‘Strategic purchasing’ in different health financing models – four case studies from three Sub-Saharan African countries

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HEALTH ECONOMICS UNIT

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Aim of the Organised Session

- Draw on results from a **multi-country study** that critically examines the function of healthcare purchasing in ten low- and middle-income countries
- Focus on how different **healthcare financing models**, i.e. the public integrated, public contract, and private contract models, affect the occurrence of **‘strategic purchasing’** in Sub-Saharan African countries

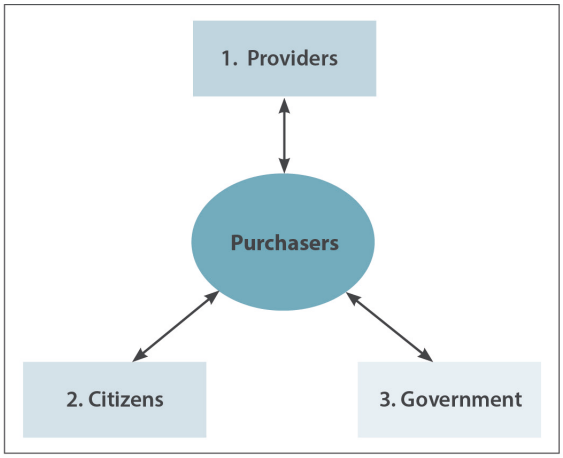
The RESYST multi-country study

- ***Purchasing*** – transfer of pooled resources to healthcare providers on behalf of population in exchange for healthcare services
- ***Limited empirical work*** undertaken on purchasing in LMICs
- Study examines how purchasing mechanisms are functioning in LMICs from a ***strategic purchasing perspective***
- ***Case study design***: the purchasing arrangements/mechanisms operating within a country are the 'case' in this study
- Each country study team selected between one and three existing purchasing mechanisms (cases) to be examined
- ***19 cases (purchasing mechanisms) in 10 countries*** are examined
- ***Qualitative study***: data to collection through document review, individual interviews and group discussions; use of both deductive and inductive approaches for data analysis

What is strategic purchasing?

- Do purchasers use their financial (and decision-making) power to promote improved quality and efficiency in the delivery of healthcare?
- Purchasing involves three sets of decisions
  - Identifying the interventions or ***services to be purchased*** to meet population needs, while taking into account national health priorities and cost-effectiveness
  - Choosing ***providers from whom services will be purchased***, giving due consideration to the quality, efficiency and equity of healthcare service provision
  - Deciding ***how these services will be purchased***, including contractual arrangements and provider payment mechanisms
- Strategic purchasing requires ***purchasers to use purchasing decisions to influence provider behaviour***; and in doing so, encourage providers to pursue equity, efficiency and quality in service delivery; and contribute to improved health systems performance

Three key strategic purchasing relationships



Adopted from Figueras et al. 2005

Key strategic purchasing themes in purchasing relationships

Assessment of how strategic purchasing functions requires examination of ***the three key relationships*** purchasers have with:

Healthcare providers

- The use of levers by purchasers to ensure that the healthcare provider delivers an appropriate mix of quality healthcare services, at an agreed price

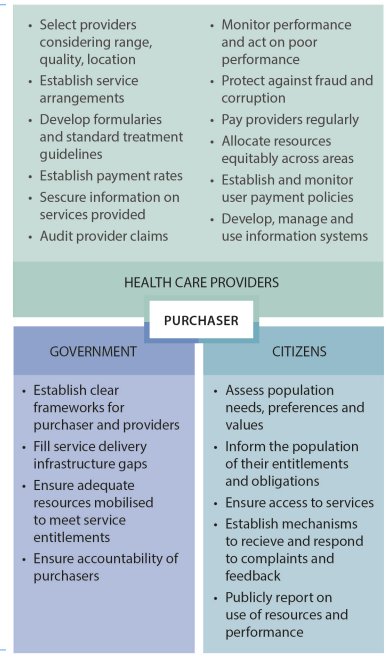
Citizens

- Purchasers are expected to be responsive to the needs and preferences of the people

Government

- Government is required to play a stewardship role by providing a clear regulatory framework and appropriate guidance to purchasers

Key strategic purchasing actions in relation to purchasers for providers, Government and citizens



Health financing models in the multi-country study

- Public integrated model
  - On-budget financing of healthcare provision by healthcare providers that are part of the government sector
- Public contract model
  - Public purchasers contract healthcare providers to supply services
  - Purchasers can be either state agencies or social security fund managers
- Private contract model
  - Private purchasers (insurance companies) contract healthcare providers to supply services

