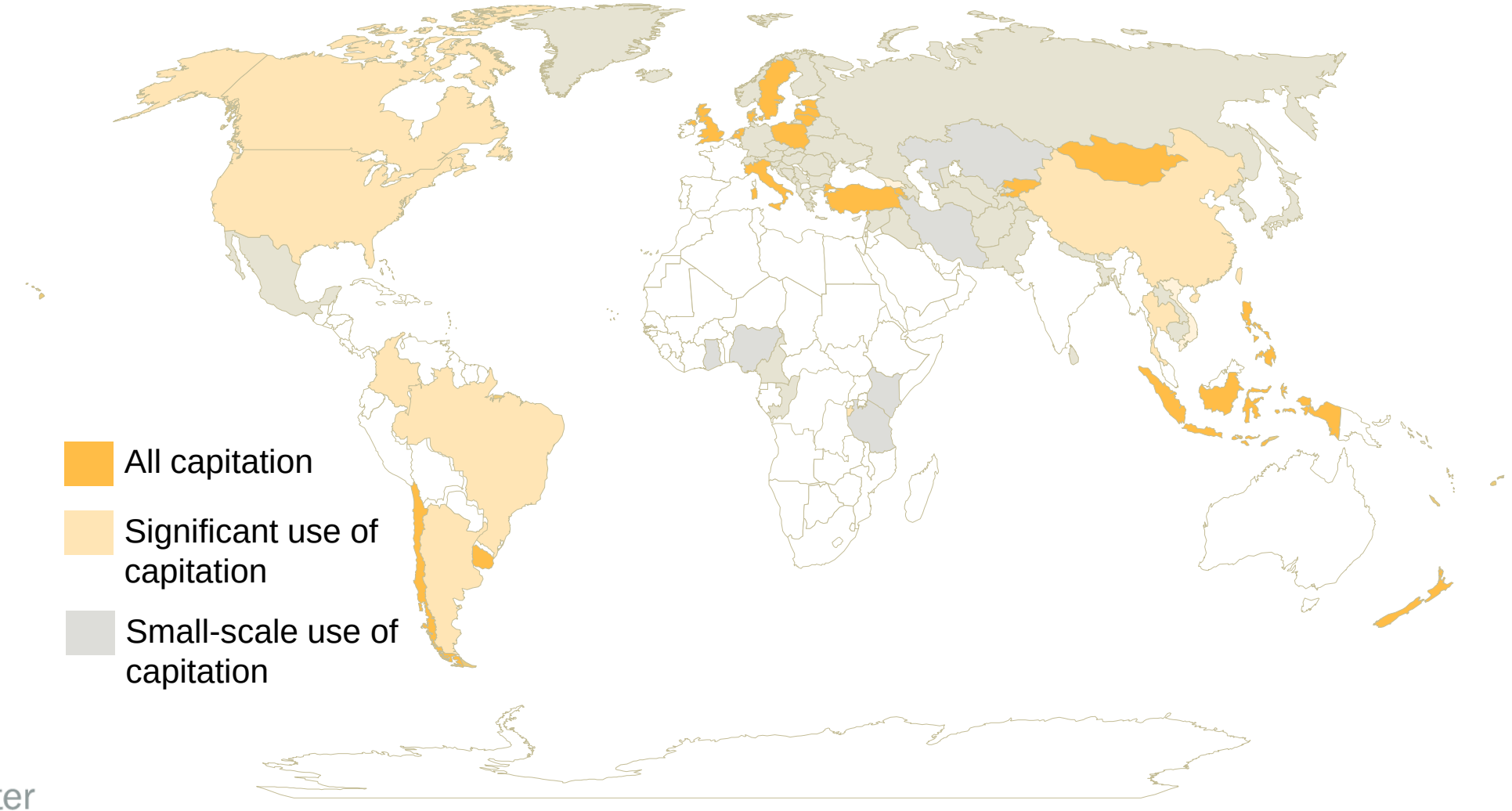
Passive purchasing → ***Increasingly strategic purchasing***

	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

COMMON PAYMENT MODELS

Level of Sophistication	**Global budget**	**Capitation**	**Fee-for-service**	**Case-based** (e.g. DRG)
BASIC	Health provider budget based on simple parameters (e.g. historical budget or projected volume)	Providers are paid one single rate for each enrolled individual. Enrollment is by assignment rather than free choice.	Providers are paid a fixed price per service delivered with or without a cap. Limited number of broad categories of services.	Providers are paid a fixed price per discharge with or without a cap.
INTERMEDIATE	Health provider budget based on simple parameters (e.g. historical budget or projected volume) with department-level case-mix adjustment	Providers are paid one single rate for each enrolled individual adjusted by age and sex. Enrollment is by assignment rather than free choice.	Providers are paid a fixed price per service delivered with or without a cap. Large number of more narrow categories of services.	Providers are paid a fixed price per discharge from each department with or without a cap.
HIGH	Health provider budget based on simple parameters (e.g. historical budget or projected volume) with patient-level case-mix adjustment	Providers are paid one single rate for each enrolled individual adjusted by age and sex; geography; chronic disease status. Enrollment is by free choice.	Providers are paid a fixed price per service delivered based on a relative value scale, with or without a cap.	Providers are paid a fixed price per discharge in each diagnosis category with or without a cap. Additional requirements may include adjustments for health facility type and outlier payments.

