Purchasing

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What is purchasing?

- There is a diversity in understanding and definitions: resource allocation to service providers, payment, contracting, commissioning, ...

- World Health Report 2000: “Purchasing is the process by which pooled funds are paid to providers in order to deliver a specified or unspecified set of health interventions”

- Figueras et al. 2005: “Purchasing is understood as the allocation of financial resources to providers, differentiating passive forms of allocation from proactive or strategic allocation in light of health gain, responsiveness and efficiency goals.”
What is purchasing?

- What services?
- How much?
- From whom?
- How to buy?
- Who should buy?
- For whom?

Strategic purchasing = “proactive decisions … about which services should be purchased, how and from whom” (WHO 2000)
Origins of the idea of strategic purchasing

• Ideological context
  – 1990s: ‘New Public Management’ ideas influenced public service reforms especially in US, UK, Australia, New Zealand
  – World Bank influential with World Development Report 1993: “for some services provided by the public sector, the system of provision is so grossly inefficient that it is unlikely to be cost-effective... Such inefficiencies have been criticised so clearly and for so long that it is evident that they will only be overcome by radical changes in the organisation of health care - such as a shift in the government’s role from providing care to financing care and stimulating competition between providers”

• Historical context
  – from traditional integrated systems to new NHS type system
Passive purchasing

Payers = passive purchasers
(MoH, regions, sickness funds)

Resource allocation
– based on geographical and (more often) institutional (e.g. number of beds or staff) or historical figures

Advantage: providers know budget in advance and can plan accordingly
Disadvantage: not based on actual workloads, outcomes or new technologies
Strategic purchasing

Advantage: services (ideally) financed according to population health needs, cost-effectiveness etc.

Disadvantages: requires information which is often not available or comparable.

Providers

Purchasing based on contracts: explicit decisions about WHICH interventions (cost-effectiveness, needs), HOW (incentives), FROM WHOM (quality etc.)

Active purchasers (MoH, regions, sickness funds)
Traditional integrated NHS-type system

Central government (MoH)

Central government (MoF)

General taxation

NHS = Payer & Provider

Direct government control

Limited choice

Population

Universal coverage

Public Providers

direct allocation of resources

12 November 2019

Purchasing
Central Regional government

Providers

Population

General (or earmarked) taxation

Universal coverage

Limit

More choice

Limited

Purchasing

Purchaser – Provider split

Regulator

Central government (MoF)

Universal coverage

Autonomous public and private providers

activity-based financing

New NHS-type systems
Traditional social health insurance systems

Collector of resources

Sickness funds (professionally defined membership)

Wage-related contributions

Contracts & FFS/ per diems

Indirect government control

Reimbursement of provider costs

Population

Coverage of employees

Providers

Public and private providers

Choice of provider
New social health insurance systems

Collector of resources → Sickness funds

- Wage-related contributions + taxes
- Indirect government control

Population
- Universal coverage

Guided → Choice of provider

Providers
- Public and private providers

Sickness funds
- (group 1: in competition/ group 2: on regional basis)

Contracts
- (group 1: → selective)
- & Capitation/
- FFS/ DRGs

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Purchasing in theory... it ought to work!

- Links resource allocation to plans/ priorities
- Gives levers to influence provider behavior
- Encourages management decentralization
- Enables purchaser and provider competition

→ Improves performance!
Analysing purchasing relationships

Purchaser (Agent)

Principal

Government / Steward (Principal)

Population / Citizen (Principal)

Providers (Agent)
How to improve purchasing

1. Strengthen stewardship and improve regulatory framework

2. Strengthening purchasers

3. Incorporate Health Needs

4. Empower the Citizens (voice, choice)

5. Establish a network

6. Cost-effective contracting

7. Employ the right payment incentives
• Challenge: problems of capacity and credibility:
  – Often financing comes to mind ...

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

*→ if governments did not have the ability to provide services themselves, it is unclear why should they be able to exercise stewardship?*
1. Strengthen stewardship and improve regulatory framework

Only a few countries have strong regulatory frameworks with clearly defined monitoring mechanisms (France, Germany, England, Netherlands)

• Build capacity to monitor and audit stakeholders (‘Watchdog’ agencies, information systems)

• Regulate and ensure accountability (of purchasers and providers)

• Develop an appropriate regulatory framework (according to capacity)
  – link health needs, plans and priorities with purchasing decisions
  – defining the benefits package (based on HTA → see separate course)
  – rules for purchasers, for contracting, quality standards, budget and price setting, negotiation and litigation rules, open information, monitoring and evaluation...

