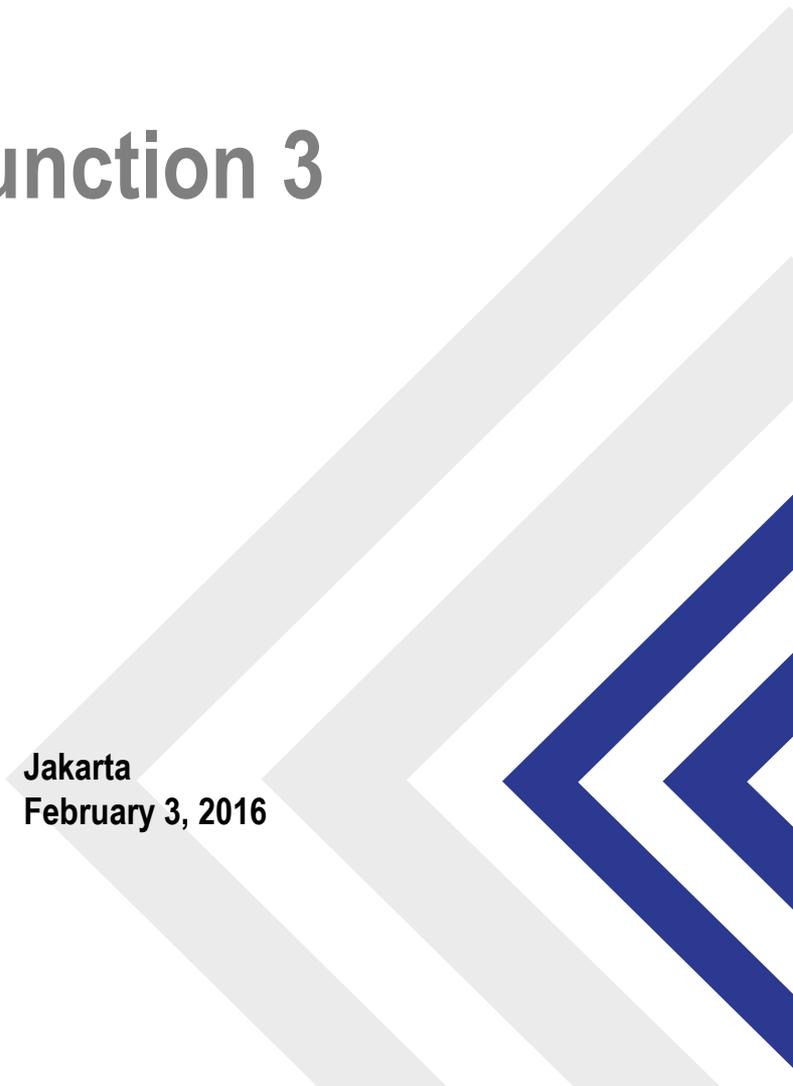




Session 4: Health Financing Function 3 **Purchasing**

Rena Eichler, PhD



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In this session

- ▶▶ What do we mean by purchasing?
- ▶▶ From passive to strategic purchasing
- ▶▶ Provider payment mechanisms – what are the options?
- ▶▶ From paying for inputs to paying for results
- ▶▶ The benefit package
- ▶▶ Why strategic purchasing matters for UHC



What is health purchasing?

Paying health care providers on behalf of a population

Who is the purchaser?

What services to purchase? → Importance of benefit package

For whom? → link to population dimension of UHC cube

From whom? → opportunity to regulate private sector

How? → provider payment mechanisms central!

Note: Health purchasing does not have to involve an insurance agency
(MOH is also a purchaser)



What **motivates** a health worker?



All provider payment mechanisms create

incentives

that affect provider behavior

Imagine you need to have a brick wall built
How would you pay the workers?



Would you pay them **per hour** ?



What's the risk if you pay
them **per brick** ?



Would you pay the full amount **in advance** ?