(Source: E Docteur and H Oxley 2003)

Case study presentations

- ***Nigerian tax-funded health system*** – issues inherent to an 'integrated' structure where purchasers and providers operate within a single organization
- ***Tanzanian tax-funded health system*** – the mechanism through which public purchasers at the decentralized level buy primary healthcare services for the population
- ***The Formal Sector Social Health Insurance programme (FSSHIP) in Nigeria*** – how 'two-tiers' of purchasers, i.e. NHIS and HMOs, work together to procure healthcare services for members
- ***The three private, voluntary healthcare financing mechanisms that operate in Kenya, i.e. CBHI, PHI, MHI*** – the differences and similarities between the three private contract mechanisms in terms of the structure of the purchaser and provider organizations and the nature of purchasers

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Can a public purchaser send signals to public providers to improve health systems performance? A case study from the Nigerian public integrated health system

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Description of the Nigerian public integrated system

Who is the purchaser?	The SMoH is responsible for the transfer of resources to primary and secondary health care providers
Government	House of Assembly, Ministry of Budget and Planning Commission, Ministry of Economic Planning Commission
Services purchased	Defined minimum package of care covering promotive, preventive and curative care at primary and secondary levels
Service Beneficiaries	All residents in the state who desire to use the services
Providers	Mainly public providers; private providers are used for some services, e.g. mortuary services, immunization, etc.
Provider payment	Facilities receive material resources from the MoH; health workers receive a monthly salary

Focus of presentation

- Purchaser-provider relationship
- Levers used by the State MoH, as purchaser, that can influence the efficiency and quality of healthcare service provision, and how the levers function in practice
- The levers include:
  - Monitoring mechanisms
  - Funding and payments mechanisms
  - Decision making and accountability

Monitoring mechanisms

- Various tools including M&E frameworks and supportive supervision exist in policy to ensure optimal provider performance and improve quality of service.
- In practice, monitoring of provider performance is weak and inconsistent.
- Implementation of M&E tools are limited, partly due to financial constraints and weak human resources capacity in MoH.

"I believe, from time to time, there should be monitoring of the health workers because assuming such monitoring is going on, they should have known that the caliber of staff we have here is not enough" (IDI Provider)

"We are supposed to be doing it [monitoring] monthly but we have not done it this year. No fund, if you allow the workers to do the work and you don't go and supervise them, of course they can do whatever they like[…]But because of fund, we can't move" (IDI Purchaser)

Payment mechanisms

- Providers do not receive direct funds from MoH but material resources drugs and equipment, part of funds accrued through user fees are again reverted back to MoH leaving limited funds for running facilities.

  "I think the ministry or the local government […] should play their own part in allocating certain funds for the running of the facility. Its only because we are getting enough clients here that we able to do certain things, otherwise there are facilities you will visit and the environment will look so untidy because there is no source of fund" (IDI Provider)

- Salaries, as a provider payment mechanism, are not linked to performance and does not send specific signals for efficient, quality health service delivery.

Decision making and accountability

- No rigorous auditing and accountability mechanisms are in place especially for smaller health facilities.
- Providers have limited involvement in purchasing decisions.

  "We have certain problems that we wouldn't even know how to relate it [to MoH]…I believe if we were involved in taking decisions, it will help a lot" (IDI Provider, 01)

Policy implications

- Purchasing health services within the tax-based health system in Nigeria is passive and ***the MoH does not effectively utilize existing tools*** to motivate healthcare providers to improve performance
- Strategic purchasing should be promoted using a range of tools, including improved monitoring and accountability mechanisms that positively influence the behaviour and performance of healthcare providers to produce better health outcomes

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Can decentralized public purchasers facilitate the strategic purchasing of primary healthcare services? A case study from the Tanzanian public integrated health system

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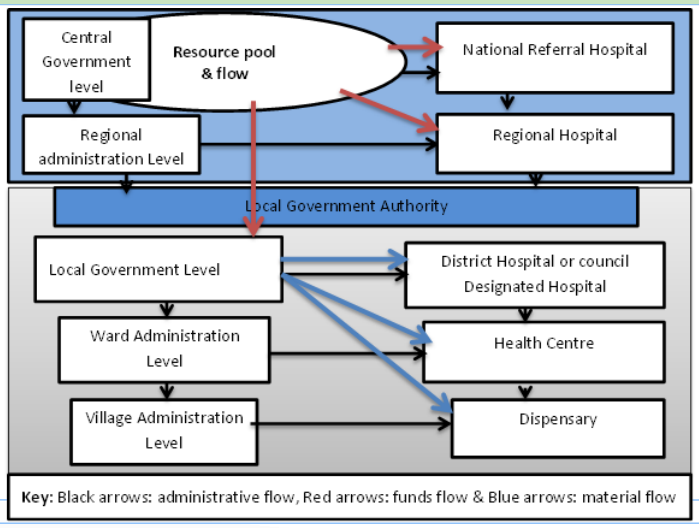
Description of the Tanzanian public integrated system