Capitation is Widely Used in OECD and LMICs



Source: Cashin 2017

NO ONE MODEL PERFECT…SO…

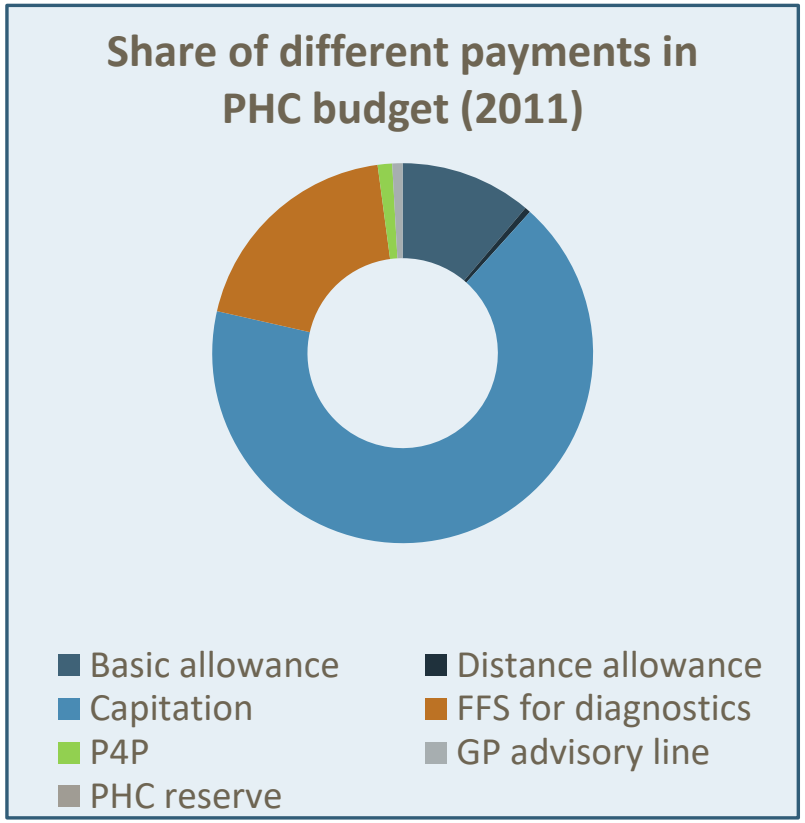
WORLD MOVING TO BLENDED PAYMENT MODELS: EXAMPLE FROM ESTONIA (similar in Croatia also)

