

# Purchasing models – the European experience

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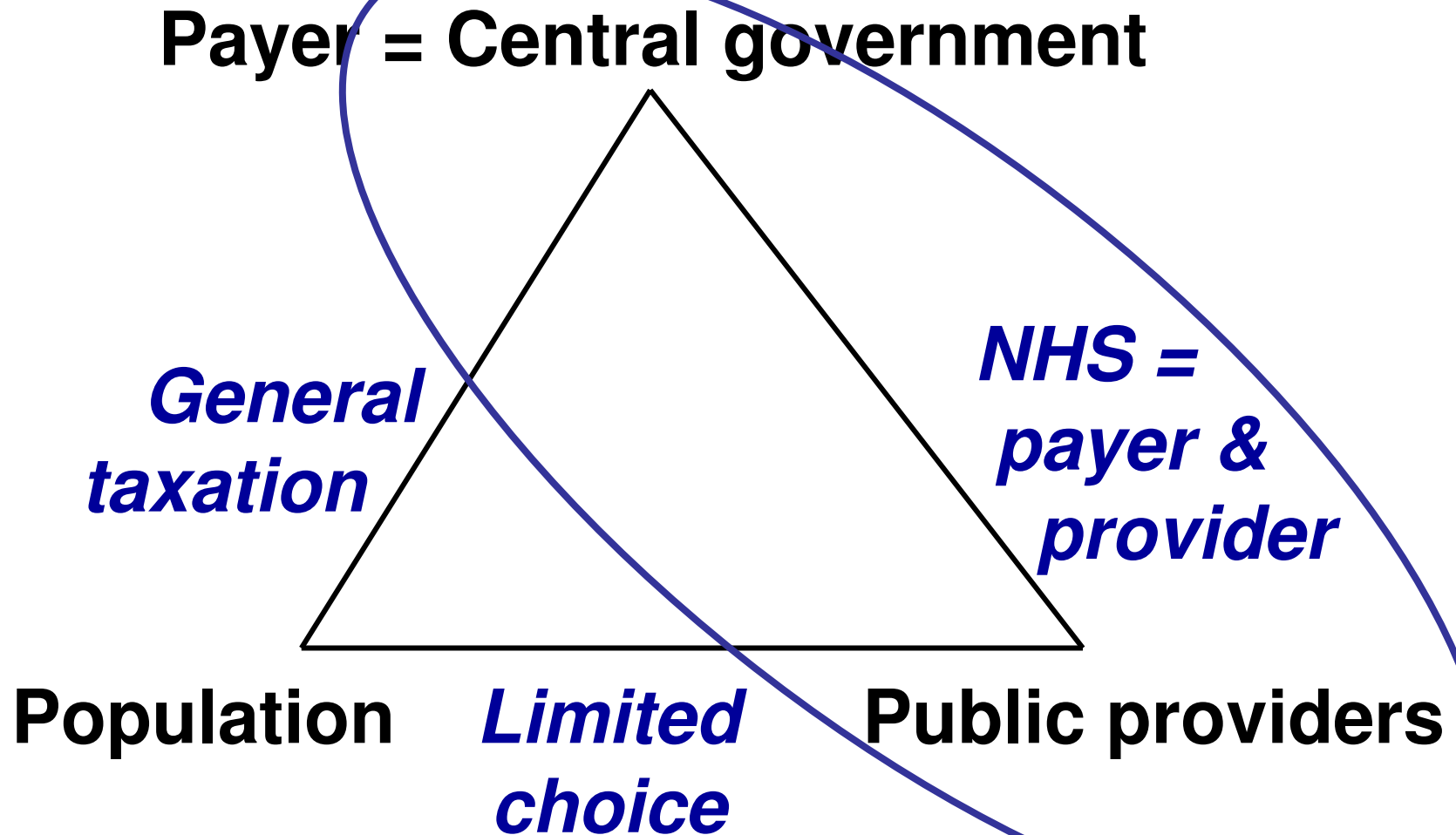
**Payer**