Bottom line:

How you pay providers matters because
financial incentives clearly matter
(even though non-financial incentives are also important)



Passive purchasing

providers are paid with
limited or no consideration for the incentives
the payment method(s) introduce

e.g. staff is paid a salary irrespective of performance,
this year's budget is last year's budget plus x%,
bills are simply reimbursed retrospectively



Strategic purchasing

providers are paid in a way that
creates the right incentives

i.e., incentives that help improve the
performance of the health system and are
aligned with the health system goals



Strategic purchasing

The way you pay providers can influence many things, including:

- ▶▶ Volume and distribution of delivered services
- ▶▶ Composition of input mix (staff, medicines, etc.)
- ▶▶ Quality of services delivered
- ▶▶ Composition of services: primary care, hospitalizations, use of high-tech diagnostics and procedures, prescriptions, etc.
- ▶▶ Patient behavior (e.g. care-seeking)



Strategic purchasing **is not easy!**

It requires:

- ▶▶ Deciding what to buy and from which providers
- ▶▶ Deciding how and how much to pay providers
- ▶▶ Knowing how providers perform



What are the **different ways**
you can pay providers?

Provider payment mechanisms

	Individual provider	Health facility
I. Input-based		
Salary	✓	-
Line item budget	-	✓
II. Output/activity-based		
Per service (Fee for service)	✓	✓
Per patient day	-	✓
Per case	✓	✓
Per target	✓	✓
Per capita (Capitation)	✓	✓
Global budget	-	✓

The unit of measurement is what is being incentivized!



Provider payment mechanisms

Line item budget

- ❖ Providers receive a fixed amount to cover specific input expenses (e.g., personnel, drugs, utilities...)
- ❖ Amounts determined by budgetary process
- ❖ Most budgetary processes give increases across the board

Incentives?

- ❖ Spend budget
- ❖ Maintain status quo



Provider payment mechanisms

Per service (Fee-for-service)

- ❖ Provider is paid for each individual service provided
- ❖ Fees are fixed in advance for each service or group of services
- ❖ Possible to reward good quality or penalize poor quality
- ❖ High transaction costs for payer and provider
- ❖ Payer does not know in advance how much it will end up paying
- ❖ Possibly combined with a global cap

Incentives?

- ❖ Powerful volume incentives
- ❖ Likely over-treatment



Provider payment mechanisms

Per patient day

- ❖ Provider is paid a fixed amount per day that an admitted patient is treated in the facility
- ❖ Simple to implement
- ❖ Low transaction costs

Incentives?

- ❖ Increase length of stay or number of visits
- ❖ Focus on easiest cases unless adjustment for severity



Provider payment mechanisms

Per Case (Diagnostic Related Groups or DRG)

- ❖ A DRG is an output classification system for acute in-patient hospital treatments
- ❖ Patients within each DRG are clinically similar and are expected to use a similar level of hospital resources
- ❖ Provider is paid a fixed amount per admission depending on patient and clinical characteristics

Incentives?

- ❖ Increase admissions
- ❖ For each case, minimizes expenses (e.g. do fewer tests)
- ❖ Discharge quicker
- ❖ Coordinate care across departments
- ❖ Admit cases for which payment is greater than costs
- ❖ Miscode



Provider payment mechanisms

Per target

- ❖ In the context of results-based financing
- ❖ Targets set for key indicators
- ❖ Payment can be conditional on full achievement of target (all or nothing) or partial achievement (proportional)
- ❖ Possible to reward good quality or penalize poor quality
- ❖ Better aligned with public health goals

Incentives?

- ❖ Focus on achieving targets
- ❖ Possibly neglect non-rewarded indicators
- ❖ Over-report performance (need for independent verification)



Provider payment mechanisms

Per capita (Capitation)

- ❖ Provider is paid a fixed amount in advance to provide a defined set of services for each individual enrolled for a fixed period of time
- ❖ Payment is unrelated to utilization
- ❖ May incorporate competition
- ❖ Caring for a certain population, not just for sick people

Incentives?

- ❖ Careful use of inputs
- ❖ Provide good services to attract patients (if competition)
- ❖ Provide fewer services / over-refer
- ❖ Avoid sick and costly patients
- ❖ Avoid services with no short-term payoff



Provider payment mechanisms

Global Budget

- ❖ Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures to deliver specified list of services to specified beneficiaries
- ❖ Budget is flexible and not tied to line items
- ❖ Low administrative cost

Incentives?