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



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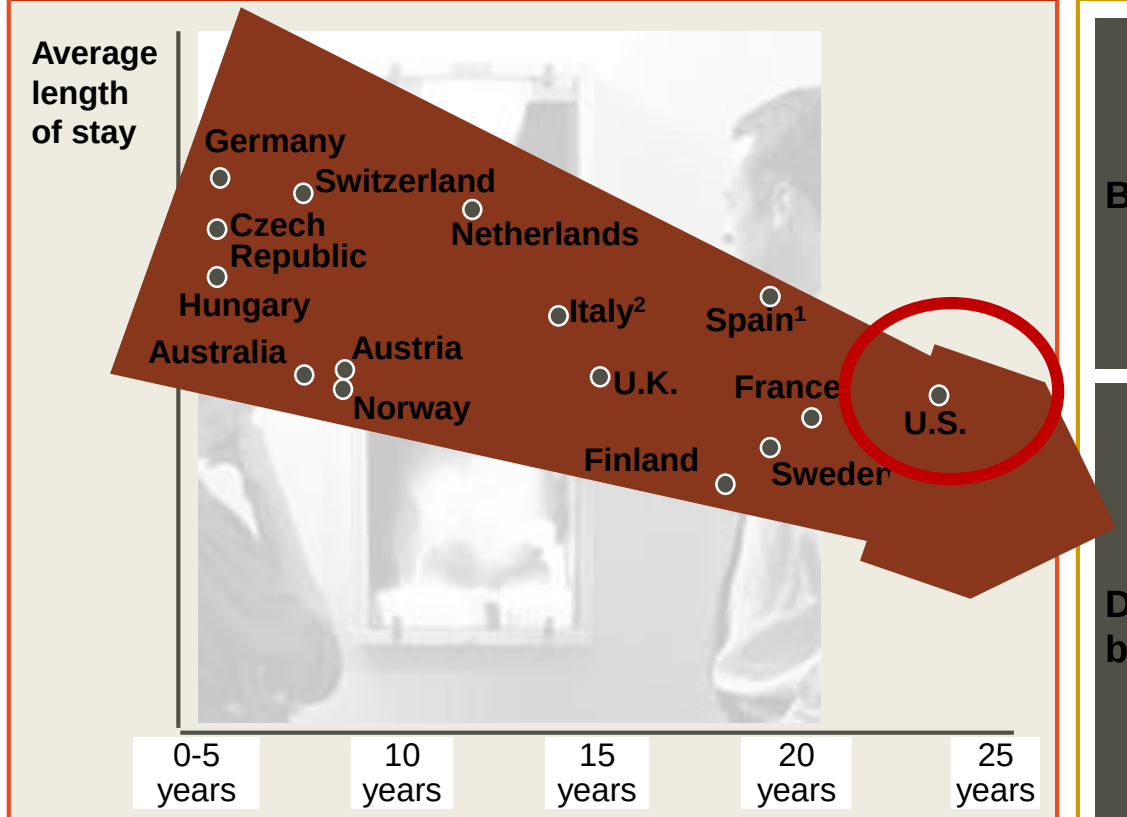
Diagnosis-Related-Groups (DRGs) is the payment mechanism towards which most develop systems are converging, having also positive implications in terms of efficiency

