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Development and institutional sustainability of health policy analysis and provider payment systems, and strengthening single payer capacity

Purchasing of health services: contracting and improving service delivery

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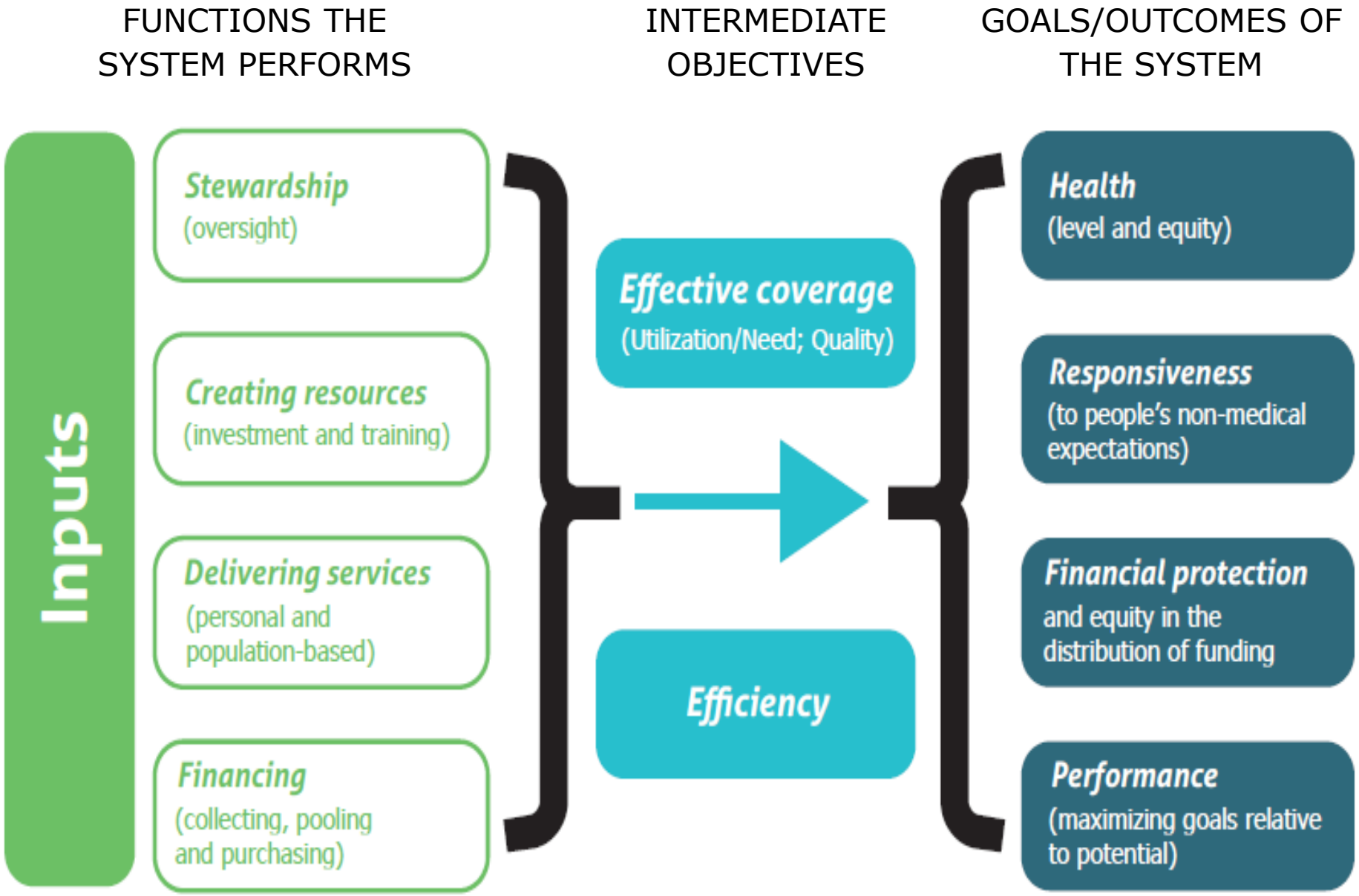
Programme:

a. Good health systems results and contractual approaches; key challenges;

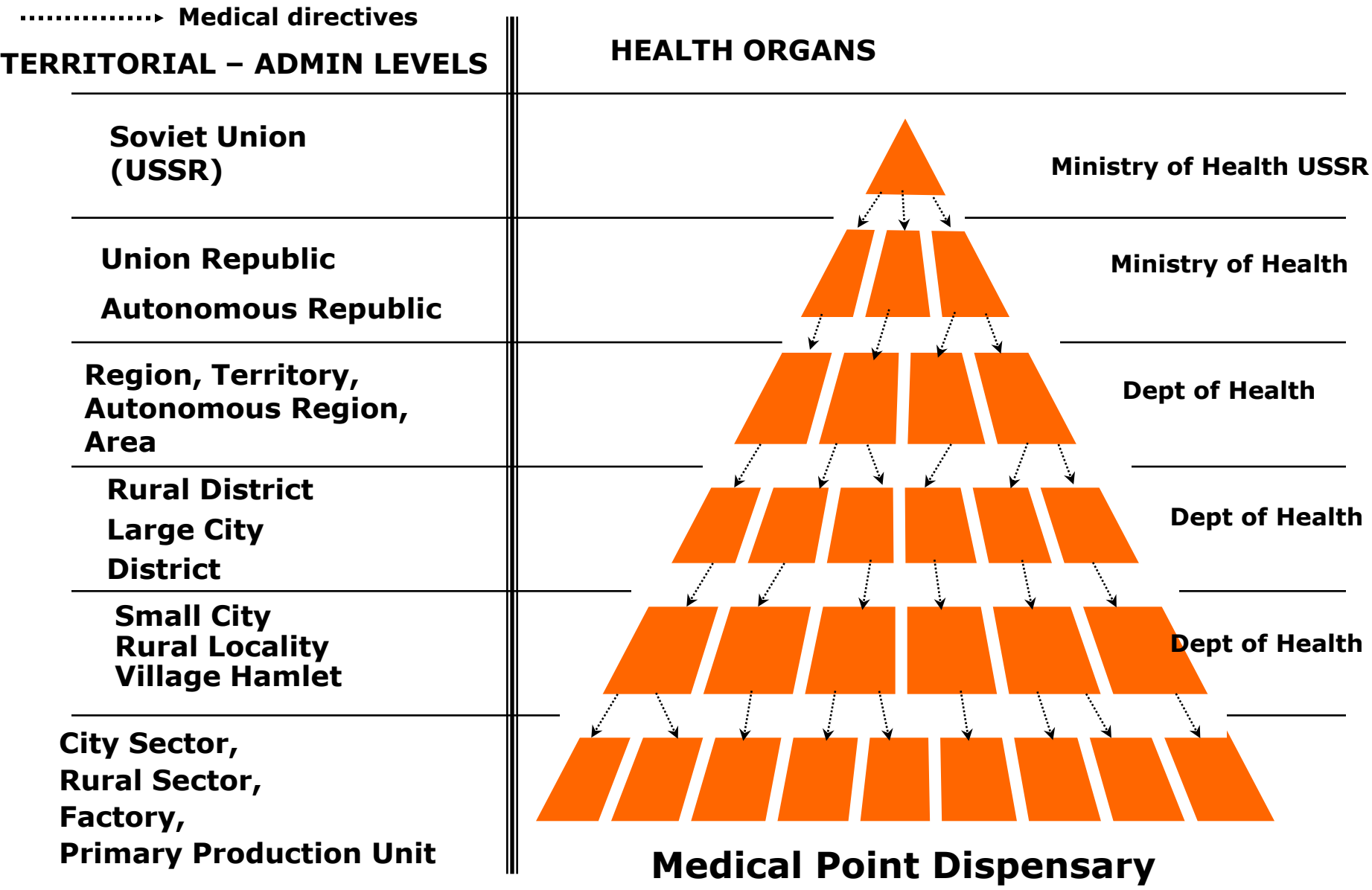
b. Strategic Purchasing; key concepts and techniques;

