SESSION #10: FOCUSING ON PRIMARY HEALTH CARE MARKETS
Outline of presentation

1. Intro to primary care markets
2. Primary care markets in OECD vs. developing countries
3. Swedish case study: Moving from public provision to mixed delivery
4. Contracting in primary care markets
5. Strategic purchasing
6. Group exercise
Definition of primary care

‘that level of a health service system that provides entry into the system for all new needs and provides person-focused care over time’

Primary care— the backbone of the health system

Equity  Quality of care  Efficiency
Stewardship vs market forces in RMNCAH-N markets

Markets organized along continuum of stewardship vs market forces

Stewardship forces dominate

- Acute inpatient services
- Diagnostics, elective surgery and specialty services
- Primary care
- Cancer diagnosis
- Surgery for ectopic pregnancy
  - Tubal ligation
  - Fistula surgery
- Maternity services
- Pediatric services
  - FP and RH services (including LAPM)
  - Adolescent RH
  - Antenatal and post-partum care
  - Management of chronic illnesses (HIV/AIDs, TB)

Market forces dominate

- Product distribution
  - Sourcing, warehousing and distribution of FP commodities, zinc, ORS, supplements, malaria nets
- Retail pharmacy, drug shops
  - Retail of FP commodities, zinc, ORS, supplements, malaria nets
  - Rapid diagnostics (anemia, glucose, HIV/AIDs, malaria, RTI, pregnancy, STDs, TB)
<table>
<thead>
<tr>
<th>Country</th>
<th>Predominant form of ownership</th>
<th>Private portion %</th>
<th>Country</th>
<th>Predominant form</th>
<th>Private portion %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Private</td>
<td>89</td>
<td>Japan</td>
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<tr>
<td>Austria</td>
<td>Private</td>
<td>80+</td>
<td>Korea</td>
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<td>Luxembourg</td>
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<td>Canada</td>
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<td>Netherlands</td>
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<tr>
<td>Denmark</td>
<td>Private</td>
<td>NA</td>
<td>New Zealand</td>
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<tr>
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<td>88</td>
<td>Norway</td>
<td>Private</td>
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<tr>
<td>France</td>
<td>Private</td>
<td>65</td>
<td>Portugal</td>
<td>Public</td>
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<tr>
<td>Germany</td>
<td>Private</td>
<td>76</td>
<td>Spain</td>
<td>Public</td>
<td>97</td>
</tr>
<tr>
<td>Greece</td>
<td>Private</td>
<td>60</td>
<td>Sweden</td>
<td>Neither is dominant.</td>
<td>NA</td>
</tr>
<tr>
<td>Iceland</td>
<td>Public</td>
<td>95</td>
<td>Switzerland</td>
<td>Private</td>
<td>NA</td>
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<tr>
<td>Ireland</td>
<td>Private</td>
<td>NA</td>
<td>Turkey</td>
<td>Public</td>
<td>NA</td>
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<tr>
<td>Israel</td>
<td>Public</td>
<td>NA</td>
<td>United Kingdom</td>
<td>Private</td>
<td>100</td>
</tr>
<tr>
<td>Italy</td>
<td>Private</td>
<td>65</td>
<td>United States</td>
<td>Private</td>
<td>Approx. 100</td>
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</table>

Only 6/26 OECD countries have predominantly public provision.
Primary care in developing countries

- Comparable data on institutional characteristics of health system in developing countries are lacking
- Demographic and Health surveys show where people access care, but sometimes difficult to distinguish between retail and primary care markets
- Many developing countries, rely on public provision of primary care with an often unregulated private sector
Where people seek care depend on the service...

Private dominate for child’s diarrhea and fever & cough, but public providers dominate for antenatal care, delivery & modern contraception

Source: Grépin (2016)

Author’s analysis of data for the period 1990–2013 from 205 Demographic and Health Surveys.
Large differences between countries and regions

Source: Grépin (2016)
Where people seek care depend on socio-economic status

Urban and wealthier women are more likely to use private sector than rural and poorer women.