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

SOURCE: OECD report, 2002

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

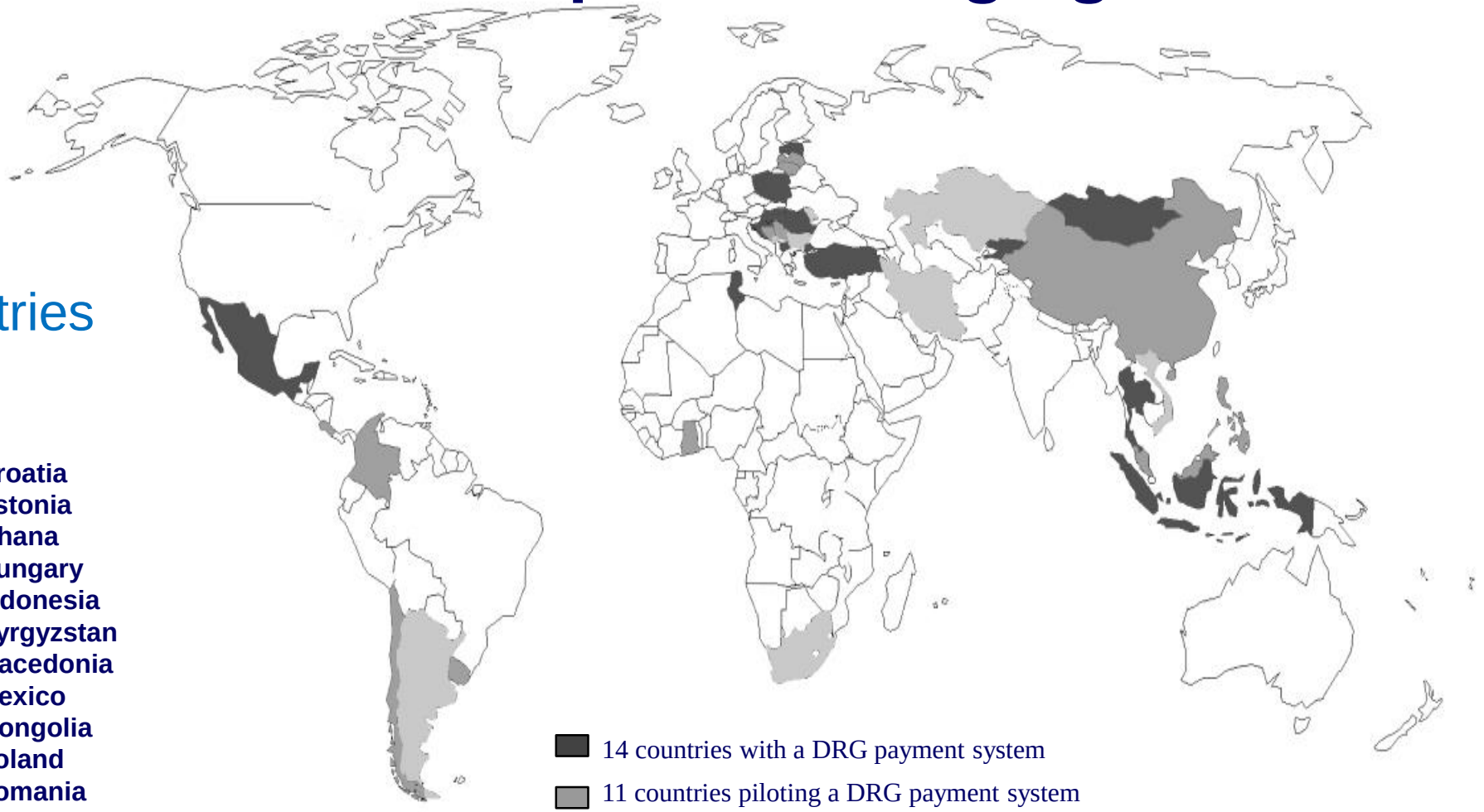
Draw-backs

- 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)

“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



WHO, 2014

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	

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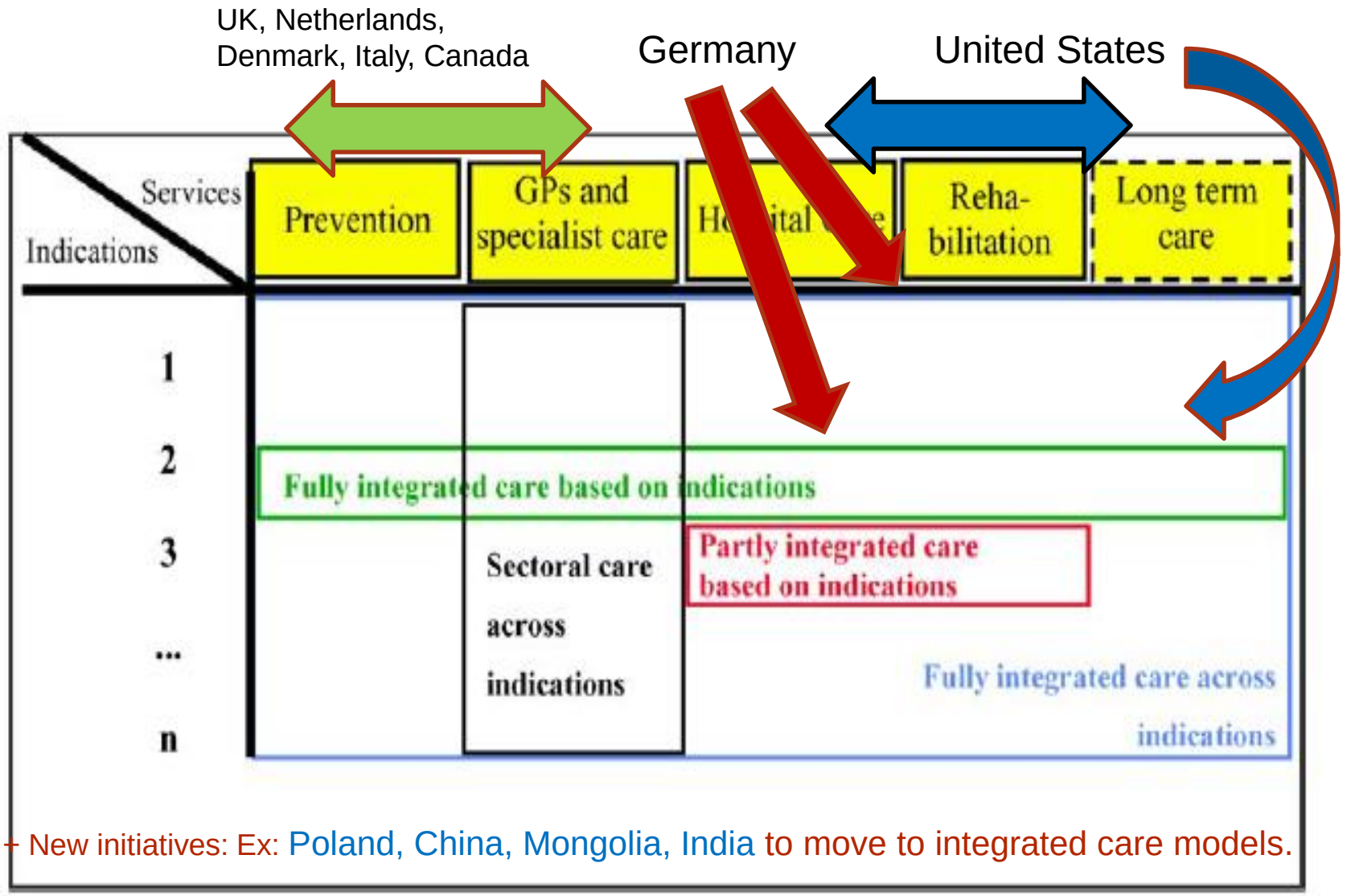
THE FRONTIER: Bundling Payments ACROSS Levels of Care