- ❖ Depends on what happens with money not spent.
 - ▶ If provider can keep it: incentive to generate savings [volume requirement can be imposed to avoid providers not producing]
 - ▶ If provider needs to give back what is unspent: incentive to spend
- ❖ No incentive to improve quality [unless payment tied to performance measures]

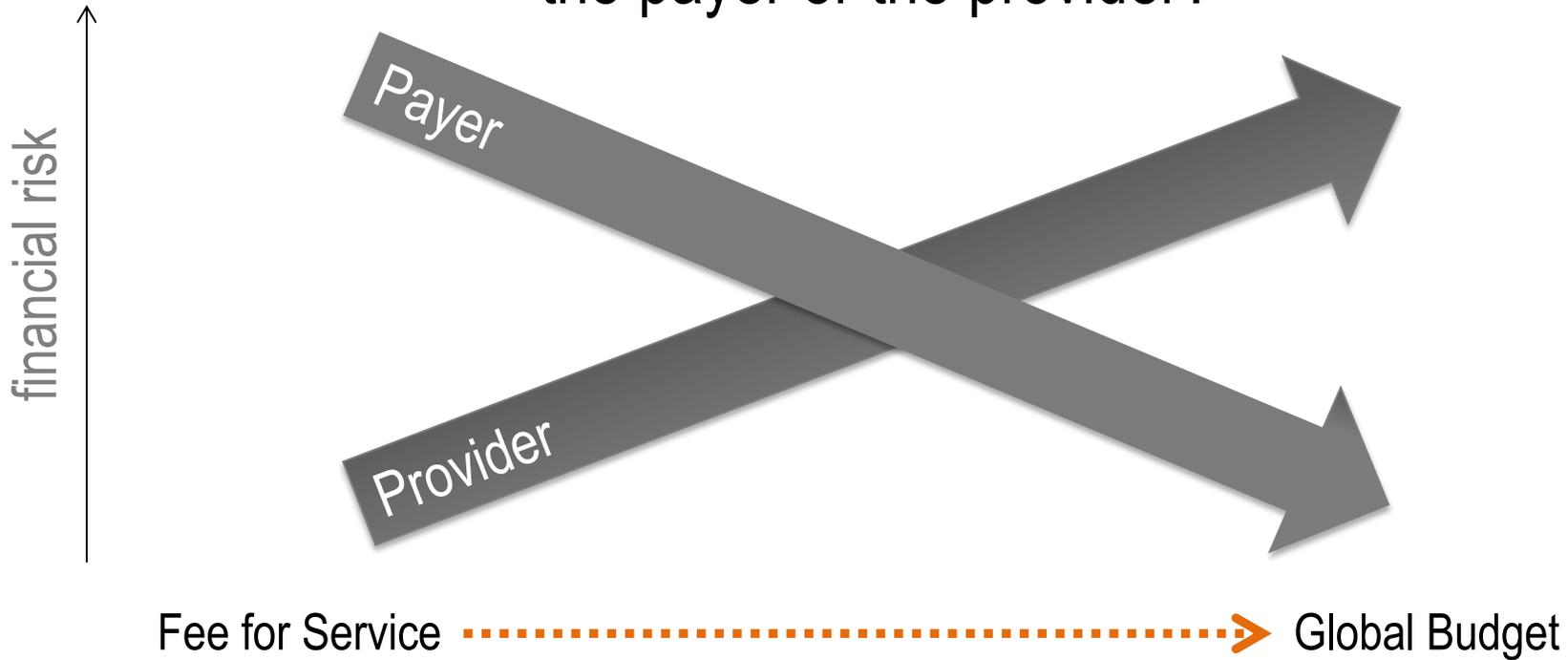


Who bears the financial risk?
the payer or the provider?