What goals is any health system expected to achieve and what interdependent things need to be done for a health system to achieve those goals?



Duran A, Kutzin J, Martin-Moreno JM and Travis P, (2011) Understanding health systems: scope, functions and objectives, en McKee M and Figueras J (eds.) Health Systems: Health, Wealth, Society and Well-being. Maidenhead, Berkshire: Open University Press and McGraw-Hill, pp. 19-36

USSR; Structure of the MoH and Supervising Organs, all levels



Source: Mark G. Field, Doctor and Patient in Soviet Union. Cambridge, Mass. Harvard University Press, 1957; p 36

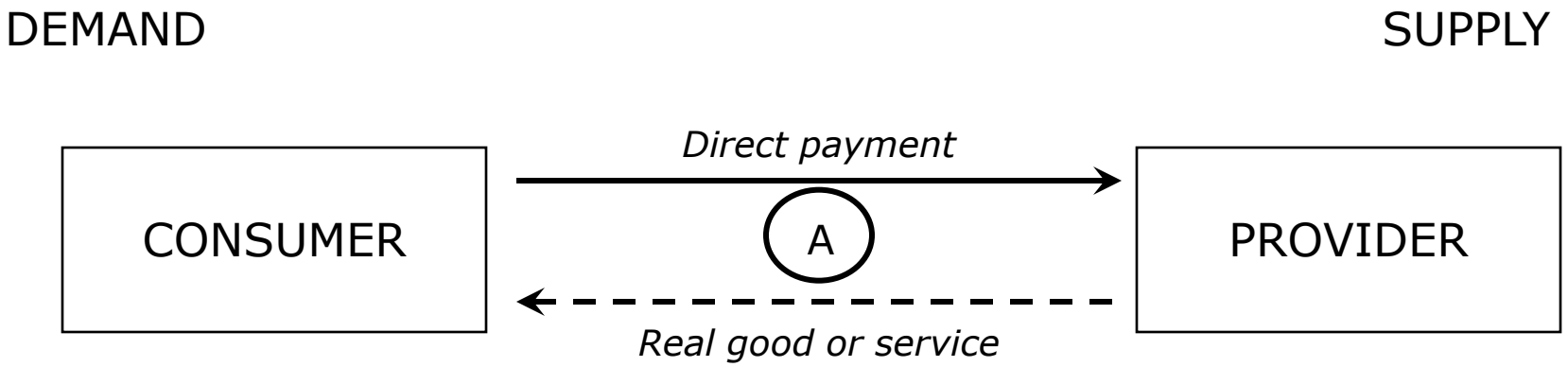
Good at “one cause-one effect” issues (communicable diseases, immunizations)...

Problems with “multi-cause diseases” (cancer, cardiovascular disease, and those resulting from alcohol and tobacco use).

Over-investments in acute care (physical and human capital); under-investment in public health and primary level services…