• Assure government credibility and capacity to enact and enforce change
2. **Strengthen** appropriate purchasing organizations

Purchasers need tools, information, expertise and enough capacity to run a purchasing process – and government that trusts them to be good agents/principals!

**Recommendation from the Slovenian purchasing and payment review (2015)**

7. **Strengthen the purchasing role of the HIIS as independent body purchasing on behalf of the people of Slovenia:**
   a. define competences vis-à-vis the Ministry of Health and the government
   b. reassess the government’s role in arbitration with regard to the GA and contracts
   c. explore putting in place an arbitration system through the judicial system or another independent body (e.g. ombudsman)
   d. consider the introduction of selective contracting
   e. introduce hard budget constraints enforced by the HIIS.

8. Consider including patient groups in the GA negotiation, to help focus discussions on quality of care instead of financing and shortfalls.

9. Improve information systems so that they mandate, collect and make available meaningful information for use by all stakeholders to enable effective purchasing.
2. Strengthen appropriate purchasing organizations

• What is the right type of purchaser?
  – Region/district: e.g. Italy, Spain, Sweden ...
  – Municipalities: e.g. Finland, Russia ...
  – Sickness funds: e.g. Germany, Netherlands, Hungary ...
  – Primary care budgets: e.g. UK, Sweden, Catalonia ...

• What is the right size of population coverage?

• Macro, meso or micro purchasing?

May differ depending on type of service that is being purchased (e.g. primary care vs. highly specialized care), and geography
3. Incorporate population health needs

• Problem:
  – health needs assessments are often not done (lack of information!) or – if done – little used for purchasing decisions

• Needed:
  – structurally or functionally integrate public health into purchasing – public health skills in purchaser organizations (in Ghana: NHIA) necessary
4. Empower the citizens

How to ensure that purchaser decision making reflects the wants, needs and demands of the population on whose behalf it purchases health care services?

Voice:

• Citizens views and values should be incorporated by letting them participate

• Enforcing purchaser accountability
  – Defined benefit package/ entitlements
  – Formal representation in purchasing boards
  – Patients rights legislation / charters
  – Ombudsperson

Choice of …:

• Provider: yes, but needs to be aligned with contents of contracts
• Purchaser: not an issue in Ghana (purchaser choice e.g. in Germany, Netherlands, Switzerland, USA)

Potential conflict: Voice and choice may both increase costs and compromise efficiency (e.g. gatekeeping, benefits package, planning an efficient network)
5. Establish a network with appropriate provider organisations

Identifying and selecting providers for network:

• Many countries have sought to rationalize the provider network and improve it in terms of quality

• Two main tools available: (1) concession and network planning system and (2) (selective) contracting

• Selective contracting still rarely practiced in Europe: e.g. Netherlands, Estonia, Slovakia, and Switzerland

• Several countries have implemented strategies, to rationalize the provider network and increase quality by concentrating care.
5. Establish a network with appropriate provider organisations

Ultimately the impact of purchasers on health systems performance is determined by the way and the extent to which providers respond to purchasers’ incentives

- Providers need sufficient autonomy (public → self governing)
- Provider ability/capacity to respond to incentives
- Define lines of accountability
- Accept a new power balance
### Provider Autonomy

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<th>Critical Factors That Influence Organizational Behavior</th>
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<th>Autonomized Unit A</th>
<th>Corporatized Unit C</th>
<th>Privatized Unit P</th>
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<td>Decision Rights</td>
<td>Vertical Hierarchy</td>
<td>Management Autonomy</td>
<td>Non Budgetary Revenues</td>
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<td>Market Exposure</td>
<td>Direct Budget Allocation</td>
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<td>Residual Claimant</td>
<td>Public Purse</td>
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<td>Private Owner</td>
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<td>Accountability</td>
<td>Direct Hierarchical Control</td>
<td>Rules, Regulations and Contracts</td>
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<td>Social Functions</td>
<td>Unspecified and Unfunded Mandate</td>
<td>Specified, Funded and Regulated</td>
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*Harding & Preker 2000*
Contracts should be specified in sufficient detail