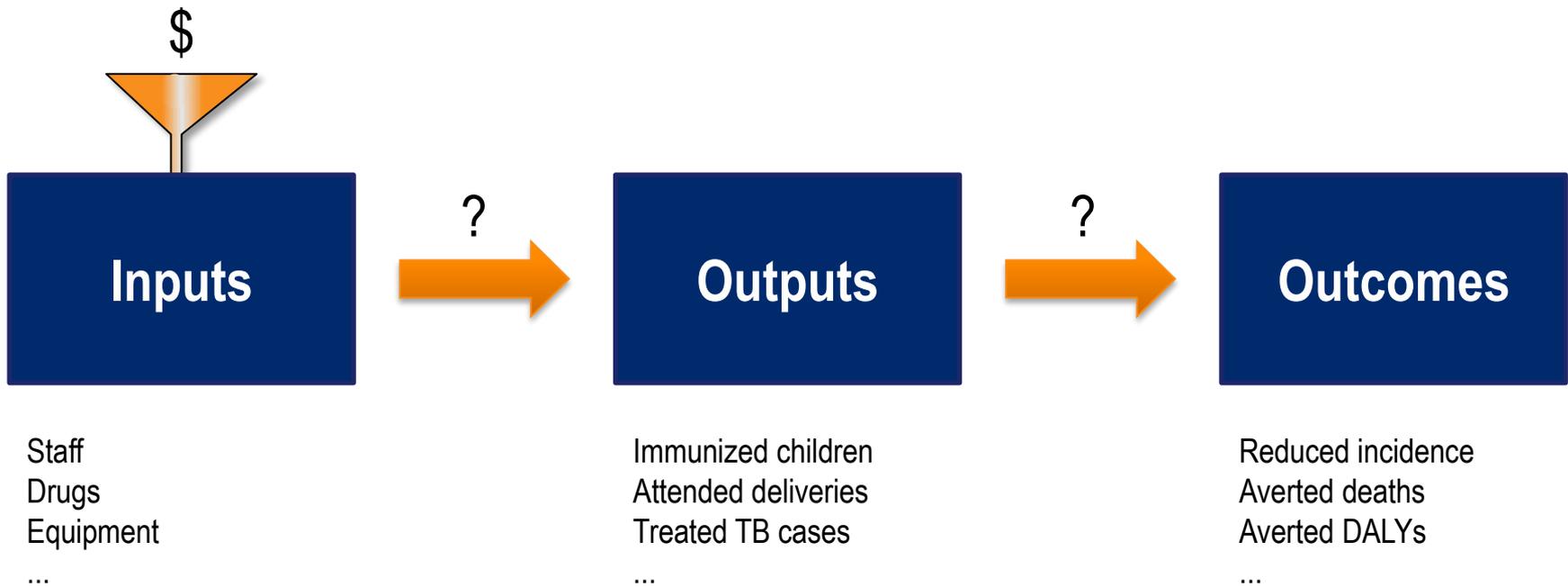
Financial risk influences the
behavior of those who bear it