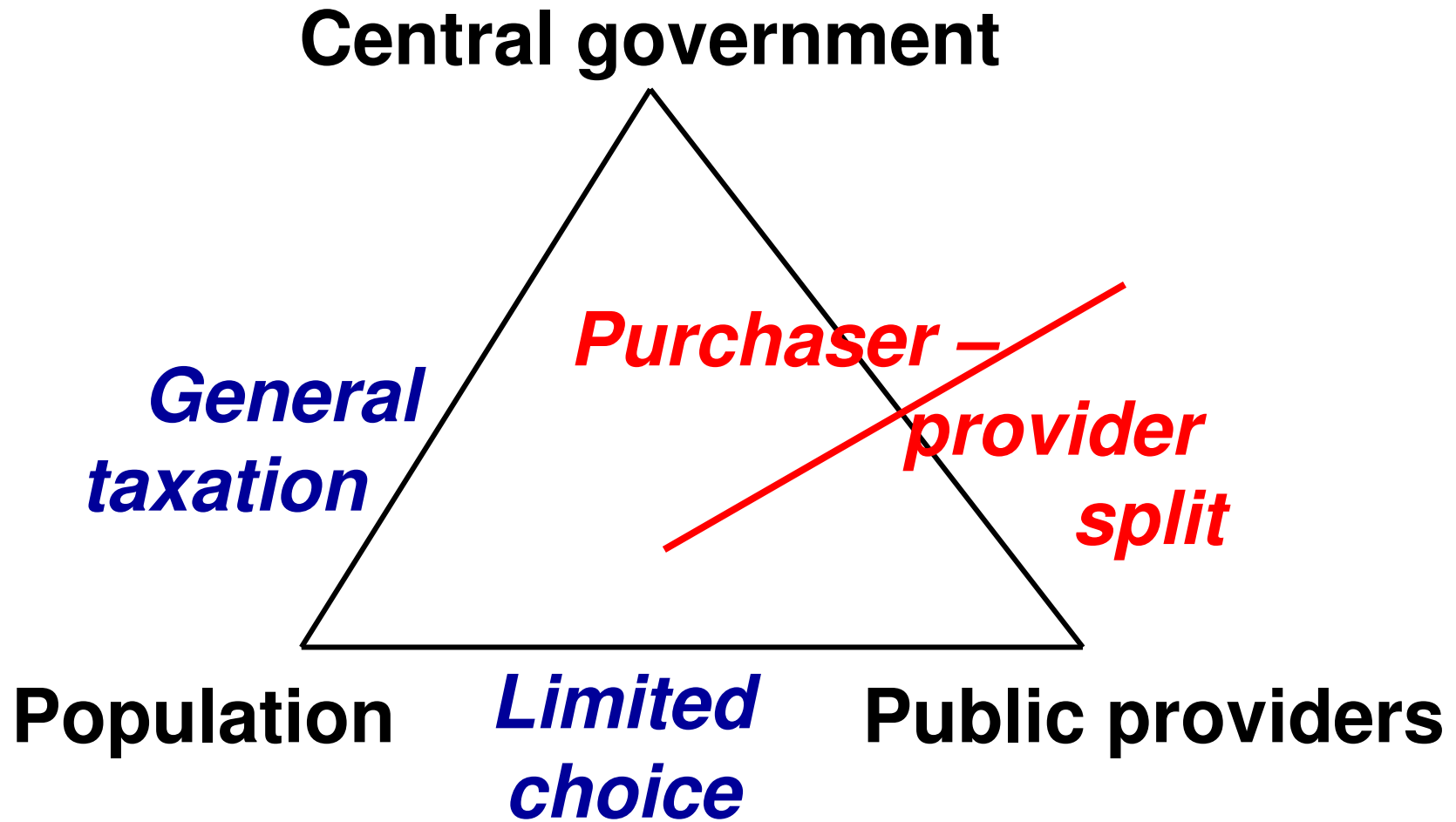
**The creation of purchasers  
in European NHS-type systems  
(UK, Italy, Spain, Sweden ...)**