• *Which services? (”Doing the right thing”)*: Health Technology Assessment → see course in 2020

• *Who may provide?:* accreditation, certification, minimum volume numbers

• *How? (”Doing the thing right”):* guidelines, protocols, standards of care

• *Necessary documentation*

• *Quality targets/ benchmarking (process)*

• *Monitoring of results?:* quality targets/ benchmarking (outcome)
Challenges

• Transaction costs can be substantial:
  – Measurement, search, bargaining, monitoring costs, legal costs
  → Determine appropriate contract duration (e.g. longer contract for concession + annual contract for financing)

• Provider competition/ selective contracts limited:
  – Choice of consumer vs. choice of purchaser → resistance
  – Monopoly – Monopsony relationships → opportunistic behaviour
  – Low leverage of purchasers: political interference
  – What happens with non-contracted providers?
How often does a purchaser close a hospital?
Two examples

**The Netherlands:** contracting is not based on health needs, takes place mostly on the basis of price and volume. Quality indicators are lacking. This is now being addressed, at least in part, through a new quality institute, and a new policy goal that, within five years, the treatment of 50% of the disease burden should be made transparent with outcome indicators.

**Slovenia:** contracts are unspecific and consist of a few pages followed by large annexes with financial details. They do not stipulate in great detail what has to be provided and how, and which evidence-based clinical pathways and protocols have to be followed.
Example from Slovenia

Recommendation from the Slovenian purchasing and payment review (2015)

3. The GA and contract negotiations need to be concluded within a predefined timeline to strengthen the role of the purchaser and provide clarity to providers. Perhaps options to delay and appeal could be constrained.

4. The duration of the GA and contracts should be revised. The HIIS should be required by law to develop strategic (long-term, e.g. 3–5 year) and operational (annual) purchasing plans in line with the National Health Plan. This will also enable providers to produce their own business plans and long-term goals.

5. In general, content of the contracts should be made much more specific and include what services have to be provided and within how much time, quality assurance mechanisms and indicators, and which evidence-based clinical guidelines have to be followed. Examples of detailed contracts are readily available from the internet (e.g. NHS standard contracts).

6. Restart the process to develop clinical guidelines to be used for purchasing in Slovenia and explore the availability of external funding.
7. Employ the right payment incentives

Ideally, provider payment mechanisms should:

• motivate actors to be productive in terms of number of cases treated and services provided
• avoid incentives that would lead to risk selection
• contribute to overall health system efficiency through expenditure control
• are administratively easy and transparent
• encourage providers to achieve optimal care outcomes.
• In practice, all payment systems have far reaching consequences for efficiency and quality of care. Blended payment systems (combing basic mechanisms) can reduce unintended incentives of basic payment mechanisms.

• Move towards paying for activity but ultimately quality
  – 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?)
Health financing for universal coverage

Strategic purchasing for UHC: unlocking the potential
25–27 April 2017 - Geneva, Switzerland

Session 1

Health benefit package design in support of UHC: evidence, process and politics

- Introduction to strategic purchasing global meeting
  pdf, 1.05Mb
  Inke Mathauer, WHO

- Benefit entitlement for universal health coverage
  pdf, 1.21Mb
  Melanie Bertram, WHO

- Evidence for decisions on health benefits – role of HTA
  pdf, 2.52Mb
  Mohamed Gad, Imperial College London

- Benefit package design for UHC: state of play in OECD countries
  pdf, 739kb
  Michael Mueller, OECD

- Intersectoral dialogue in Burkina Faso
  pdf, 321kb

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<th>Weak or absent governance of purchasing function in particular</th>
<th>Unclear mandates of purchasing agencies and inadequate levels of autonomy of providers and purchasers</th>
<th>Sub-optimal benefit package design processes</th>
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<tbody>
<tr>
<td>Fragmentation causing incoherence in payment methods; and public financial management regulations as hurdle to more output-oriented payment methods</td>
<td>Inadequate generation and use of data related to provider payment for wider system monitoring and informing decision-makers</td>
<td>Political economy factors and group interests</td>
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</table>
1. Strengthen stewardship and improve regulatory framework
2. Develop, trust and equip purchasers
3. Incorporate population health needs
4. Empower the citizens (voice, choice)
5. Establish an appropriate provider network, ensure its accountability, manage and monitor performance
6. Develop good and cost-effective contracts
7. Employ the right payment incentives
Conclusions