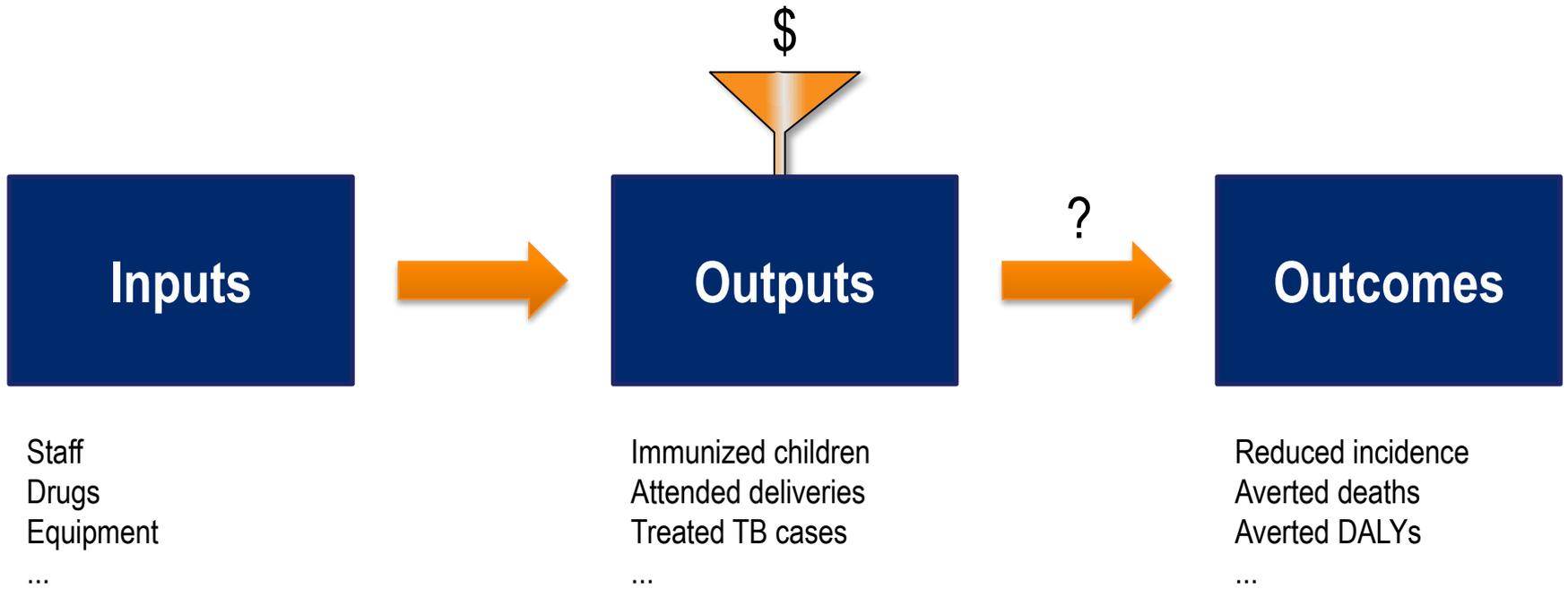
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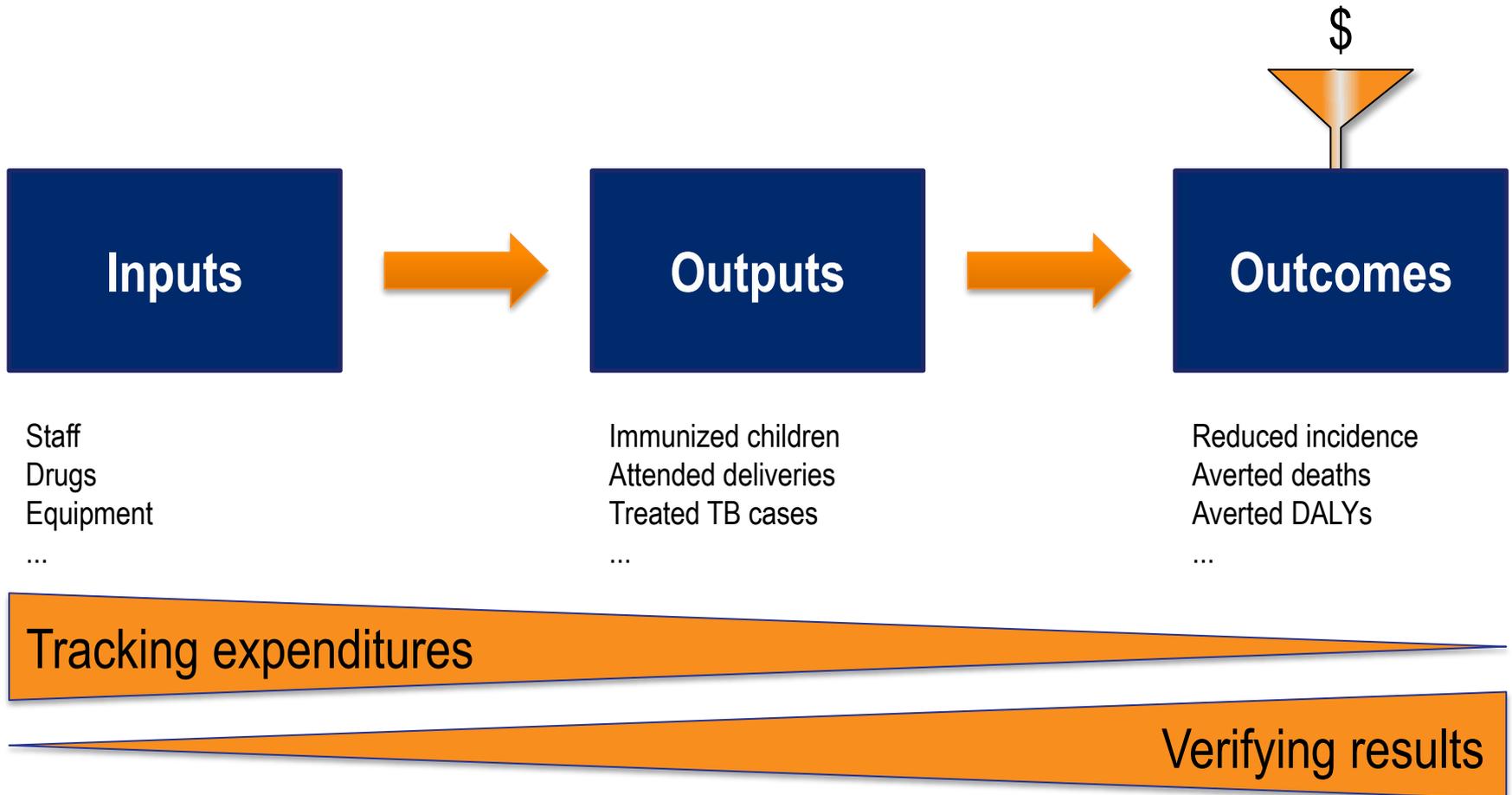
A shift in paradigm