Source: Grépin (2016)
Swedish Choice Reform
–from public primary care to mixed delivery
Background to Swedish health care system

- Governed primarily at the regional level by 21 autonomous county councils
- Locally elected every 4\textsuperscript{th} year

- NHS type, tax-based system
- Financed 80% from local income taxes, 15-20% national government grants + user fees
Primary care system before reform

- Reimbursement method: global budget
- Predominantly public providers
- GPs salaried employees by county council
- Multi-disciplinary teams managed by county council
  - 4 to 10 GPs, nurses, physical therapists and dieticians
- Allocation of primary care centers centrally planned
  - Based on population statistics, health care needs and equity and access goals
Primary care BEFORE the Choice Reforms

- **Operational Autonomy**: 0% (No conditionality)
- **Customer Competition**: 100% (Total conditionality)
- **Market Prices**: 100% (Total conditionality)
- **Freedom of Market Entry and Exit**: 100% (Total conditionality)
- **Financial Autonomy**: 100% (Total conditionality)
- **Contract Conditionality**: 0% (No conditionality)

Total conditionality: 0%
No conditionality: 100%
Challenges – limited access & responsiveness to patients
Goals of more structure vs. more market reforms

MORE STRUCTURE
Equity in Reach and Distribution?
Great control over quality?

MORE MARKET
Responsiveness to patients?
Increased Efficiency?
Private Investment?

Structuring & Market Forces Have Opposite Potential Strengths and Weaknesses
The Choice Reforms

- **Objectives:** increase access to services, responsiveness to patients and better conditions for private entrepreneurship

- **Logic:** Patient choice and competition between public and private providers under fixed price regime leads to improved quality and responsiveness to patients

- **Process:** started as a local initiative in one county in 2007 that was replicated by others. Based on these experiences, mandatory national regulation

- **2010 National Law:**
  - Free establishment of providers with entry contract
  - Patient choice (money follows the patient)
  - Other aspects of reform defined locally
Money follows the patient. Provider revenue is dependent on whether provider attracts new patients.

From global budget to capitation and fee-for-services
- Centers receive a fixed sum per listed patient (capitation fee) (40-100% of reimbursement) + payment per visit (risk-adjusted to avoid patient selection) + results based payment

14/21 counties pay extra to providers located in remote areas to ensure equity.

Competition neutrality key principle -- public and private providers compete on quality of care.
Primary care AFTER the Choice Reforms

- **Operational Autonomy**: 0% - 100%
- **Customer Competition**: 0% - 100%
- **Market Prices**: 0% - 100%
- **Freedom of Market Entry and Exit**: 0% - 100%
- **Financial Autonomy**: 0% - 100%
- **Contract Conditionality**: Total conditionality - No conditionality
Institutional arrangements

- County councils new role as PURCHASERS & STEWARDS OF MARKET

- Institutions that support the new governance structure:
  - **The Swedish Competition Authority** evaluates the competitive conditions primary care market
  - **Kammarkollegiet** provides procurement support to the counties and a national website for tender docs
  - **National Board of Health and Welfare** supervises and monitor the quality of care and operations
  - **Swedish Association of Local Authorities and Regions** offers legal advice, process support and organize conferences for local authorities that are implementing the reforms
  - **Swedish Agency for Health and Care Services Analysis** analyzes health care and social care services from a citizen perspective and provides independent policy advice to the Swedish government
  - **Dialogue groups** between county councils and all providers
Results of Choice reform

- **Accessibility** ↑ new establishment of private providers particularly in densely populated areas, # visits per capita increased

- **Equity** ? everyone benefitted but population with higher health status, income and education benefitted more

- **Quality** ? because measure few indicators but existing ones are improving

- **Patient satisfaction** remained unchanged but people like choice

- **Costs** have been stable (18% of THE)
Challenges...

- Number of visits have increased but what about **quality of care**?
  - Do providers prioritize ‘easy’ patients?
  - Or split up visits to earn more?
  - Reimbursement system revised to improve equity – introduction of Care Need Index (CNI) and Adjusted Clinical Groups (ACG)
Challenges

- **Ownership** – many small providers bought by large healthcare companies
  - What implications have this market structure and patients? Private-equity ownership?
  - Should ownership have been regulated?
  - Were public clinic sold to a fare price?