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

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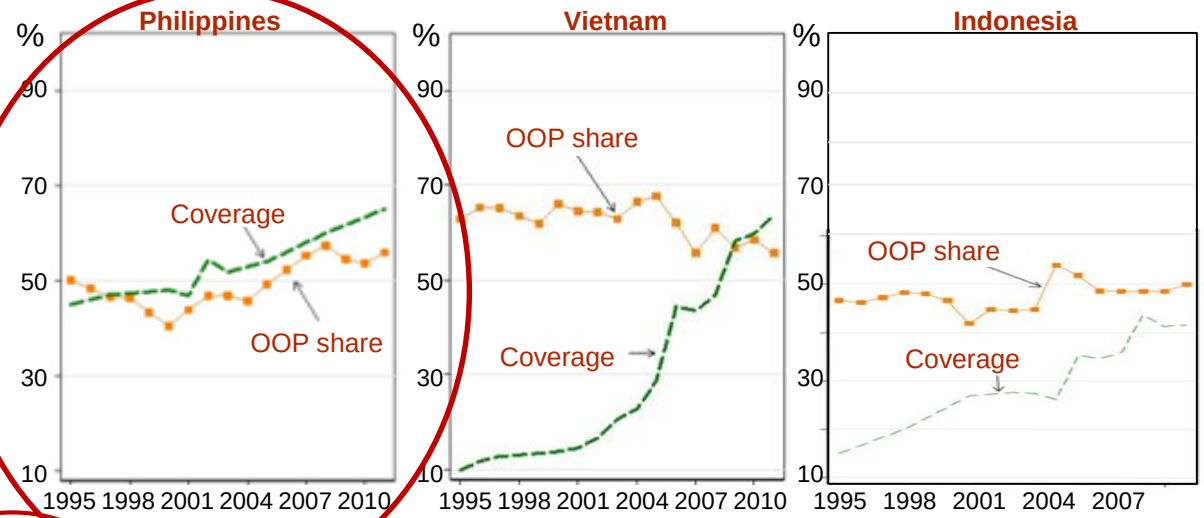
MANY COUNTRIES EXHIBIT UNSTRATEGIC PURCHASING

COVERAGE WITHOUT FINANCIAL PROTECTION

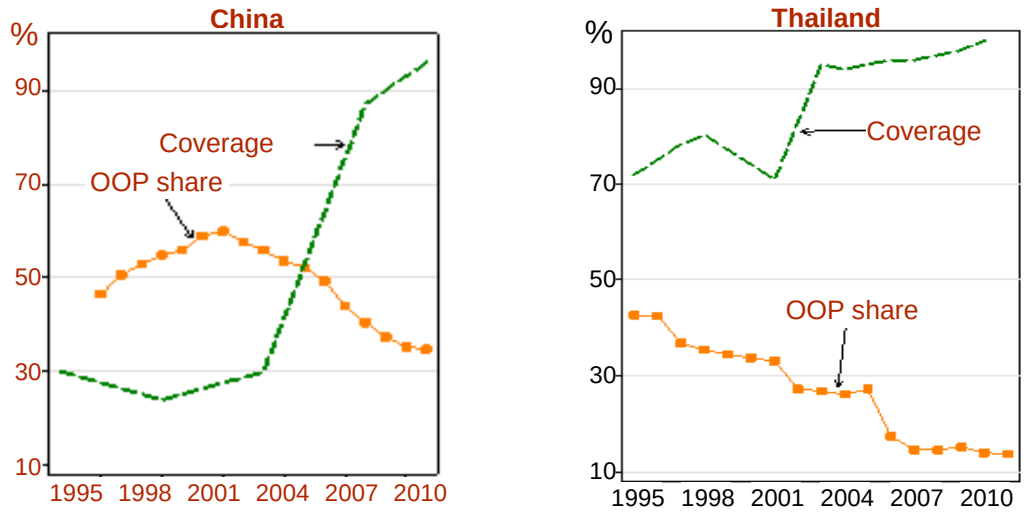
Philippines, Vietnam and Indonesia have all seen increases in population coverage but no decrease in OOP payments