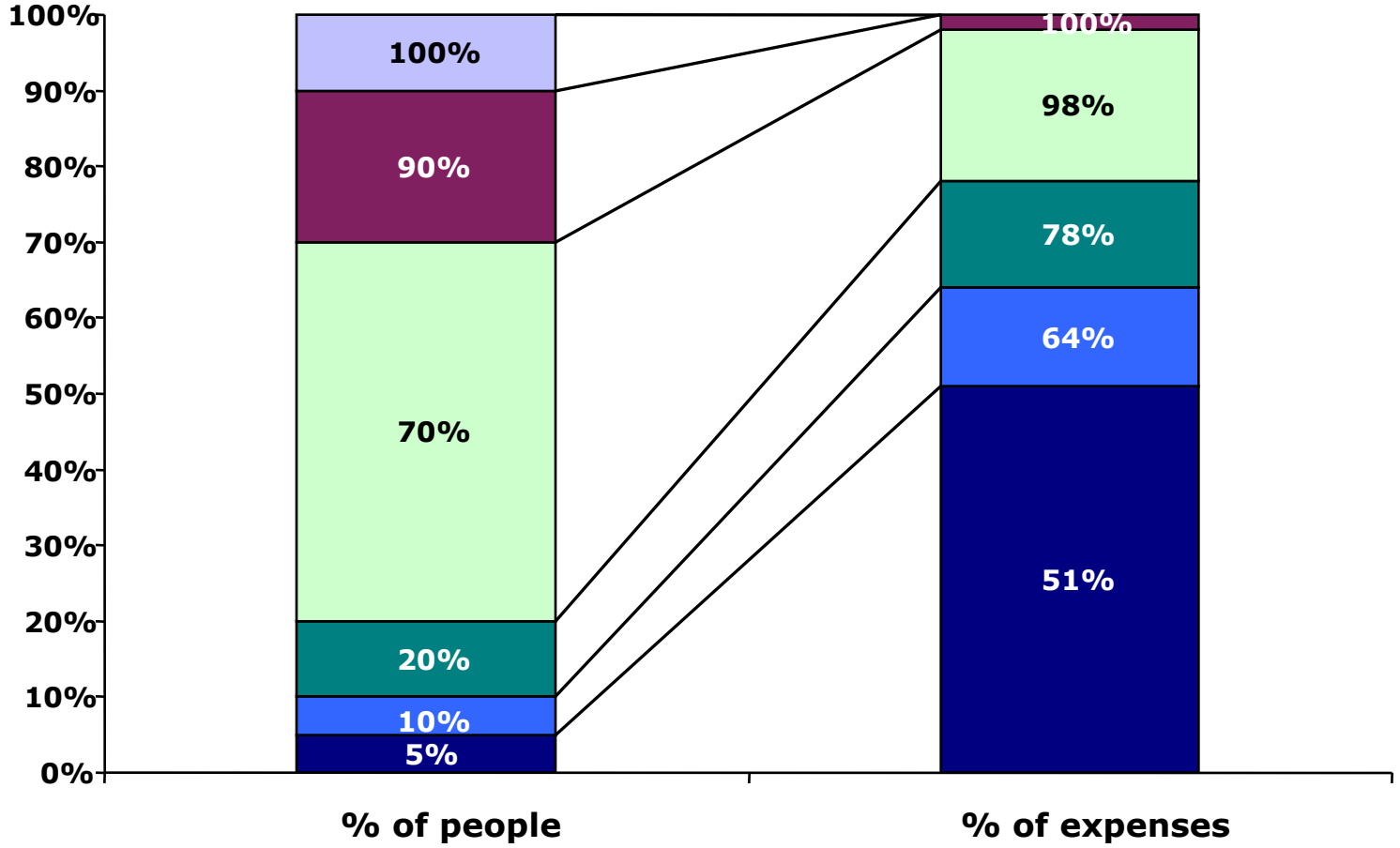
Rigid handling… but poor health results

Market relationships



Producers and consumers exchange goods at a *price,* which is the "signal" for both about what kinds of goods or services to produce, how many of each, etc.

Concentration of total health expenditures, France 2001 and 2008

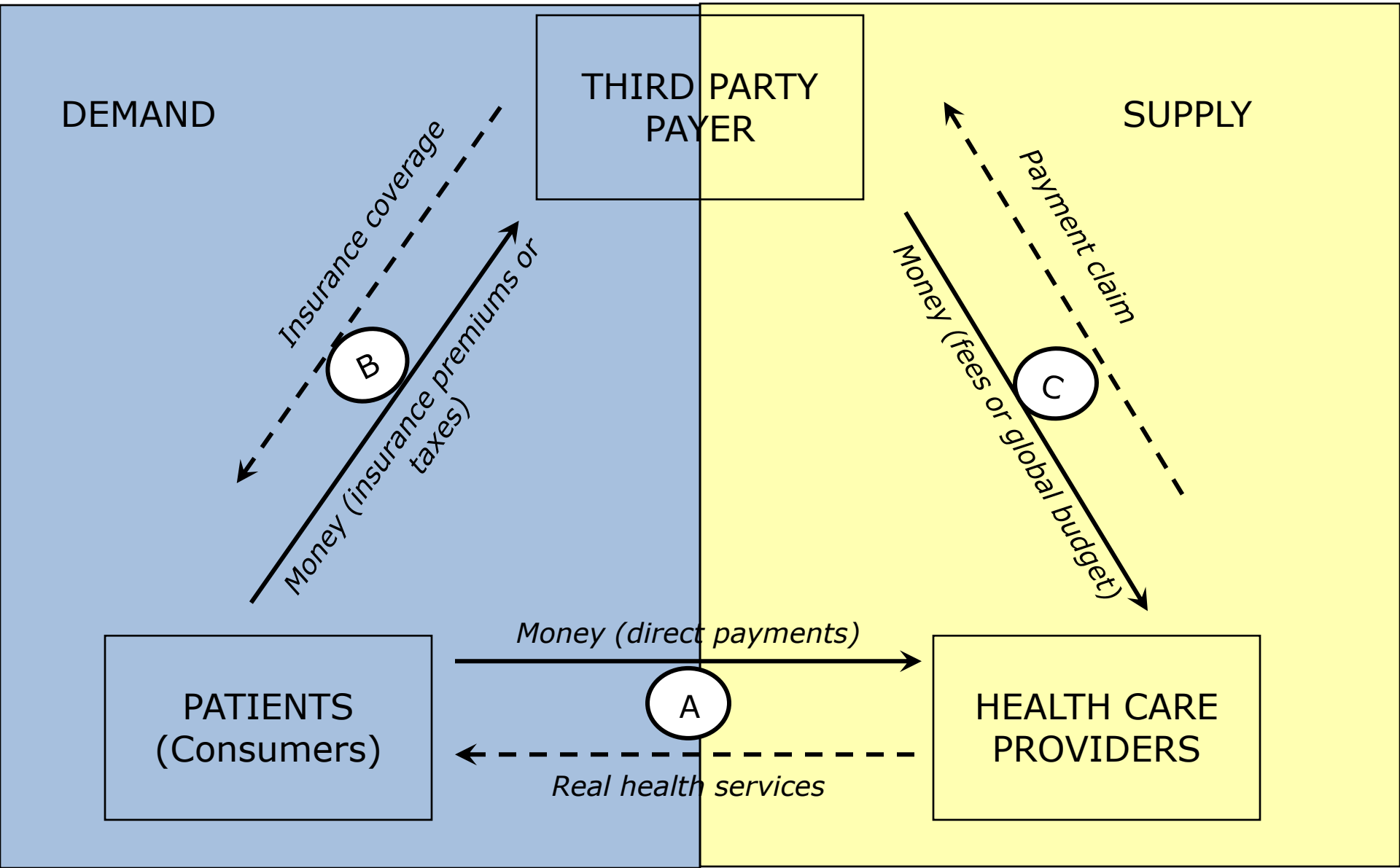


Institut de Recherche et Documentation en Économie de la Santé IRDES, 2004, Rapport d'activité, National Health Insurance Agency For Wage Earners CNAMTS/National survey of health and social protection EPAS data linking. No meaningful changes in IRDES, 2010, EPAS (*Echantillon Permanent d'assurés sociaux* – National Panel for insured population) from CNAMTS (*Caisse national d'assurance maladie des travailleurs salariés*, National Health Insurance Scheme for salaried employee). Exploitation : Julien Mousquès (mousques@irdes.fr) for IRDES (www.irdes.fr). Sample size: 79.035 individuals. Field: only for consumers (at least one consumption of health care or services