Who is the purchaser?	Local Government Authority (LGA)
Government	Ministry of Health and Social Welfare and Prime Ministers Office Regional Administration and Local Government
Services purchased	Primary health care (PHC) and district hospital services
For whom?	General population and Community Health Fund (CHF) members
Providers	Public PHC and district hospital services and contracted/ private facilities
How providers are paid	Payments to service providers is by line items and advance payment to contracted private facilities.

Link between the central and decentralized public purchasers



Focus of the presentation

- Examining whether the central government creates an environment that allows LGA to operate as a decentralised purchaser for primary healthcare services under the tax-funded health system
- Illustrating the challenges that LGA faces in undertaking strategic purchasing
  - Purchasing of PHC by the LGA
  - Provider payment mechanism
  - Resource flow
  - Resource allocation

The LGAs are both purchasers and PHC service managers

- The LGAs are both purchasers and managers of (primary) healthcare services under the decentralised system.

  "…at the council level [LGA] all the infrastructure belong to the LGA which is under the Prime Ministers Office Regional Administration and Local Government, the LGA own the public facilities and they are the one responsible to ensure people receive the service they need, they purchase and supervise the process [….], the Ministry of Health are responsible for assuring quality standards are met, they are dealing with developing the policies but they are also responsible in purchasing preventive services from national to council level…" (IDI, District Manager, Rural District Council)

  "…we own the public facilities and responsible to ensure our people get the needed services, we do the purchase also to private facilities…" (IDI, District Manager, Urban Council)

Purchasing of PHC services by LGAs

- The LGAs purchase/transfer all medical supplies/materials to public (PHC) providers, including those for complementary schemes, such as CHF.
- ***The overall purchasing function at the LGA is limited***, including the ability to purchase clinical services from private facilities as purchasing must not exceed a pre-determined budget ceiling set by the Ministry of Finance and Economic Affairs (MOFEA).

  *"…our system is big and receives different kinds of resources that we LGA through the District Executive Director controls, and the resources come according to **the pre-determine ceiling** allocated and providers are only limited in use according to **what has been allocated** by the ministry of finance…"* (IDI, District Manager, Rural District Council)

  *"…in the implementation process there is normally **a limited room with a complex bureaucratic process to reallocate the funds to facilities**, which affect choices of services that were not identifies during the planning…"* (IDI, District Manager, Urban District Council)

Frequent delays in funds from the central government

- The LGAs have experienced delays in receipt of funds from the central government (MOFEA), ***affecting the flow of supplies (from LGAs) to providers and ultimately affecting the quality of health services***.

  "…you know my sister [researcher] the challenge we are facing here is the funding, we expect to receive quarterly from the central government but ***the delay in disbursement is a common challenge****…its often worse at the start of the financial year July to September […], how can you succeed in such an environment and people do not understand that because what they want are services…"* (IDI, District Manager, Urban Council)

Ineffective resource allocation

- The Government uses a population-based formula to guide the allocation of public resources to districts (i.e. LGAs)
  - However, does not consider factors relating to local needs.
  - The budget can constrain the financial capacity of LGAs to operate effectively as healthcare purchasers.

  "…Planning starts at the facility level because health management team sits and set their priorities for dispensaries and health facilities for the respective year the population based formula that applies when funds are allocated to the council and not to service providers which limit the process of meeting the needs, maybe the formula is old […] more criteria's are necessary to provide a room to extent the coverage to service providers..." (IDI-health planning officer urban district)

Key policy implications

- The current public finance management framework under which LGAs operate limits the extent to which LGAs can undertake strategic purchasing.
- Separate the purchaser and provider functions at the LGA level
  - Give the autonomy to service providers to plan and use their own revenue for quality improvement.
- Good public financial management systems is important to impose a certain degree of flexibility to the providers in the use of inputs they have to achieve results.
  - Strengthening reporting and auditing use of financial resources
  - Extend the auditing process to include performance audit in order to assess efficiency in the use of LGA resources
- Proper formula should apply on allocation of resource to ensure equity in the distribution of resources from LGA level to individual service providers