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

Thailand has had greater success



14.7%



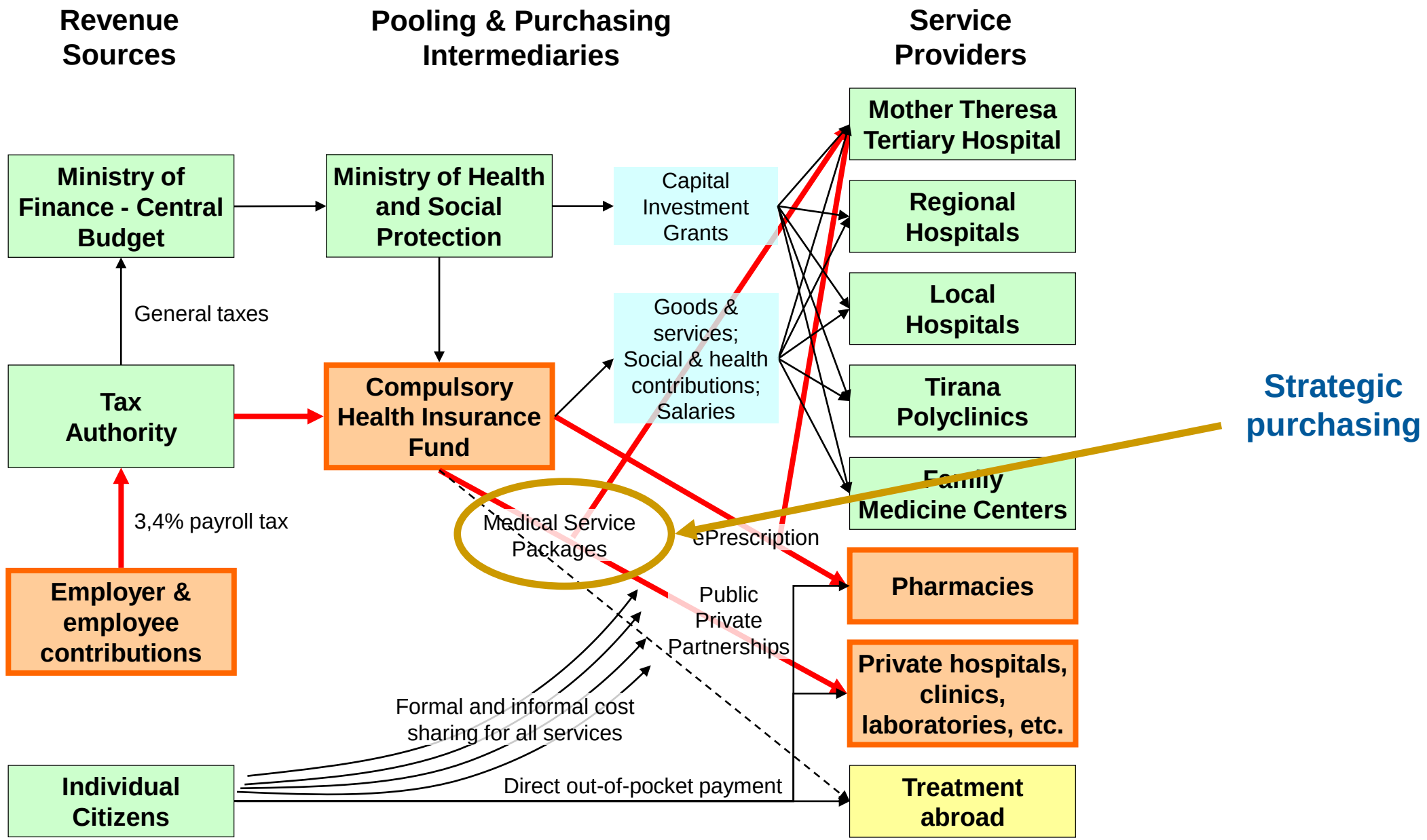
- No change in % households facing catastrophic expenses (12% in 2003, 13% in 2011)
- No change in % spent on health out of total household spending (11% in 2003, 13% in 2011).

es Foundation

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.