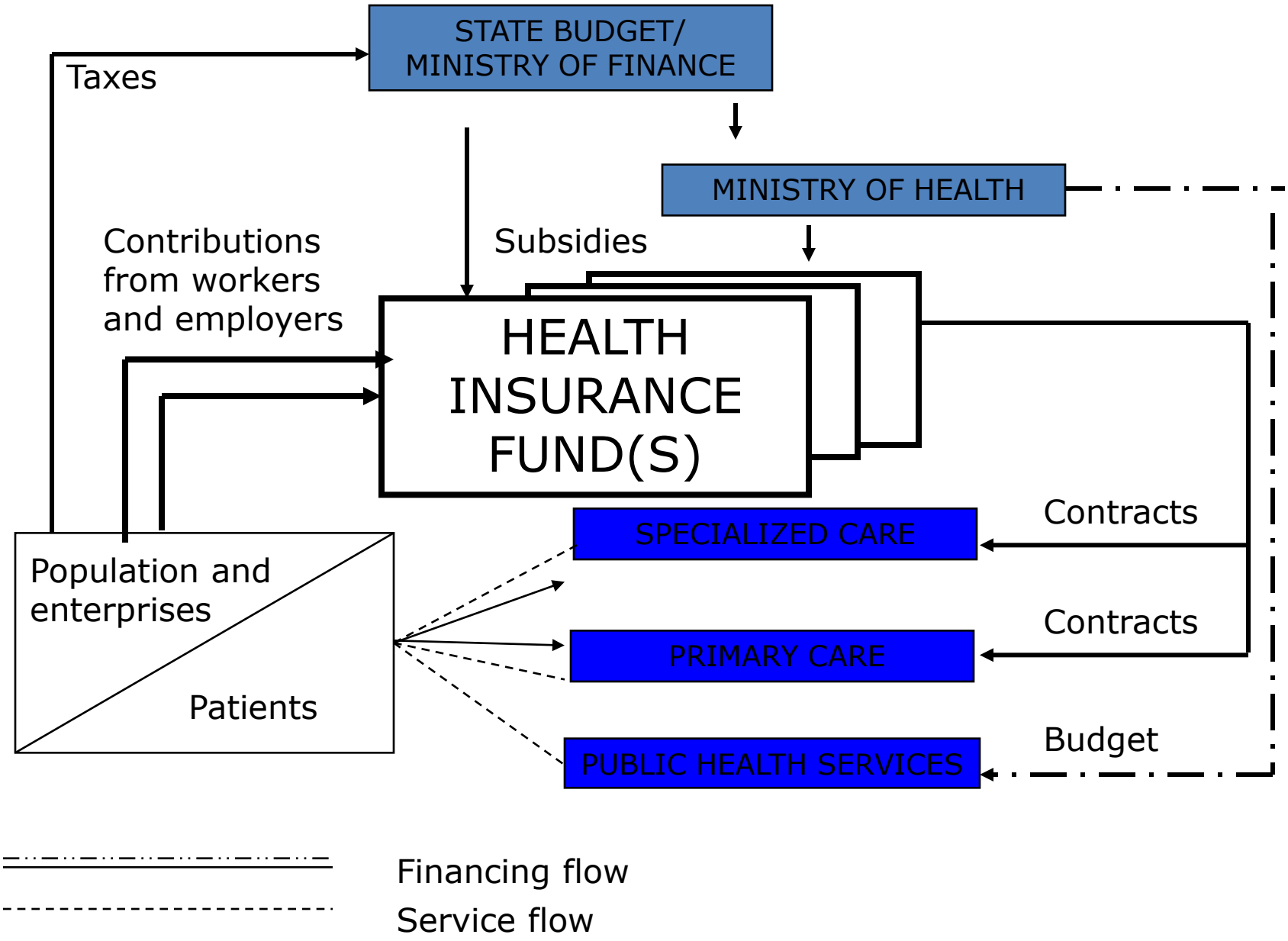
A “free market” (private finance and private provision) will not yield an efficient result in health because of “market failures”; various public policy interventions are feasible (e.g. *informing, regulating, mandating, funding or providing).*

But *governments also fail* (e.g. capture by powerful interests, populism above efficiency and consumer satisfaction, low supervision and implementation capacity, poor planning, corruption, etc).

Economic relationships embedded in health systems



BISMARCK MODEL ("SOCIAL INSURANCE SYSTEM")



Many countries achieve predictability and adequacy of health funding without need for systematic high level of State involvement in an area with an enormous degree of variability; they use Agencies and related quasi-governmental bodies with semi-public status instead.

Germany in particular uses Funds -that is: non-governmental bodies regulated by law with the mandate to manage those resources, of which in 2014 there were 132

Usual basic principles in this area:

- Free and voluntary agreements – no party to a contract can force another party to accept obligations (i.e. outside to some extent of the scope established by legislation);

- Equality of parties – parties to a contract are equal, regardless of ownership or other characteristics (i.e. the *authoritas* of the State is not directly included);

-Presumption of good faith –each party is considered to be consistent in implementing contract commitments properly (yet if depends on "what contrary" is proved…);

- Amicable settlement of disputes –i.e. if disagreement the dispute could be resolved in arbitration (but by definition, laws and decrees are not challengeable).

Launching the SHIF has not been the most difficult step reformers have faced in the European experience.