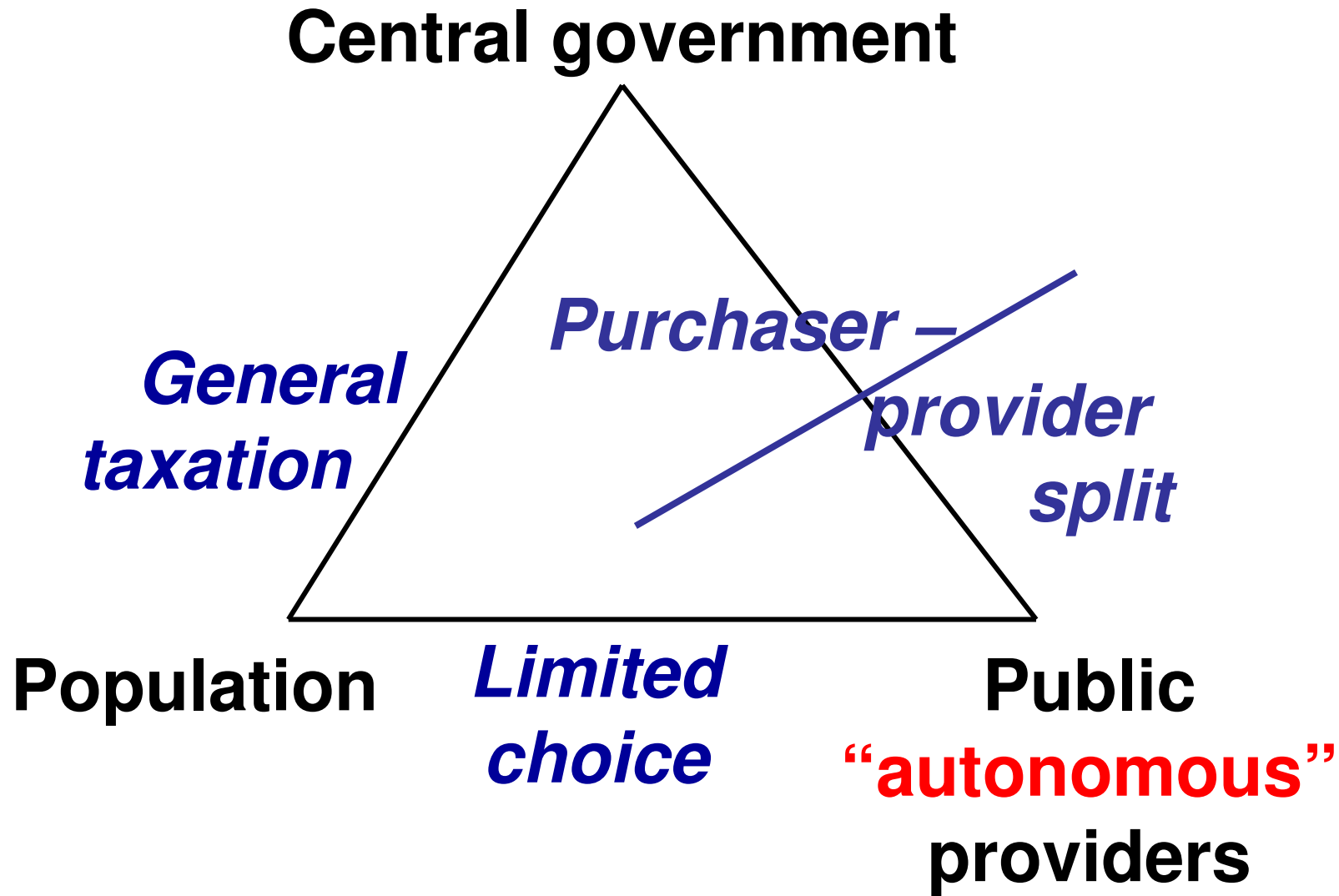
**Population**

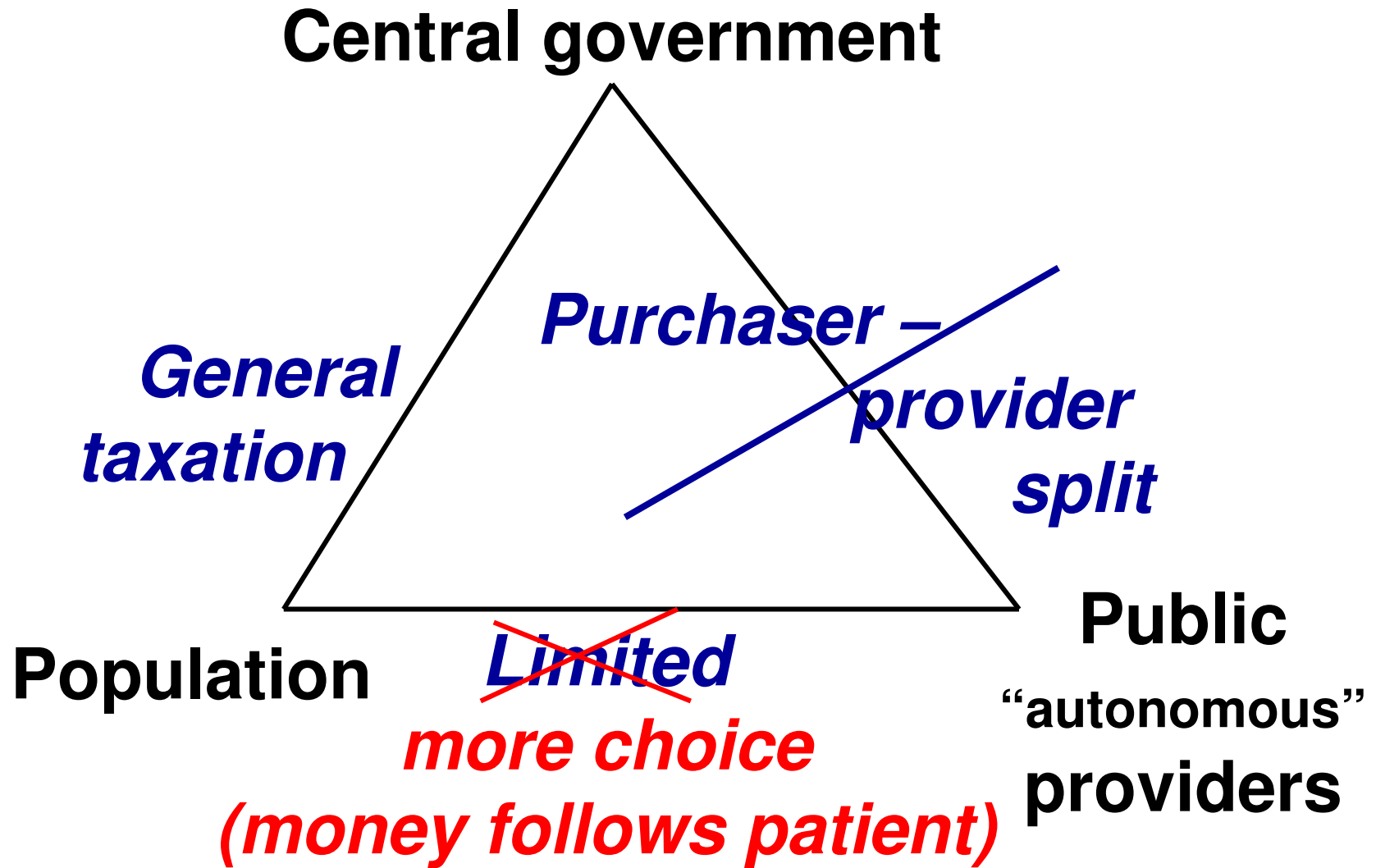
**Providers**

# Classical integrated NHS-type system

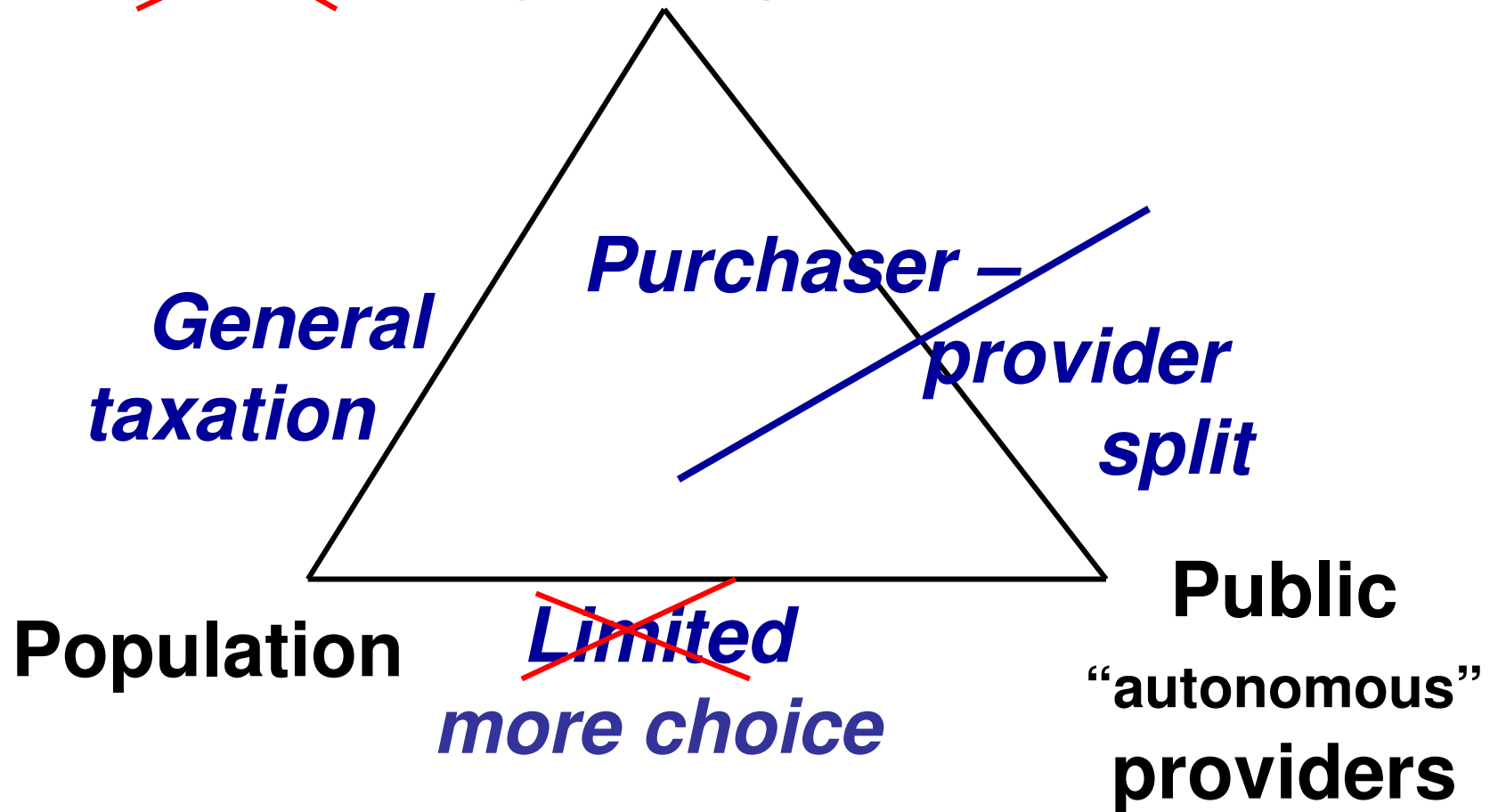




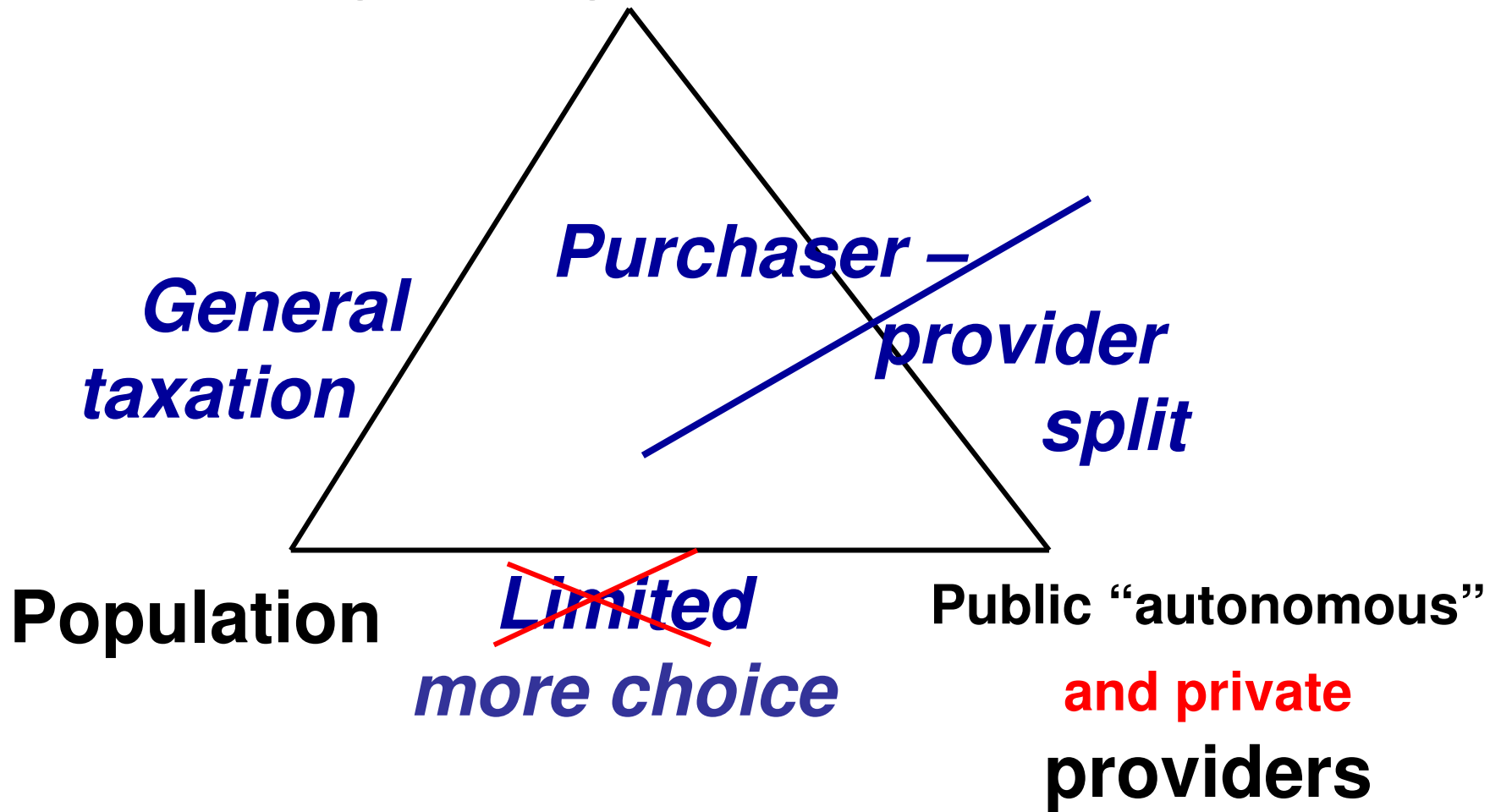




~~Central~~ **Regional** governments