A shift in paradigm



A shift in paradigm





A definition of Performance Based Incentives (P4P, RBF)

“Any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered.”

*Musgrove, Rewards for Good Performance or Results:
A Short Glossary*



Performance Based Incentives (P4P, RBF)

Performance-based incentives can be targeted to:

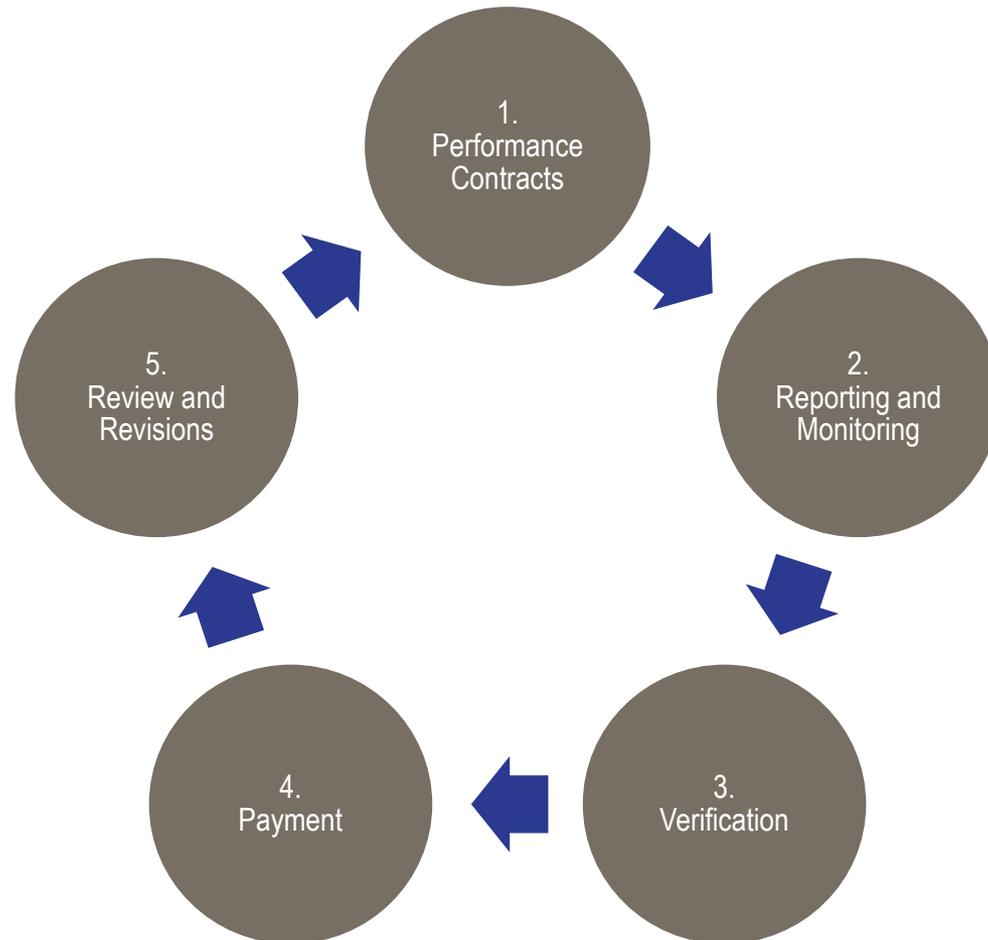
▶▶ [on the supply side]