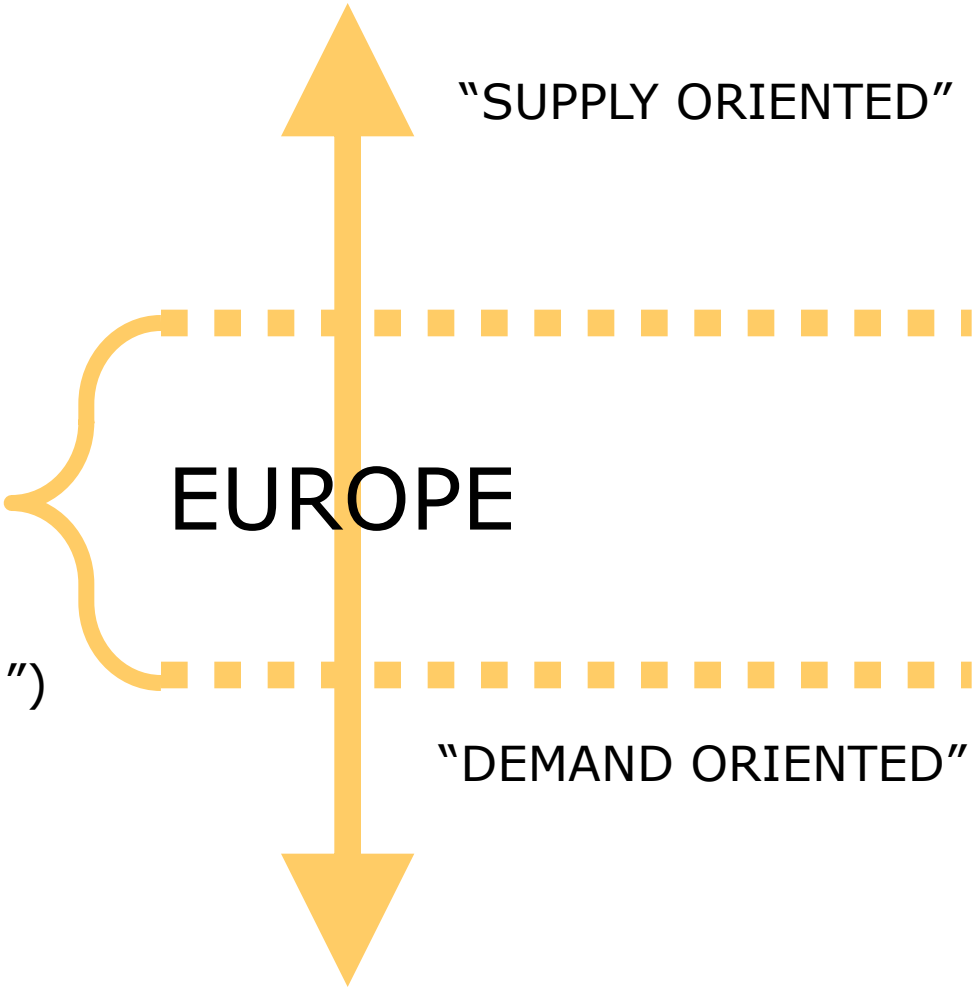
The really difficult part starts immediately afterwards

- New activities, new skills
- New context, need for a new "culture"
- Insufficiency of qualified resources

Big lessons learnt at world level

1. Get rid of the extremes

- SEMASHKO
- BEVERIDGE
- BISMARCK
- LIBERAL (OR "NO SYSTEM")



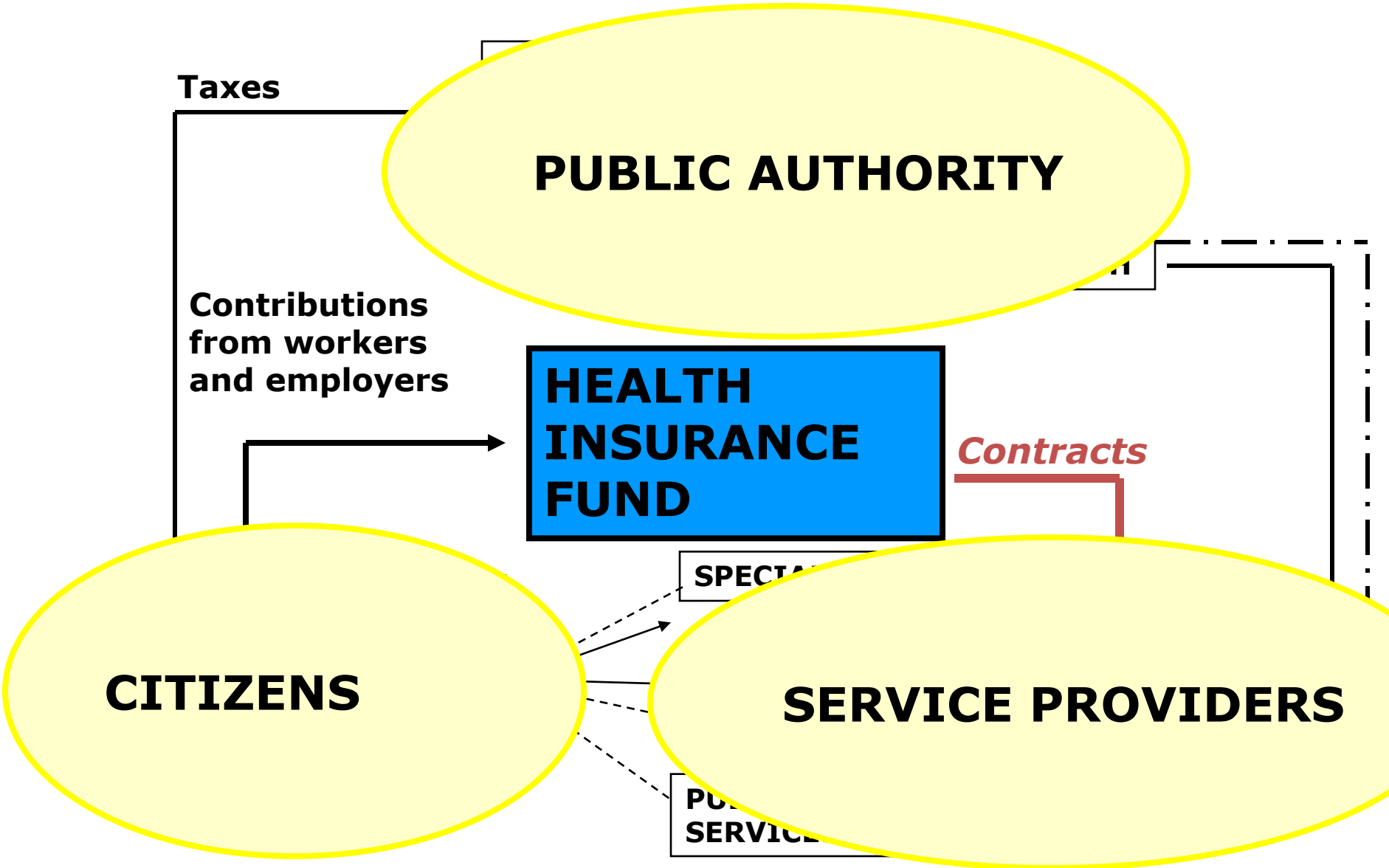
Hsiao, W.C. 1992, "Comparing Health Care Systems: What Nations Can Learn From One Another", Journal of Health Politics, Policy and Law, Vol 17, 4, 613-636