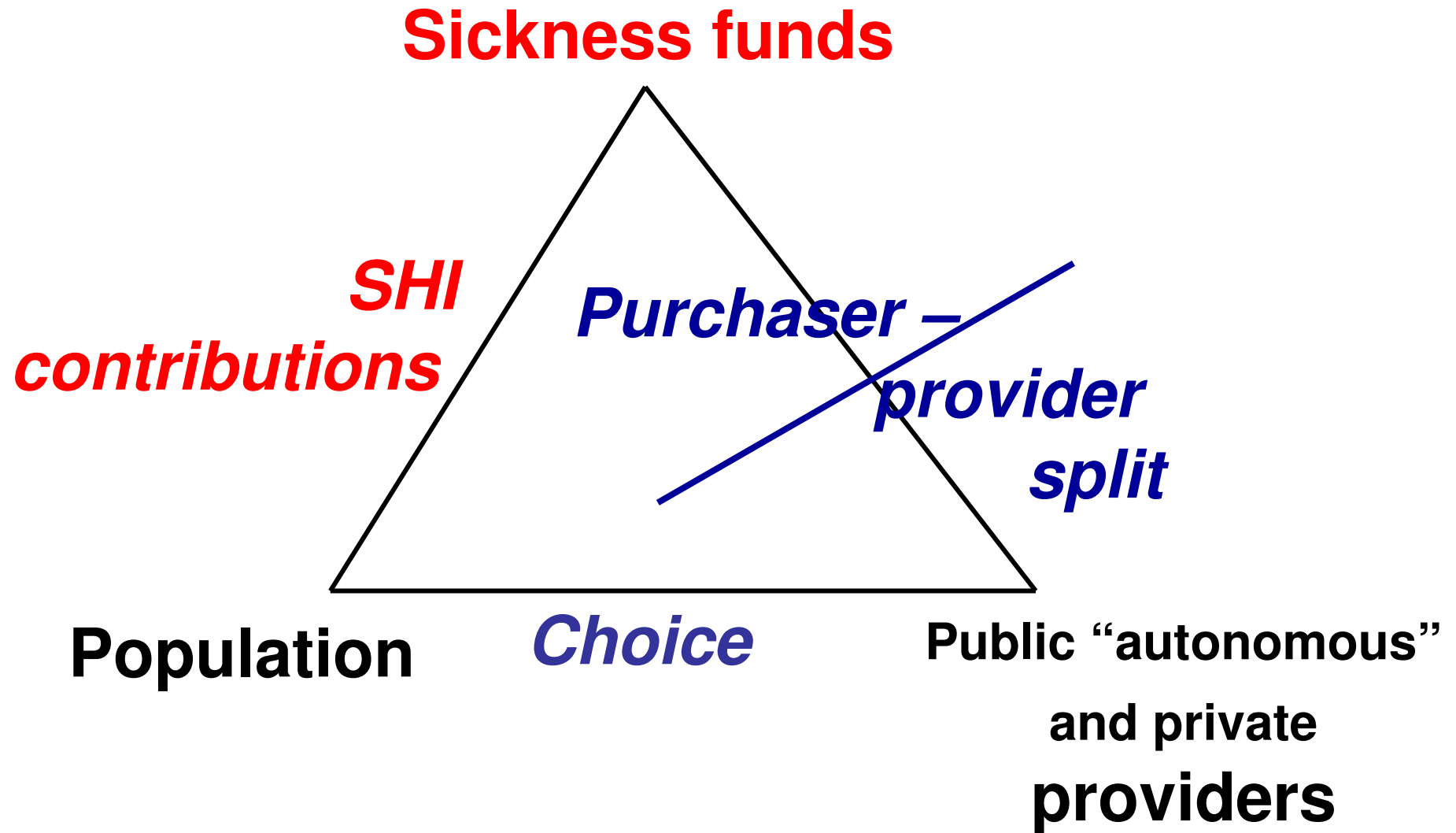


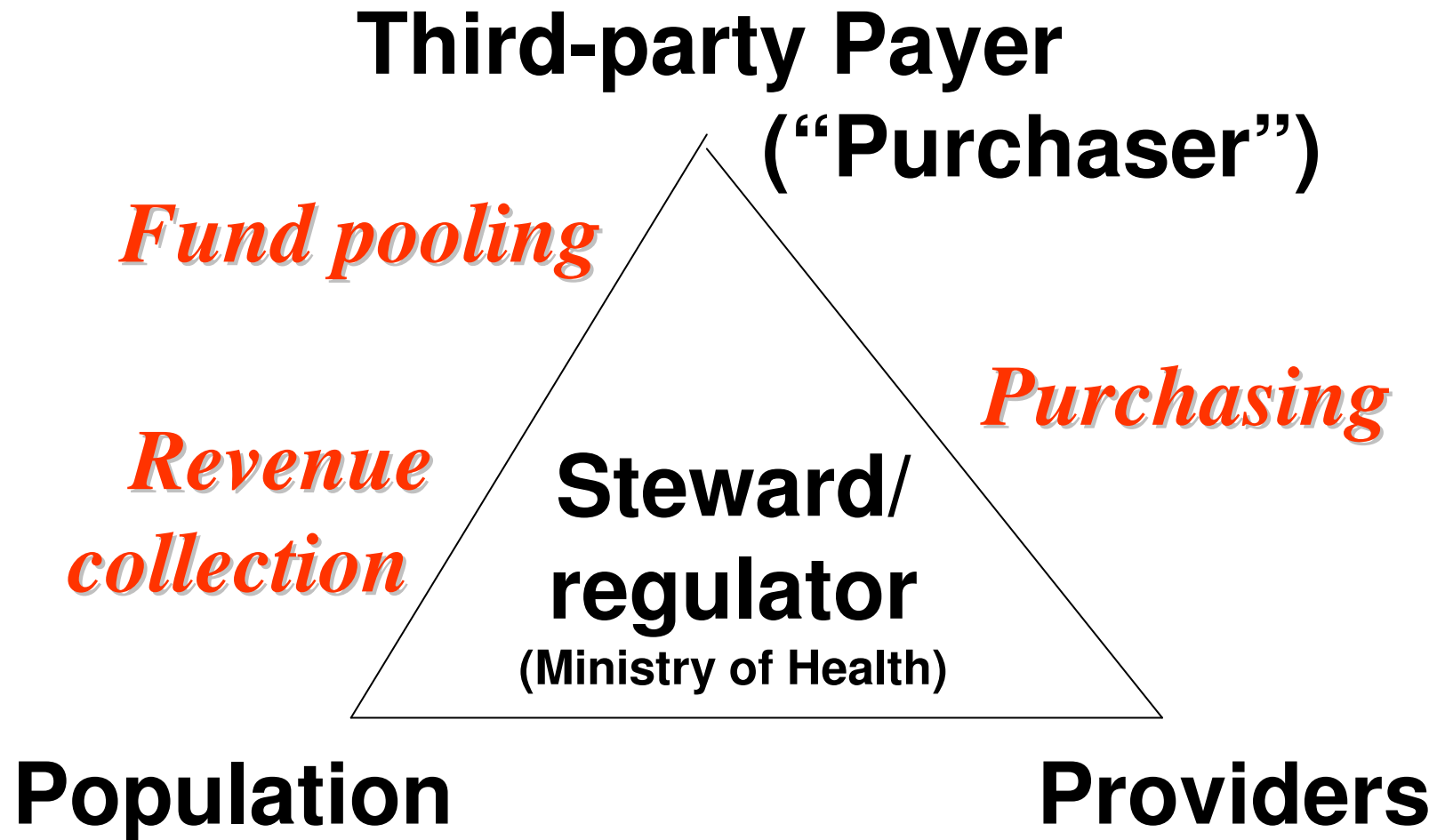
# Regional governments





# Social Health Insurance (SHI) systems





# ***But what is purchasing?***

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- Diversity in understanding and definitions: resource allocation to service providers, payment, contracting, commissioning,...
- *Purchasing is the process by which pooled funds are paid to providers in order to deliver a specified or unspecified set of health interventions (WHR2000)*

# *In theory ... it ought to work!*

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- **From passive to active (strategic) purchasing?**
  - Who should buy?
  - For whom?
  - What and how much?
  - From whom?
  - How to buy?
  - .
  - .