- ❖ Sub-national levels of government
- ❖ Health facilities
- ❖ Teams of health workers
- ❖ Service delivery NGOs

▶▶ [on the demand side]

- ❖ Communities
- ❖ Households
- ❖ Individuals / Patients

The P4P cycle





Pay for Performance Design

Critical design questions:

- ❖ Which priority health problems need to be addressed?
- ❖ Whose behavior needs to be changed?
- ❖ Which indicators capture the desired change in behavior?
- ❖ How can these indicators be measured and verified?
- ❖ How will changes in the indicators be rewarded?
- ❖ How will the information flow?
- ❖ How will the money flow?
- ❖ What are the institutional arrangements?



The Future of Pay for Performance

So far, P4P incentives in low- and middle-income countries have mostly been introduced as stand-alone **schemes**

Growing recognition that P4P incentives should be better **integrated into a comprehensive health financing strategy**

They should be seen for what they are: **one tool among many other...** to be used smartly



Provider payment mechanisms – Take Away Messages

- ▶▶ There is no ‘best’ provider payment mechanism
- ▶▶ They all have their strengths and weaknesses
- ▶▶ Many ways to combine different mechanisms
- ▶▶ They can all introduce both desired and perverse incentives

The challenges:

- ▶▶ What is the **best mix** in a given environment?
- ▶▶ How to **adjust the mix** in response to changes in the environment?



The benefit package

- ▶▶ Defines interventions covered (**positive list**) and/or not covered (**negative list**)
- ▶▶ Defines quality of services and their timing
- ▶▶ Sets cost-sharing: co-payments, deductibles, coinsurance provisions
- ▶▶ Contains conditions of responsiveness (confidentiality, minimum standards of accommodations, privacy, access to patient information, provider choice, patient rights, and other elements for the preservation of dignity)



Some useful definitions

Cost-sharing: individual who is covered still needs to pay part of the cost of medical care received. Can take three forms:

- ▶▶ **Deductible:** individual pays all charges for covered services out-of-pocket until the total cost reaches the deductible amount
- ▶▶ **Coinsurance:** individual pays a share of the costs for covered services out-of-pocket
- ▶▶ **Copayment:** individual pays a fee for each covered health service. No additional administrative requirements for the insurer



Which benefit package?

- ▶▶ Governments may establish essential or minimum benefit packages to specify:
 - ❖ What public systems should deliver
 - ❖ What social insurance systems should cover
 - ❖ What private and public insurers should cover to be eligible for government subsidies
- ▶▶ Employers may specify benefit packages to:
 - ❖ Guide shopping for insurers
 - ❖ Provide information to their employees to choose
 - ❖ Attract and retain employees
- ▶▶ Insurers specify benefit packages to:
 - ❖ Determine what they will cover in order to estimate costs and price premiums



“Right to health” is included in 70% of Constitutions worldwide

▶▶ *In South Africa:*

- ❖ 1996 Constitution guaranteed the right to health care
- ❖ Challenge: HIV+ people have the constitutional right to ART while many lack access to primary health care

In Brazil:

- ❖ Right to health was included in 1988 Constitution
- ❖ Challenge: Litigation has been growing exponentially- but research shows that higher income people benefit more than those with low incomes from these court cases

What do right to health mandates imply for benefits packages?



Some considerations

- ▶▶ Who gets the benefit package?
 - ❖ Single universal package
 - ❖ Targeted packages
 - ❖ Multiple packages
- ▶▶ What types of services are included?
 - ❖ Public health interventions
 - ❖ Clinical health interventions
 - ❖ Rationing decisions
- ▶▶ How to provide coverage and services?
 - ❖ Public private mix in insurance
 - ❖ Public private mix in service delivery
- ▶▶ How much will it cost?
 - ❖ Sources