2. Better being pragmatic and mixing up!

	LIBERAL	*VOLUNTARY INSURANCE*	*COMPULSORY INSURANCE*	*NATIONAL HEALTH SERVICE*
GERMANY	+	++	++++	-
BELGIUM	+	+++	+++++	-
SPAIN	+	++	+	+++++
FRANCE	+	+++	+++++	-
ITALY	+	++	-	+++++
NETHERLANDS	+	+++	++++	-
UNITED KINGDOM	+	+	-	+++++
USA	+++	++++	++	+

THE CONTEMPORARY MIX OF HEALTH SYSTEMS MODELS

3. The way others do it: *separate functions and specialize*



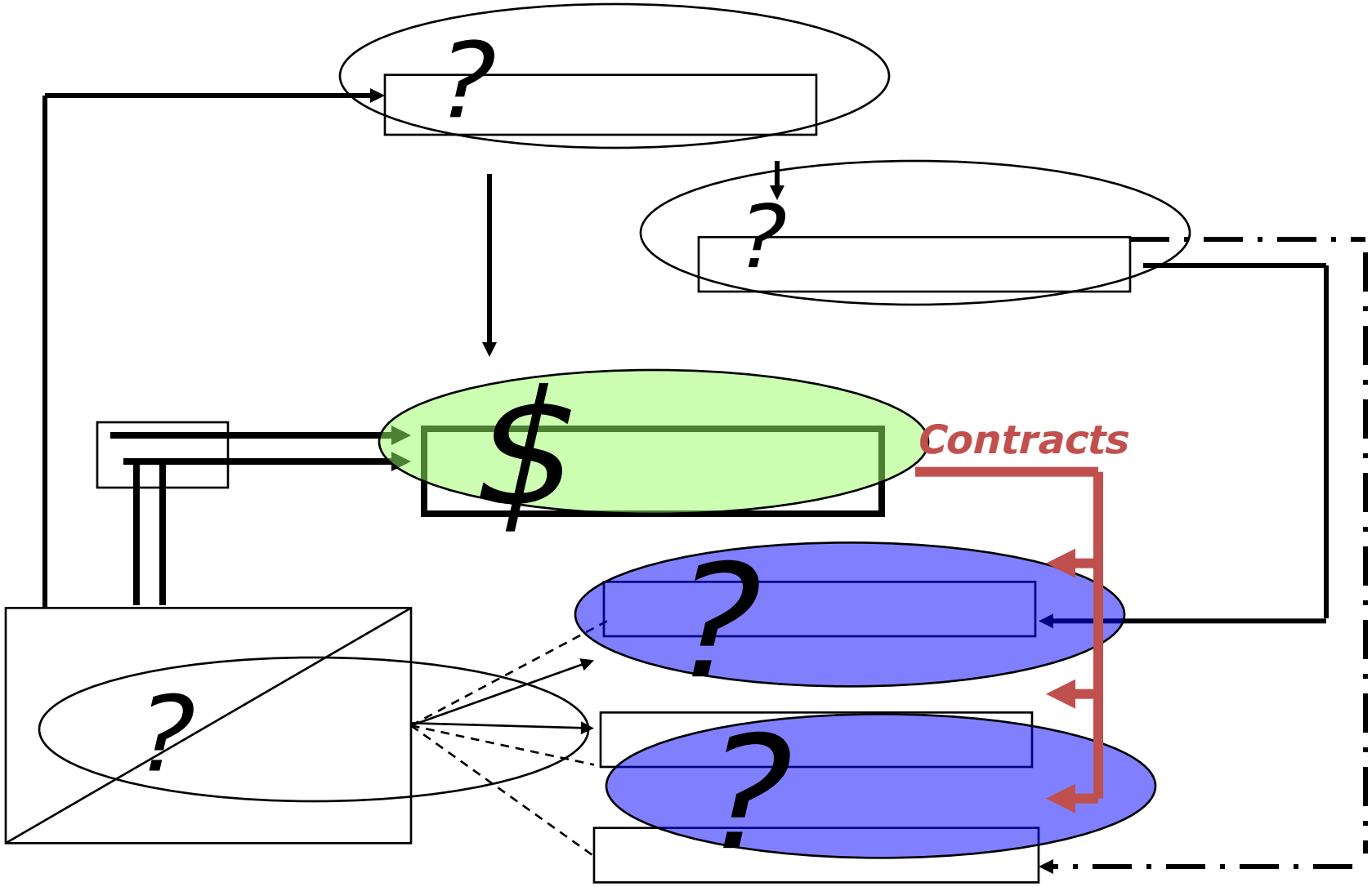
4. ABANDON TRADITIONAL RESOURCE ALLOCATION MODALITIES, namely:

- INTEGRATED RESOURCING
- RETROSPECTIVE BILLING OF SERVICES

And move towards forms of

CONTRACTING

5. Can strategic purchasing and contracting induce service provision improvement?



Contracts, in the health sector also: an attempt to govern *agency relationships* ensuring that the agent (the health care providers) acts in the principal(s)' (the purchaser) interests.