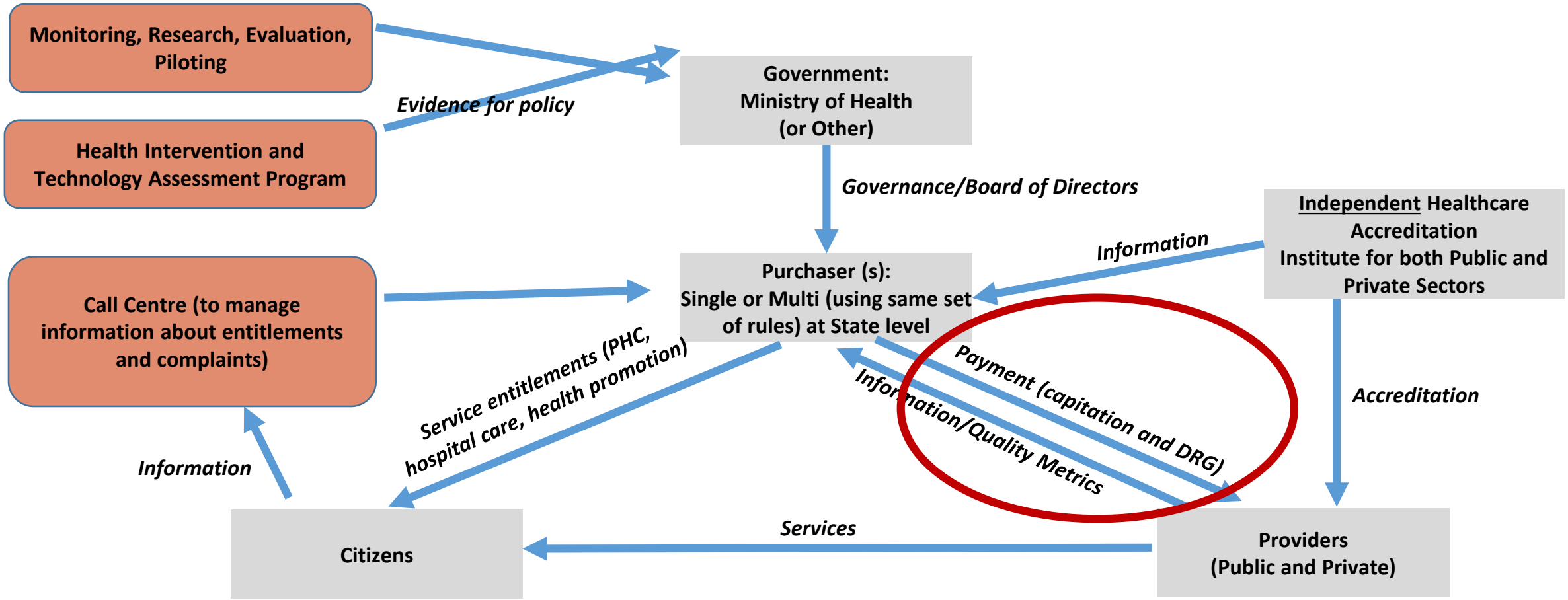
Source: WHO country reports; SUSENAS; WHO China Health Services Report; Tandon, iHEA 2015


Revenue Sources
Pooling & Purchasing Intermediaries
Service Providers
Ministry of Finance - Central Budget
Ministry of Health and Social Protection
Capital Investment Grants
Mother Theresa Tertiary Hospital
Regional Hospitals
Local Hospitals
Tirana Polyclinics
Family Medicine Centers
General taxes
Goods & services; Social & health contributions; Salaries
Tax Authority
Compulsory Health Insurance Fund
Strategic purchasing
3,4% payroll tax
Medical Service Packages
ePrescription
Pharmacies
Public Private Partnerships
Private hospitals, clinics, laboratories, etc.
Employer & employee contributions
Formal and informal cost sharing for all services
Direct out-of-pocket payment
Individual Citizens
Treatment abroad

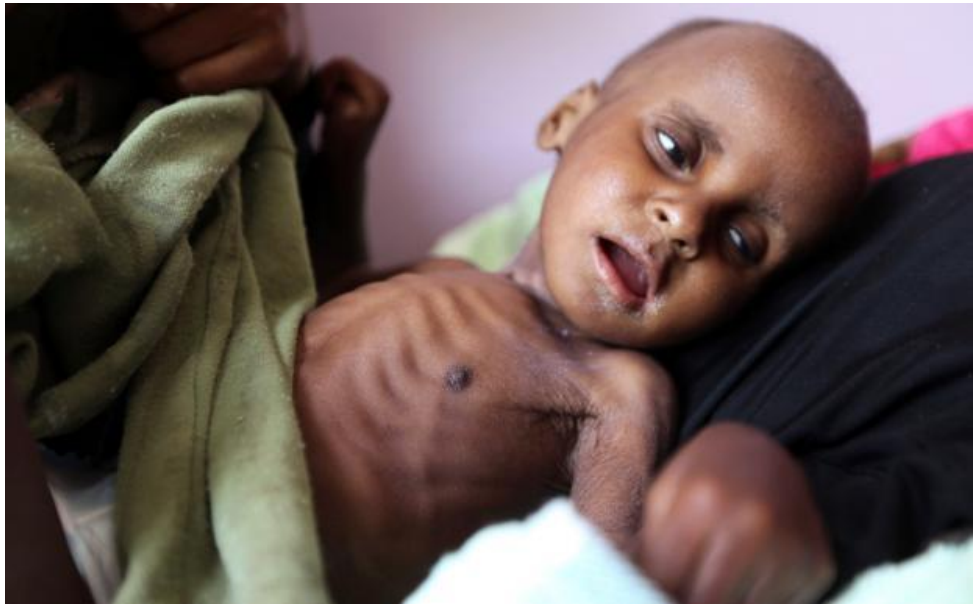
THE ROAD AHEAD: WHAT DOES "GOOD" LOOK LIKE?