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How do NHIS and HMOs work together as purchasers under the FSSHIP? A case study from Nigeria

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THE FSSHIP IN THE NIGERIAN NHIS

Purchaser (s)	• The NHIS as top level purchasers and Health Maintenance organizations (HMOs) as mid-level purchasers. • NHIS receives funds from the national government solely to purchase and pay for healthcare packages.
What services are purchased?	• Set packages of preventive and curative care ranging from primary to tertiary care. • Partial exclusions from high technology investigations (CT scan, MRI, etc.). • Total exclusions from occupational diseases, family planning and epidemics.
Who uses the services?	• Federal civil servants and organized private sector. • Currently just 5% of the Nigerian population.
Who provides the services?	• Public, private and faith-based healthcare providers
How are providers paid?	• Staff are paid salaries • Capitation payments for (primary) healthcare packages and fee-for-service (secondary care)

STRUCTURE OF HMOs AND NHIS

- Theoretically based on a full purchaser-provider split (PPS) model
- NHIS purchases primary, secondary and tertiary healthcare services for beneficiaries
- NHIS hires Health Maintenance Organizations (HMOs) to manage contracts between NHIS and providers – NHIS uses an accreditation mechanism to select HMOs
- NHIS sends funds to HMOs on a quarterly basis; HMOs make quarterly capitation payments to healthcare providers and reimburse fee-for-service payments according to claims received
- NHIS develops a framework for the operation of HMOs and oversees the work undertaken by HMOs

FINDINGS

- Compares Ideal practice (policy) and Actual Practice
- Following themes were identified:
  - ➢ Selection and regulation of HMOs and providers
  - ➢ Provider Payment mechanisms
  - ➢ Monitoring and Accountability mechanisms

SELECTION & REGULATION OF HMOS AND PROVIDERS

Ideal	Actual Practice
HMOs: NHIS is responsible for accreditation and registration of HMOs and is required to provide quarterly operation monitoring visits to HMO.	Due to financial and human resource capacity constraints and a number of political reasons, NHIS rarely oversees the work done by HMOs. *"In a year we were supposed to carry out monitoring and accreditation of about three thousand facilities per zone, You'd find out that you can't go to some facilities even once" (NHIS purchaser)*
Providers: NHIS is responsible for the accreditation and annual re-accreditation of healthcare providers.	Due to capacity and political constraints, re-accreditation of healthcare providers is not always undertaken.

PROVIDER PAYMENT MECHANISMS

Ideal	Actual Practice
NHIS receives funding from the Federal Government and subsequently transfers quarterly payments to HMOs. HMOs make capitation payment to providers and reimburse fee-for-service claims. HMOs send monthly and annual financial and service provision reports to NHIS.	Capitation payment from HMOs to healthcare providers is often delayed. Reimbursement of Fee-for-Service to providers by HMOs is also often delayed, partly due to a lengthy claim verification process. The delay in payment from HMOs, together with provider dissatisfaction with payment rates, has discouraged healthcare providers from treating FSSHIP members. *"…There is something they are doing now when you go to the hospital…they will ask you to wait that they are going to call the HMO to get approval to treat that illness…There was a day I was there till evening, and I didn't get the go ahead, and they asked me to go home…"* (Female FSSHIP member)

MONITORING AND ACCOUNTABILITY MECHANISMS

Ideal	Actual
The NHIS develops a framework for the operation of HMOs and oversees the work undertaken by HMOs. HMOs are required to provide quarterly visits to healthcare providers to ensure quality and efficiency in healthcare service provision.	Visits by HMOs are ad-hoc rather than regular quarterly as stipulated and sometimes covert; informal interviews of enrolees present at facilities during their visits; *"That's why I said that you cannot ask a provider whether he is giving a quality care and he will tell you no; he will always admit that he's giving a quality care. So how do you find out? It's from the patients" (HMO staff)*

KEY MESSAGES FROM STUDY

- Current arrangements between the NHIS and HMOs do not foster strategic purchasing.
- A reform of the NHIS is required which should give consideration to re-structuring purchasing organizations (i.e. NHIS and HMOs) in order to facilitate the administrative functions of healthcare purchasing by:

-----Improving the quality and capacity of purchasing administrators in terms of financial management.

-----Monitoring of healthcare providers to allow strategic purchasing to influence provider behaviour and improve healthcare service quality.