The main "tool", most practical and visible part through which a purchaser can influence a provider.

Duran A, Øvretveit J, Schneider M, Sheiman I, 2004, *Health care contracts* in Figueras J, Robinson R & Jakubowski E (Eds), "Purchasing to improve health systems performance", Open University Press, Buckingham, 187-214

Contractual ideal

- Specific volumes of care, at
- Certain unit prices,
- Performed by selected providers,
- Under strict quality specifications and
- With strong safeguards concerning risks and incentives

Local governments everywhere, interested in avoiding political problems with redundancy and closure of facilities) but recent progress in selective contracts in Germany, the Czech and Slovak Republics and the Netherlands.

Contracts for reimbursing service costs, refused.

Most health insurers have greatly reduced excess capacity through (i) operational purchasing plans, (ii) pre-admissions and hospital concurrent reviews and (iii) analyses of inefficiency zones in provision.

Wagstaff A, 2009, Social Health Insurance vs. Tax-Financed Health Systems—Evidence from the OECD. Policy Research Working Paper 4821.The World Bank Development Research Group, Human Development and Public Services Team. The World Bank Washington, https://openknowledge.worldbank.org/bitstream/handle/10986/4018/WPS4821.pdf?sequence=1

Content of health service contracts

(i) **a few sections**, namely

a. Preamble;
b. Rights and responsibilities of the purchaser;
c. Rights and responsibilities of the provider;
d. Contract duration, termination and variation, as well as

(ii) **some schedules** (Parties may adjust the provisions):

1. Types of Services and Volumes Covered;
2. Types of Drugs and Other Pharmaceuticals Covered;
3. Prices and Method of Payment
4. Quality and Performance Standards;
5. Procedures for Claims and Payments;
6. Requirements for Patient Records;
7. Content of Annual Reports;
8. Dispute Resolution Procedures.

10 key items in most contracts:

1. Objectives and definitions
2. Participating elements/eligibility for contracting
3. Types and volumes of services involved
4. Quality issues and standards
5. Prices, remuneration and invoicing
6. Monitoring (with indicators) –agent, tools…
7. Rewards and sanctions (for excellence/ default)
8. Extra-contractual payments, referrals, outliers
9. Specific duration, capacity and service locations
10. Notifications, confidentiality and restrictions

England hospital contracts , three separate documents (several hundred pages,) as follows:

1. General Conditions	2. Service Conditions	3. Local commissioning
- Review and Contract Management - Liability, Indemnity and Warranties - Assignment and Sub-Contracting - Variations - Dispute Resolution - Governance, Transaction Records and Audit - Contract Suspension and Termination - Data Protection, Freedom of Information and Transparency - Conflicts of Interest - Force Majeure - Governing Law and Jurisdiction	- Compliance with the Health care law and Regulatory Requirements - Essential Services and Service Standards - Service User Rights, Choice, Bookings, Referrals, consent and personalised care - Transfer of and Discharge from Care - Equity of Access, Equality and Non-Discrimination - Services Environment and Equipment - Service user health records and complaints - Service Development and Improvement Plan - Clinical Procedures and Protocols - Managing Activity and Referrals - Quality Requirements and Quality Incentive Schemes	- Effective Date and duration and relevant commissioning documents - The Specific Services, essential from the SGBP and non-essential, a - Indicative activity plan, transfer and discharge procedures etc. - Payment methods and rules - Quality requirements including quality incentive provisions - Governance and rules over use of mandatory material suppliers - Contract Management reporting and information requirements

In the public sector in Australia, much shorter health contracts (plus a massive background of calculations and references). In Victoria State, for example, 12-14 pages:

-One or two pages on Background and Policy Directions

-Four main sections of some three pages each:

Part A, including (i) Strategic overview, (ii) Mission statement, (iii) Service profiles, (iv) Strategic planning and (v) Strategic priorities;

Part B, with (i) Performance priorities, (ii) Financial performance, (iii) Access performance, and (iv) Service performance;

Part C, strictly reduced to Activity and funding; and

Part D, on Accountability and Funding requirements.

Experience with contracts in the last two decades: mixed picture

- US mostly hard contracts.

- Transition economies in Eastern Europe and Central Asia: struggling with contracts under very adverse circumstances

- Social insurance systems: rather detailed (yet far from "complete") contracts,

- UK and Beveridge systems: soft ("relational") contracts and networks, pilot experiences

Ham C, Smith J and Eastmure E, 2011, *Commissioning integrated care in a liberated NHS, Nuffield Trust, London*