• Purchasing is central function of health care financing systems
• In theory ... it ought to work:
  – Good purchasing strategy can bridge the gap between planning and budgetary allocations
• In practice ... no country has found the holy grail
  – Comprehensive approach best, but there is a continuum from passive to more strategic purchasing.
• Inadequate governance and organisational arrangements as well as lack of capacity and reliable information challenge effective purchasing
Points for discussion

• Are the roles and competences of stakeholders (ministry, NHIA, etc.) clear and well defined?

• How can the role of the NHIA be strengthened further?
  – Policy capacity?
  – Enforcement?
  – Independence?

• Can the negotiation process be improved? Is selective contracting an option?

• How can the contracts be improved to better integrate quality? Are guidelines available?

• Is enough meaningful information available to purchase or make informed choices?
For further reading: 1. WHO (2000)

- The use of public health to determine priorities for financing, enforce stewardship, and use population health data in choosing which interventions to buy.
- Prioritize units in purchasing in order to promote the creation of more long-term contracts.
- Avoid micro-purchasing and micro-managing which prevents the pooling of health services and populations and prevents risk-sharing.
- Through budgeting and contracting, establish an environment in which there are appropriate incentives for providers
- Establish appropriate political capacity and governance
2. European Observatory (2005)

- Citizen Empowerment
- Strengthening Government Stewardship
- Ensuring Cost-Effective Contracting
- Developing Appropriate Purchasing Organizations
- Improving Provider Performance
### TABLE 1.1 Implementation Arrangements for Strategic Purchasing of Health Care

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<tr>
<th>Political economy</th>
<th>Resource allocation and purchasing arrangement</th>
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<tr>
<td></td>
<td>For whom to buy—members, poor, sick, other?</td>
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<tr>
<td></td>
<td>What to buy, in which form, and what to exclude?</td>
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<tr>
<td></td>
<td>From whom to buy—public, private, nongovernmental organization?</td>
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<tr>
<td></td>
<td>How much to pay—competitive market price, set prices, subsidized?</td>
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<td></td>
<td>How to pay—what payment mechanisms to use?</td>
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<tr>
<td>Underlying revenue collection mechanisms</td>
<td>Level of prepayment (full versus partial with some copayment or cost sharing)</td>
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<td>Degree of progressivity (high versus flat rate)</td>
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<td>Earmarking (general versus targeted contributions)</td>
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<td>Choice (mandatory versus voluntary)</td>
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<td>Enrollment (unrestricted versus restrictions in eligibility, waiting periods, and switching)</td>
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### Underlying pooling of revenues and sharing risks

<table>
<thead>
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<th>Size (small versus large)</th>
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<tr>
<td>Number (one versus many)</td>
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<tr>
<td>Risk equalization (from rich to poor, healthy to sick, and gainfully employed to inactive)</td>
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<tr>
<td>Coverage (primary versus supplementary, substitutive, or duplicative)</td>
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<tr>
<td>Risk rating (group or community rating versus individual)</td>
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</tbody>
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### Organizational structure

| Structural configuration (extent of horizontal and vertical linkages versus purchaser-provider split or fragmentation) |
| Incentive regimes (extent of decision rights, financial responsibility, market exposure, accountability, and coverage of social functions) |

### Institutional environment

<table>
<thead>
<tr>
<th>Legal framework</th>
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<tbody>
<tr>
<td>Regulatory instruments</td>
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<tr>
<td>Administrative procedures</td>
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<tr>
<td>Customs and practices</td>
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</tbody>
</table>

### Management capacity

| Management levels (stewardship, governance, line management, client services) |
| Management skills |
| Management incentives |
| Management tools (financial, human resources, health information) |

<table>
<thead>
<tr>
<th>Possible outcome indicators</th>
<th>Efficiency</th>
<th>Equity (mainly poverty impact)</th>
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<tbody>
<tr>
<td>Financial protection</td>
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<td>Coverage</td>
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<td>Household consumption</td>
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<td>Access to health care</td>
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<td>Labor market effects</td>
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*Source: Modified from Preker and Langenbrunner 2005.*