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Is the type of purchaser important? Examination of three private purchasing mechanisms in Kenya

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Private purchasing mechanisms

	Private health insurance (PHI)	Micro health insurance (MHI)	Community-based health insurance (CBHI)
Purchaser	For profit private enterprise	For profit subsidiary, private or social enterprise	Not for profit community-owned and managed
Government	Insurance Regulatory Authority	Insurance Regulatory Authority	Ministry of Labour, Social Security & Services
What is purchased?	All services*	All services*	All services*
For whom?	Premium payers : usually employees. About 700,000	Premium payers : SMEs, organized groups.	Contributors : Sub-location level. About 80,000
From whom?	Private and public providers	Public and mid/low-tier private providers	Public and low cost private providers
How are they paid?	Fee for service	Fee for service	Fee for service
At what price?	Some negotiation but provider power significant	Negotiation	Some negotiation but depends on public rates

Focus of presentation

Key findings from the cross-case comparisons

1. Contracting
2. Provider payment rate setting
3. Provider payment mechanism
4. Benefit entitlement design
5. Regulatory framework

Contracting

Contracts exist as the basis of relationship between purchaser – provider for all three mechanisms

Self-developed model contracts based on non-statutory generic template and, for CBHI, simplified to accommodate community literacy

"Relational" contracting widely utilized especially to resolve conflict, with sanctions rarely imposed, but also due to provider power

> *"… you know you have to convince in a simple way, or in a cleverly manner, so that perhaps next time if your person comes back that person will not be treated badly…" CBHI_15*

Rate setting

Provider power because of:

- Multiple revenue streams including from out-of-pocket
- Limitations in quantity, quality and geographic spread
- Control of statutory rate setting and licensing processes

MHI greatest negotiators because they can influence revenue streams for small private providers

> *"Yes…so there are institutions that have only one revenue stream; so they only- they depend majorly or predominantly on [PHI] for their funding, so you can influence their behaviour." PHI_10*

> *"And if these providers are not on the marketing plan, then the purchasers are not able to get business" PHI_06*

Provider payment mechanisms

Widespread use of fee for service; new methods e.g. capitation resisted by providers

Limited use of other efficiency levers e.g. standard treatment guidelines or essential drug lists: left to providers

Limited monitoring of quality, some monitoring of costs: limited information sharing, low capacity, provider resistance

"No they don't, what happens with them is that once you have a license from the board then they assume that everything is OK…" KII_20

"So those ones generally even if you don't have the claims here with you, you pay them without even invoices and wait to get the invoices " PHI_04

Benefit entitlement

PHI: choice, ability to pay, wide range of high-cost, individual-risk based insurance products with a range of cover limits

MHI: simplicity and affordability with a limited variety of moderate cost, family-based insurance products with access to a limited number of providers and moderate cover limits

CBHI: limited range of community-defined and priced family-based packages with access to a limited number of providers and low cover limits

Regulatory framework

No statutory or regulatory framework to support strategic purchasing practice for all three mechanisms

PHI & MHI: Accountability mechanisms predominantly financial

CBHI: Strong social accountability for various aspects of performance; extends to advocacy for non-CBHI members

"Now, through IRA what I can say they do all it's not being very seriously taken. Obviously they will look at the performance of the business both in terms of revenue and profit…But beyond that they don't."PHI_04

"…even those who are not part of our schemes we still want them to be part of, to achieve the quality care…we want all people to be treated the same." CBHI_04

Policy implications

Stewardship needed for private mechanisms e.g.

- PHI & MHI: integration other rate setting mechanisms to reduce medical inflation
- CBHI: recognition and support for potential to expand coverage of universal coverage initiatives

Overall purchasing framework to allow for strategic purchasing activities:

- Resource mobilization for universal coverage
- Benefit entitlement that matches needs and not demand, and protects from financial catastrophe
- Accountability that extends beyond finances
- Efficiency and quality improvement

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Agenda for future research

- Strategic purchasing in the public integrated system – ***how the current public management framework constrains public purchasers*** from using levers strategically to influence provider behaviour
- ***How the government / central purchasers can establish governance arrangements*** that allow a decentralised purchaser to undertake tasks to achieve their roles and responsibilities
- Public and private contract systems – ***rules and regulations to allow purchasers to fully function*** in their roles and fulfil their responsibilities
- How ***the mixture of provider payments influences provider behaviour*** in healthcare service provision and ***the extent to which parallel financing flows undermine the ability of purchasers*** to undertake strategic purchasing