- **Competition Neutrality** – is public and private treated equally?
Trust Based Strategy

Only trusted providers are allowed in the implementation network
Two **distinct approaches** to contracting in primary care markets

<table>
<thead>
<tr>
<th>Traditional contracting</th>
<th>Institutional contracting</th>
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<tbody>
<tr>
<td>is a contracting process where.....</td>
<td>is a contracting process where.....</td>
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<tr>
<td>the <em>identity</em> of contractual partners <em>changes</em>;</td>
<td>the <em>identity</em> of contractual partners <em>is stable</em> over time;</td>
</tr>
<tr>
<td>the <em>exchange</em> of services and/or goods for payment <em>is the focus</em> of negotiation and agreement; and,</td>
<td>the <em>process</em> of interacting and means of <em>coordinating</em> is the focus of negotiation and agreement; and,</td>
</tr>
<tr>
<td>This form of contracting <em>enables exchange of services/goods</em> between contracting parties.</td>
<td>This form of contracting <em>crafts a governance structure</em> among contracting parties.</td>
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</tbody>
</table>
Traditional contracting of primary care services

**Contract for services to specific target group:**
The Government of Uruguay contracts with an NGO that provides services for mentally ill children.

**Contract for services to specific geographical area:**
Bangladesh contracting service providers in urban areas.
Contracting --- pathway to strategic purchasing

- People
- Revenue collection
- Pooling
- Purchasing/payment
- Service provision
- People
Strategic purchasing requires …..

1. Decide where to locate pooling and purchasing agent (who will supervise the agent?)
2. **Build pooling and purchasing capacity**: pooling, contracting of providers, timely payments to providers, monitor performance of providers
3. **Decide what to buy and from whom**: define sustainable basic benefit package & who to contract with
4. **Decide how to pay providers**: public/private, co-pay, incentive structure
5. Implementation may require policy/law changes → autonomy (can providers react?)
6. **Strengthen supervisory role of MOH**: evaluate contract performance/entry eligibility
7. **Evidence-based health policy**: Monitor, evaluate, adjust
Key obstacles to realizing efficiency gains from strategic purchasing

- Unclear mandate and accountability of the purchaser
- Lack of political will to actually change resource allocation
- Persistence of line-item budgets
- Lack of provider autonomy
- Poor information systems and lack of accountability measures

Source: Cashin 2016 “Provider payment reforms as a driver of the efficiency agenda: What have we learned?”
Evidence based approach: over half of health facilities private, hence included them in performance-based financing (PBF) scheme

With PBF, private & public facilities have performance contracts for provision of a package of services

All health facilities with a PBF contract receive:
- PBF subsidies proportional to their performance;
- Coaching and quarterly supervision to improve performance;

All contracted facilities produce monthly reports for the MOH

Subsidies are higher for private sector to match higher costs of provision

Successful PBF pilot is now being scaled up nationwide
Cameroon PBF stimulated the private sector to increase availability of services...

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| % of health facilities providing FP at the start of PBF and during the ten following quarters |
|---------------------------------------------|------------------------------------------|------------------------------------------|
| Non Faith Based                             | Faith-Based                              | Public Health                            |
| % of health facilities offering FP at the start of PBF                                      |
| % of health facilities offering FP during the ten months following PBF                      |

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| % of health facilities providing PMTCT at the start of PBF and during the ten following quarters |
|---------------------------------------------|------------------------------------------|------------------------------------------|
| Non Faith Based                             | Faith-Based                              | Public                                  |
| % of health facilities offering PMTCT at the start of PBF                                    |
| % of health facilities offering PMTCT during the ten months following PBF                    |
Group exercise

- Map your country’s primary care market in the market forces framework
- Name a reform that you are currently implementing in primary care
- Is it a “marketizing” or a “structuring reform?”
- If the reform is implemented, how would it change the mapping of your primary care sector in the market forces framework?