What to include in a benefit package

Example of criteria

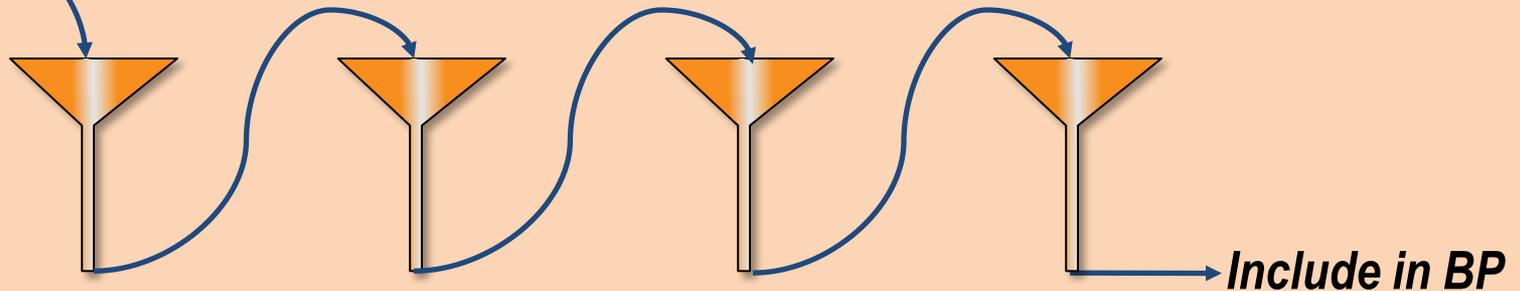
**Health
problem**

1.
Importance
according to
burden of disease

2.
High cost
effectiveness
of available
treatment

3.
Importance
of financial burden
to households

4.
Social consensus
on priorities





How the UK does it

- ▶▶ National Institute for Clinical Excellence (NICE) forms appraisal committees that recommend which drugs and other treatments can be prescribed by the UK National Health Service based on these considerations:
 - ❖ How much does a drug or procedure cost?
 - ❖ How much does the treatment extend the average patient's life?
 - ❖ And what is the quality of that life gained as experienced by patients?

"We have a limited budget for health care, voted by Parliament every year, and we have to live within our means," said Michael Rawlins, chairman of NICE



Benefit Packages are not static

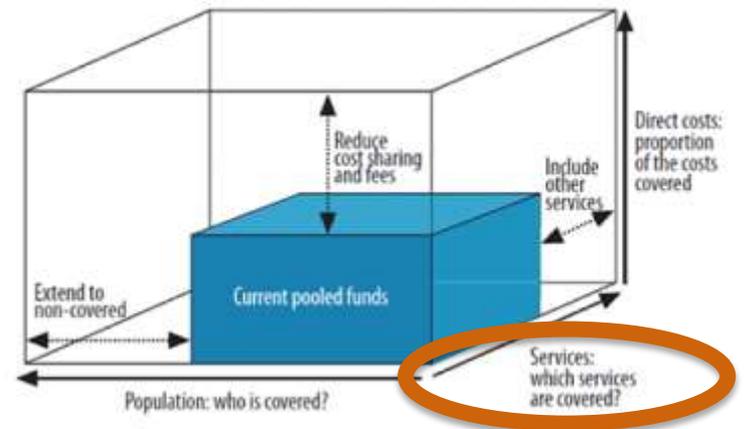
Need for a system to **update** the benefit package as:

- ❖ Burden of Disease Changes
- ❖ New technologies are developed
- ❖ Economies grow and can afford more
- ❖ Costs change



Why strategic purchasing matters for UHC

The 'services' dimension





UHC as a goal

- ▶ Fully comprehensive coverage cannot be achieved
 - ❖ Financial constraints
 - ❖ Service delivery capacity constraints
 - ❖ New technologies are always being developed
- ▶ Given that not everything can be covered, choices need to be made about what is in and what is out – **clear priorities** need to be set
- Need to define and regularly update a **benefit package** (what to purchase)



Strategic purchasing to achieve UHC goals

- ▶▶ Improving **equity** in access
 - ❖ Purchasing services that disproportionately benefit the poor (i.e., making fair choices in moving along the services dimension)
 - ❖ Paying more for services delivered in hard-to-reach areas and/or to disadvantaged populations
 - ❖ Regulating prices in the private sector
- ▶▶ Ensuring the services are of **quality**
 - ❖ Requiring providers to be licensed/accredited
 - ❖ Making payments conditional on quality
- ▶▶ Improving **efficiency** in service delivery
 - ❖ Incentivizing appropriate referral
 - ❖ Incentivizing more rational use of limited resources
 - ❖ Incentivizing increased provider performance



Thank you

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