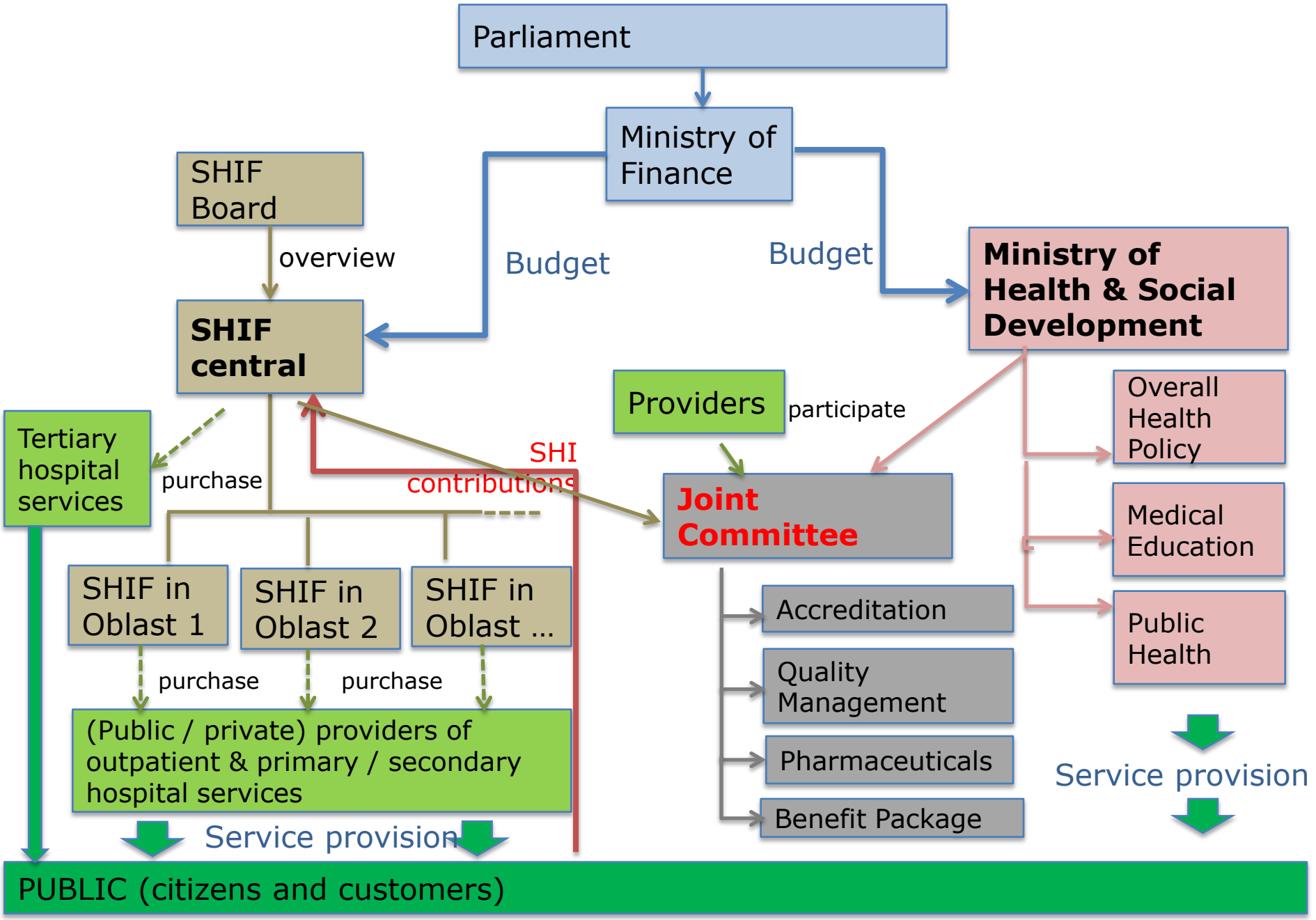
In most European countries, general trend towards higher product specification in all types of contracts, reflecting case-mixes.

Main expectation: to increase cost consciousness of providers and avoid manipulation of the workload structure.

During the nineties, prospective cost-per case payments according to diagnostic groups (DRGs) became the dominant form of payment of inpatient services (and increasingly used for outpatient services).

Duran A, Øvretveit J, Schneider M and Sheiman I, 2004, "Health care contracts", in Figueras J et al (Eds), "Purchasing to improve health systems performance", Open University Press, Buckingham, 187-214

Kazakhstan; overall new health system picture



Center stage needs to be given in contractual sphere to the SHIF as a main, *fully qualified* protagonist for purchasing (while State remains as guarantor of the law).

Transfer of central position compatible with keeping transitorily provisions on performance and quality of care, indicators and targets.

In due course, the list of service indicators will need to be reviewed (not a top priority in the short run until the SHIF is established).

Process of contracting, as important as any contract agreed at any particular time

Contracting provides a structured way to help purchasers and providers focus on key subjects, build a common understanding and reach agreement. The transfer of risks to service providers also depends on *how the negotiation between the payer(s) and the providers is designed*.

World Bank: "Seven Steps" in contracting:

1: Dialogue with stakeholders
2: Define the services
3: Design the monitoring and evaluation
4: Decide how to select a contractor
5: Arrange for contract management
6: Draft the contract and bidding documents
7: Carry out bidding /manage the contract

Loevinsohn B, 2008, Performance-Based Contracting for Health Services in Developing Countries, *A Toolkit,* Health, Nutrition, and Population Series, World Bank, Washington, p 20, DOI: 10.1596/978-0-8213-7536-5, http://siteresources.worldbank.org/INTHSD/Resources/topics/415176 1216235459918/ContractingEbook.pdf

Achieving greater value in health care means challenging the pattern of provision and service use - the product of the complex interaction of professional and public culture, regulatory systems, legislation and governance

Charlesworth A, Davies A and Dixon J, 2012, Reforming payment for healthcare in Europe to achieve better value, Nuffield Trust, p. 6-7

Payment to institutions -pay for:

-Lump sum for a period of time (global budget), with amount being calculated according to actual costs of units, historical spending patterns, bed-supply, or population covered;

- (More or less) Open-ended payment for a volume of services according to price list (fee-for-service payment), patient-days (daily charge) or activity measured by cases treated (case-mix payment). –

- Line by line expenses to recover costs (e.g.: salaries, investments, etc.)

Paying professionals: pay for

Availability of the staff? (salary and capitation)

Activity? (fee-for-service) or

Desired behavior and results? (P4P)

"There are many mechanisms for paying doctors; some are good and some are bad. The three worst are fee for service, capitation and salary"

(Robinson, J. C., 2001, "Theory and Practice in the Design of Physician Payment Incentives." Milbank Quarterly 79(2): 149-177.)

OPM recommendations re: service provision:

- Public and private provider institutions in Primary and Specialized Care (hospitals) will get public funds (PHC through weighted capitation and hospitals through DRGs) only if they meet certain quality requirements

- Provider institutions will need more autonomy and improve their management to ensure sustainability

- Current Sanitary-Epidemiological services Infrastructure to be optimized (regardless of PH remaining with MHSD);

-Provider institutions affiliated to other line ministries: to be decided (SHIF has no funding obligation);

-Raion hospitals currently funded by Oblasts: SHIF has no funding obligation

Kazakhstan, some recommendations

(i) Set up improved institutional accountability and a proper contracting process

(ii) Invest in human resources from the very start.

(iii) Avoid both perverse incentives and distractions

- Define unambiguously the desired outcomes (attributable to the incentive target);
- Measurable indicators and data availability.

In Conclusion

Many reasons for hope in Kazakhstan:

- extensive preparation/ right signals from the "Modernization Committee"
- motivated staff,
- ample experience,
- strong leadership…

Yet for the SHIF to succeed, service providers have to be ***fully on board***

Thank you very much