Strategic purchasing =  
“proactive decisions ...  
about which services  
should be purchased,  
how and from whom”  
(WHO 2000)

# Strategic purchasing involves:

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- **Purchasing entities** allocating money to health care **providers**, on behalf of **patients** for the exchange of health services.
- A set of **relationships** (e.g. purchaser – provider; government – purchaser; purchaser – patient)
- A set of **mechanisms** (or “tools”) to achieve certain objectives in the purchasing process:
  - Contracting
  - Incentives
  - Health Needs Assessments
  - ...

# ***In theory ... it ought to work!***

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- From passive to active (strategic) purchasing?
- **Central function for improving performance**
  - **Links resource allocation to plans/priorities**
  - **Levers to influence provider behavior**
  - **Encourages management decentralization**
  - **Enables purchaser and provider competition**

# Learning from European experience: How do we improve purchasing?

1. Incorporate population health needs
2. Empower the citizen
3. Strengthen government stewardship
4. Develop appropriate purchaser organization(s)
5. Ensure cost effective contracting
6. Establish appropriate provider organizations

# 1. Incorporate population health needs

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- Lack of evidence on health needs
- If existing, not incorporated into purchasing decisions
- **Ensure structural or functional integration of public health into purchasing**
  - Public health skills in purchaser organizations?
  - Particularly problematic in SHI countries (with few exceptions, e.g. France, Netherlands)



## 2. Empower the citizen

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- **Ascertaining the views of citizens -**  
***Voice***
  - **Consultation of public views**
  - **Advocacy groups**

## 2. Empower the citizen

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- Ascertaining the views of citizens - *Voice*
- **Enforcing purchasers accountability**
  - ***Voice***
    - **Defined benefit package/ entitlements**
    - **Formal representation in purchasing boards**
    - **Patients rights legislation / charters**
    - **Ombudsperson**

## 2. Empower the citizen

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- Ascertaining the views of citizens - *Voice*
- Enforcing purchasers accountability – *Voice*
- **Enabling choice of purchaser and/or provider - *Exit***

	<b>Estonia</b>	<b>France</b>	<b>Kyrgyzstan</b>	<b>Lithuania</b>	<b>Russian Federation</b>	<b>The Netherlands</b>	<b>United Kingdom</b>
<b>Choice of purchaser</b>	No	No	No	No	Yes	Yes	No
<b>Formal representation</b>	Elected representatives	No	No	Elected representatives	No	Elected representatives	Appointed representatives
<b>Claims in courts</b>	No	Yes	No	Yes	Yes	Yes	No

## 2. Empower the citizen

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*"On an individual level, the patients rights developments have resulted in effective tools for influencing purchaser decision making particularly when legally codified. However, those developments may incur increased costs, threatening social solidarity and financial stability; but they are a consequence of a democratic evolutionary process in many health systems and cannot be ignored."* **den Exter**

# 3. Strengthen government stewardship

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- Formulating national health policy / plan
- Linking health targets into purchasing decisions
- Establishing an integrated regulatory framework:  
Rules for collective contracting, quality standards, payment requirements, price regulations, negotiation and litigation rules, open information, monitoring and evaluation, accreditation of providers ...

# 3. Strengthen government stewardship

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- **Low capacity and credibility**
  - Information and technical skills
  - Conflict between public guarantees and funding
  - Cultural change from ***command and control***
- **Unclear organizational roles**
  - Accountability lines between insurance fund / purchaser and the Ministry of Health

### 3. Strengthen government stewardship

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*If some governments have been unable to row, how will they be able to steer?*

*Or: if governments do not have the ability to provide services themselves, it is unclear why should they be able to exercise stewardship!*



# 4. Develop appropriate purchaser organization(s)

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- What is the right purchaser?
  - Region, e.g. Italy, Spain, Sweden ...
  - Municipalities, e.g. Finland ...
  - Sickness funds, e.g. Germany, France, Netherlands, Hungary ...
  - Primary care budgets, e.g. UK, Catalonia ...

## 4. Develop appropriate purchaser organization(s)

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- What is the right type of purchaser?
- What is the right size of purchaser for population coverage?
- Meso or micro purchasing?

**Single or multiple competing purchasers?**

	<b>Czech Republic</b>	<b>Estonia</b>	<b>Germany</b>	<b>Hungary</b>	<b>Italy</b>
<b>Main purchasers</b> <b>•Number</b>  <b>• Average population size</b>	9 health insurance funds  Largest fund: 7.2 million. Others: 100,000 to 800,000	1 health insurance fund  1,230,390 (93% of population)	>200 sickness funds  Ca. 350,000 (variable from 1000 to >6 million)	1 health insurance fund  10 million	197 local health units or regional governments  300,000
<b>Organizational groupings</b>	Originally occupational	Geographic	Originally occupational/ geographical/ "substitute"	Geographic	Geographic
<b>Competition</b> <b>• Choice of purchaser</b>  <b>• Premiums/ contribution rates</b>  <b>• Statutory benefits</b>  <b>• Complementary benefits</b>	Yes  Fixed contribution rate  Uniform  No	No  Fixed contribution rate  Uniform  Yes	Yes  Variable contribution rate  Uniform  Yes	No  Fixed contribution rate  Uniform  No	No  Fixed capitation rate  Uniform  No