FUNCTIONS MUST FORM COHERENT TASK NETWORKS ACROSS ACTORS AND INSTITUTIONS

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

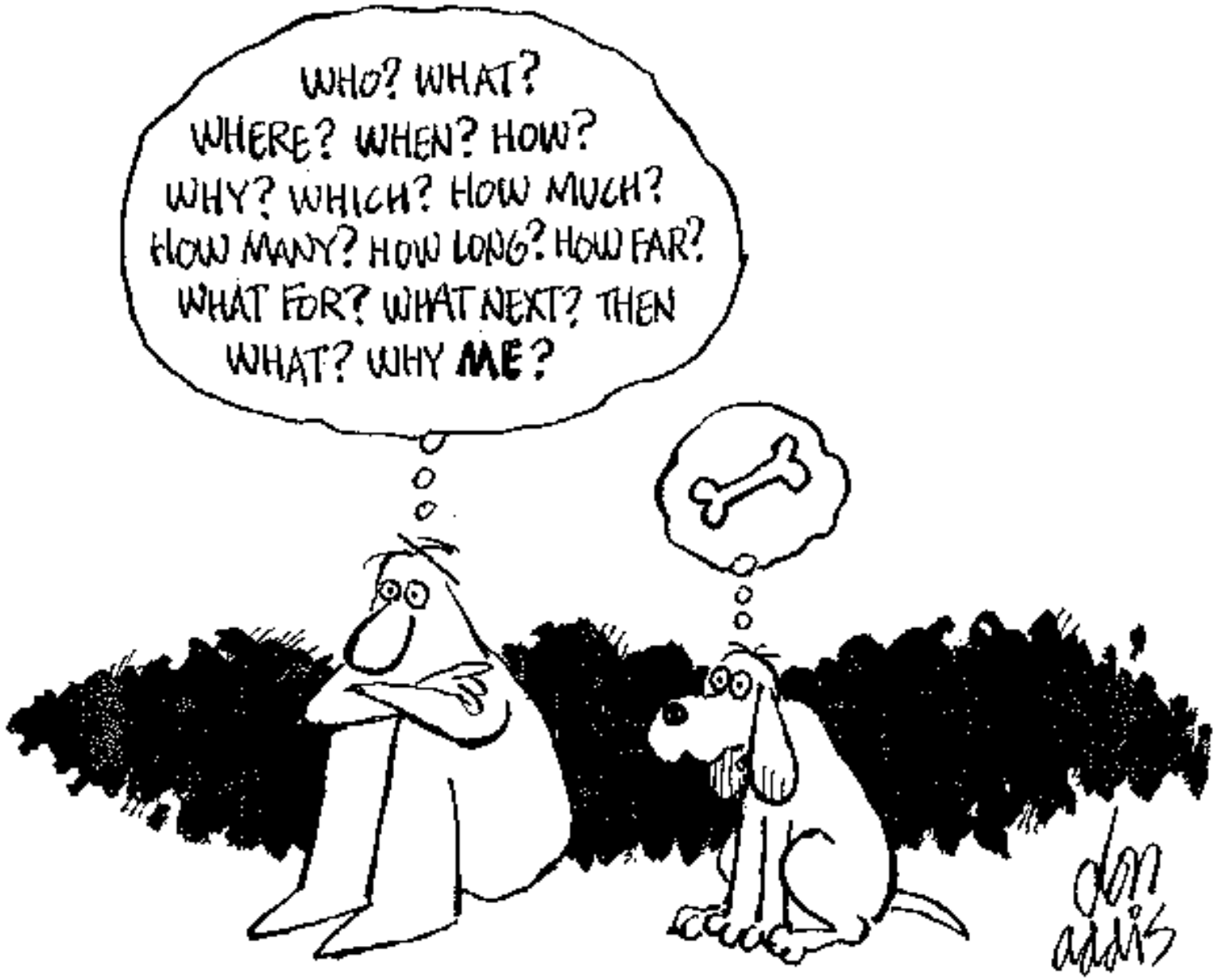


Source: K. Hanson, 2017



Under-funded health system

Internal and external inefficiencies


WHO? WHAT?
WHERE? WHEN? HOW?
WHY? WHICH? HOW MUCH?
HOW MANY? HOW LONG? HOW FAR?
WHAT FOR? WHAT NEXT? THEN
WHAT? WHY ME?
don addis

Thank you for your attention!