What is strategic purchasing?

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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)*

WHO's "purchasatives"

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1) Purchasing is a central function for improving health systems performance.

2) Where a purchaser model exits, countries should move from passive to strategic forms of purchasing.

(3) Implicit: From hierarchically integrated systems to separation of purchaser and provider functions ("purchaser-provider split").

Some Western European examples

Integrated → P/P Split

- Finland
- Italy (certain regions)
- Portugal (limited)
- Spain (limited)
- Sweden (not all provinces)
- UK

Existing P/P Split

Reimbursing → Purchasing

- Austria
- Germany
- Israel
- Netherlands
- Switzerland

In theory … it ought to work!

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:

- 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
  - ...

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 exeptions, e.g. France, Netherlands)

2. Empower the citizen

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- Ascertaining the views of citizens - *Voice*
  - Consultation of public views
  - Advocacy groups
- Enforcing purchasers accountability - *Voice*
  - Defined benefit package/ entitlements
  - Formal representation in purchasing boards
  - Patients rights legislation / charters
  - Ombudsperson
- Enabling choice of purchaser and/or provider - *Exit*

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

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 them-selves, it is unclear why should they be able to exercise stewardship!

4. Develop appropriate purchaser organization(s)

- What is the right type of purchaser?
- What is the right size of population coverage?
- Macro, meso or micro purchasing?

Single or multiple competing purchasers?

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/ concentration of services*
  - *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

6. Establish appropriate provider organizations

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

- 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")?