# 5. Ensure cost effective contracting

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- **Linking contracting with planning**
  - **Planning:** assessing needs, health policy strategy, establishing priorities, service models
  - **Purchasing strategy:** service requirements, budget constraints and performance targets
  - **Contracting cycle:** identifying and selecting providers, negotiating and agreeing a contract, managing and monitoring the contract

# 5. Ensure cost effective contracting

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- **Promoting and ensuring quality**

- *Which services? (“Doing the right thing”): Health Technology Assessment*
- *Who may provide?: accreditation, certification*
- *minimum volume numbers (e.g. Germany)*
- *How? (“Doing the thing right”): guidelines, protocols, standards of care*
- *necessary documentation*
- *quality targets/ benchmarking (process)*
- *Results?: quality targets/ benchmarking (outcome)*

# 5. Ensure cost effective contracting

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- **Paying for performance**

- Step 1: from input-based monetary allocation to (block) contracts
- Step 2: from block contracts to activity-related cost and volume contracts
  - ▶ increased specification of product (e.g. DRGs)
- Step 3: make quality/ outcome data collection and reporting mandatory
- Step 4: from activity-related to outcome-based (initially only as bonus?)

# 5. Ensure cost effective contracting

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- Linking contracting with planning
- Promoting and ensuring quality
- Paying for performance

**With or without provider competition?  
Selective contracting**

# Selective contracting

## *Some Paradoxes*

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- Only works if linked to the planning process
- Goes against need for integration / coordination
  - Ageing and chronic diseases
  - Disease management programmes
- Choice of consumer vs choice of purchaser
  - Consumer resistance
- Scarce implementation capacity
- Low leverage of most purchasers: political barriers



# 6. Establish appropriate provider organizations

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***Ultimately the impact of purchasers on health systems performance will be determined by the way and the extent to which providers respond to purchasers incentives***

- Increasing provider autonomy (self governing)
- Provider ability/capacity to respond to incentives
- Lines of accountability
- Accepting a new power balance

# *Feasibility, capacity and credibility*

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- Public interest against public choice theories
- Inappropriate information systems
- Poor technical, management and administrative skills
- Political obstacles
  - Low leverage of most purchasers
  - Violation of governments own obligations weakens control
  - Weaknesses to enforce statutes and legislation
  - Divergence in policies between different government bodies

# ***Feasibility, capacity and credibility***

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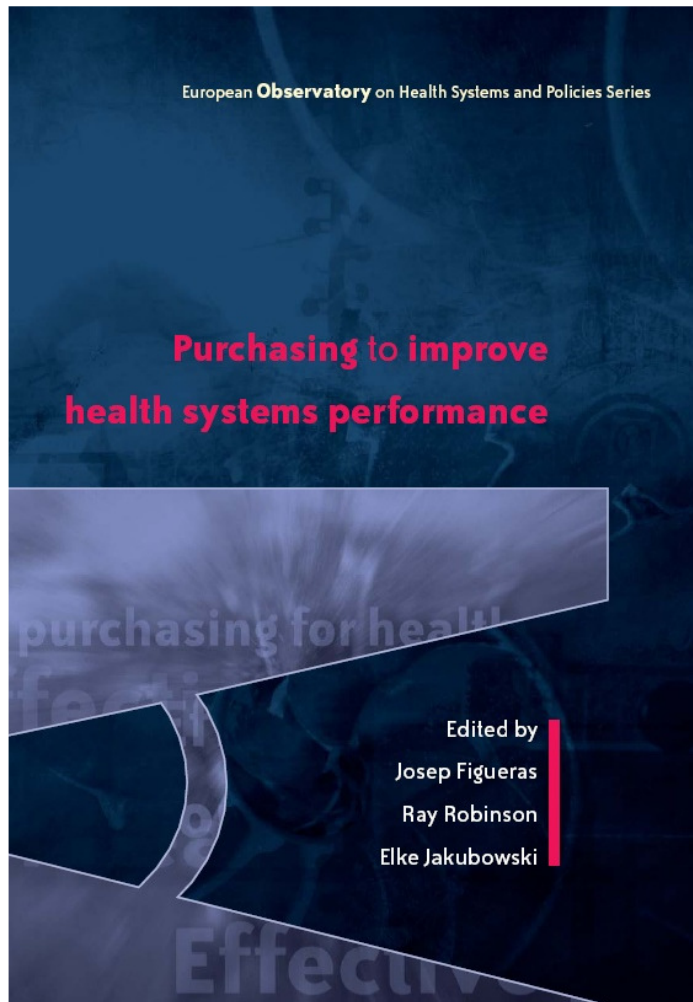
- **Economic obstacles**
  - Substantial transaction costs involved
  - Gap between public guarantees and funding available
- **Institutional / organizational design weaknesses**
  - Unclear organizational roles of purchasers and providers
  - Accountability lines between purchasers and government
  - Low autonomy of providers
- **Cultural difficulties**
  - Closed social networks between gov officials and providers
  - Change in the management culture of command and control

# Conclusions

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- Purchasing = central function of health systems (*here to stay!*)
- In theory ... it ought to work
- In practice ... no country has found the holy grail, many questions remain
- How transferable are experience and results (“contextualisation”)?



This presentation, the book and more material can be found on the following websites:

<http://mig.tu-berlin.de>

[www.observatory.dk](http://www.observatory.dk)