MANAGING MARKETS FOR HEALTH

SESSION #10: FOCUSING ON PRIMARY HEALTH CARE MARKETS

GLOBAL FINANCING FACILITY

SUPPORTED BY WORLD BANK GROUP

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'

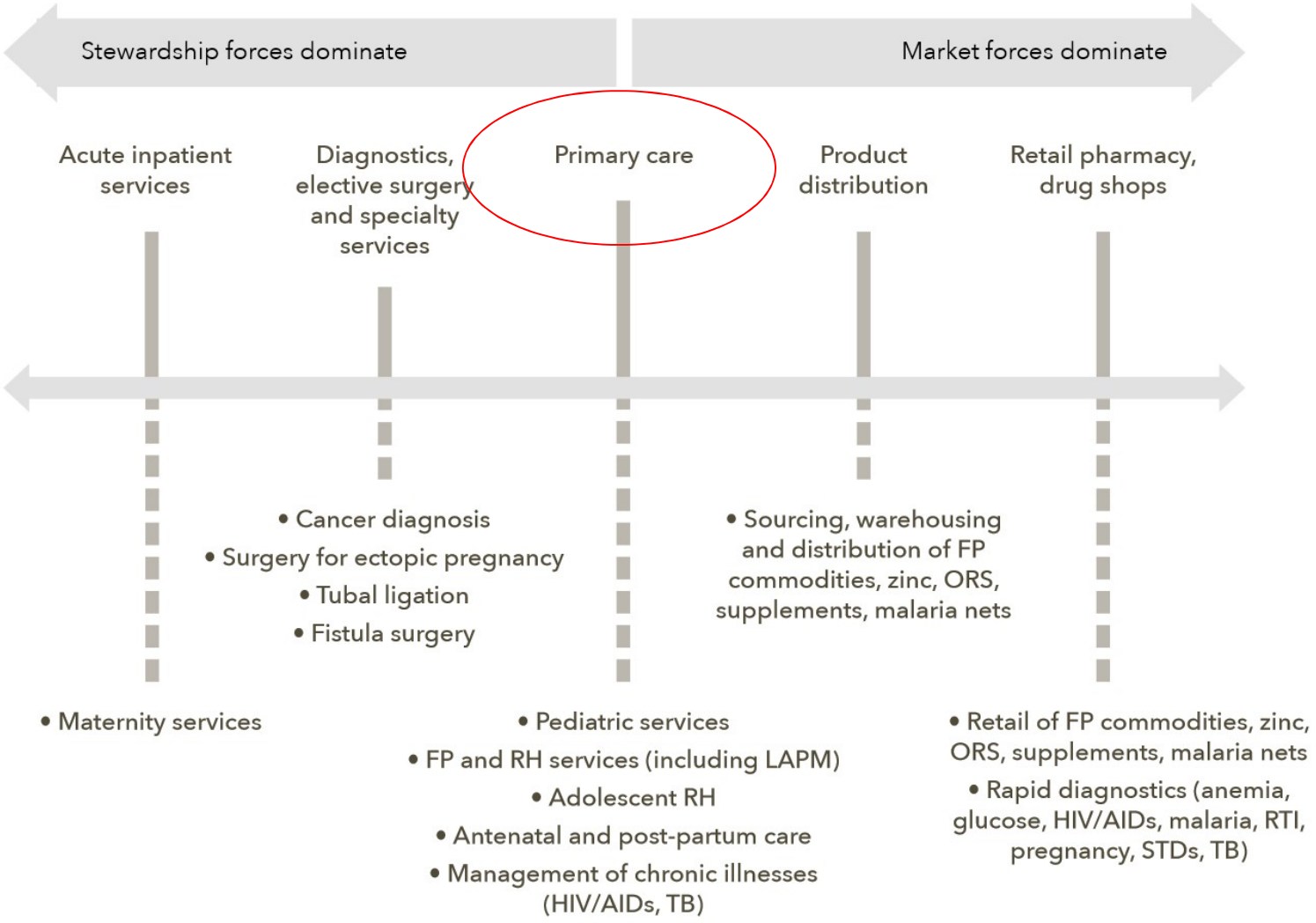
Starfield B. Primary Care: Balancing Health Needs, Services, and Technology. New York: Oxford University Press; 1998

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



Predominant form of ownership & share of private provision in OECD countries

Country	Predominant form of ownership	Private portion %	Country	Predominant form	Private portion %
Australia	Private	89	Japan		
Austria	Private	80+	Korea		
Belgium	Private	75	Luxembo		
Canada	Private	52	Netherland		
Denmark	Private	NA	New Zealand		
Finland	Public	88	Norway	Private	
France	Private	65	Portugal	Public	100
Germany	Private	76	Spain	Public	97
Greece	Private	60	Sweden	Neither is dominant.	NA
Iceland	Public	95	Switzerland	Private	NA
Ireland	Private	NA	Turkey	Public	NA
Israel	Public	NA	United Kingdom	Private	100
Italy	Private	65	United States	Private	Approx. 100

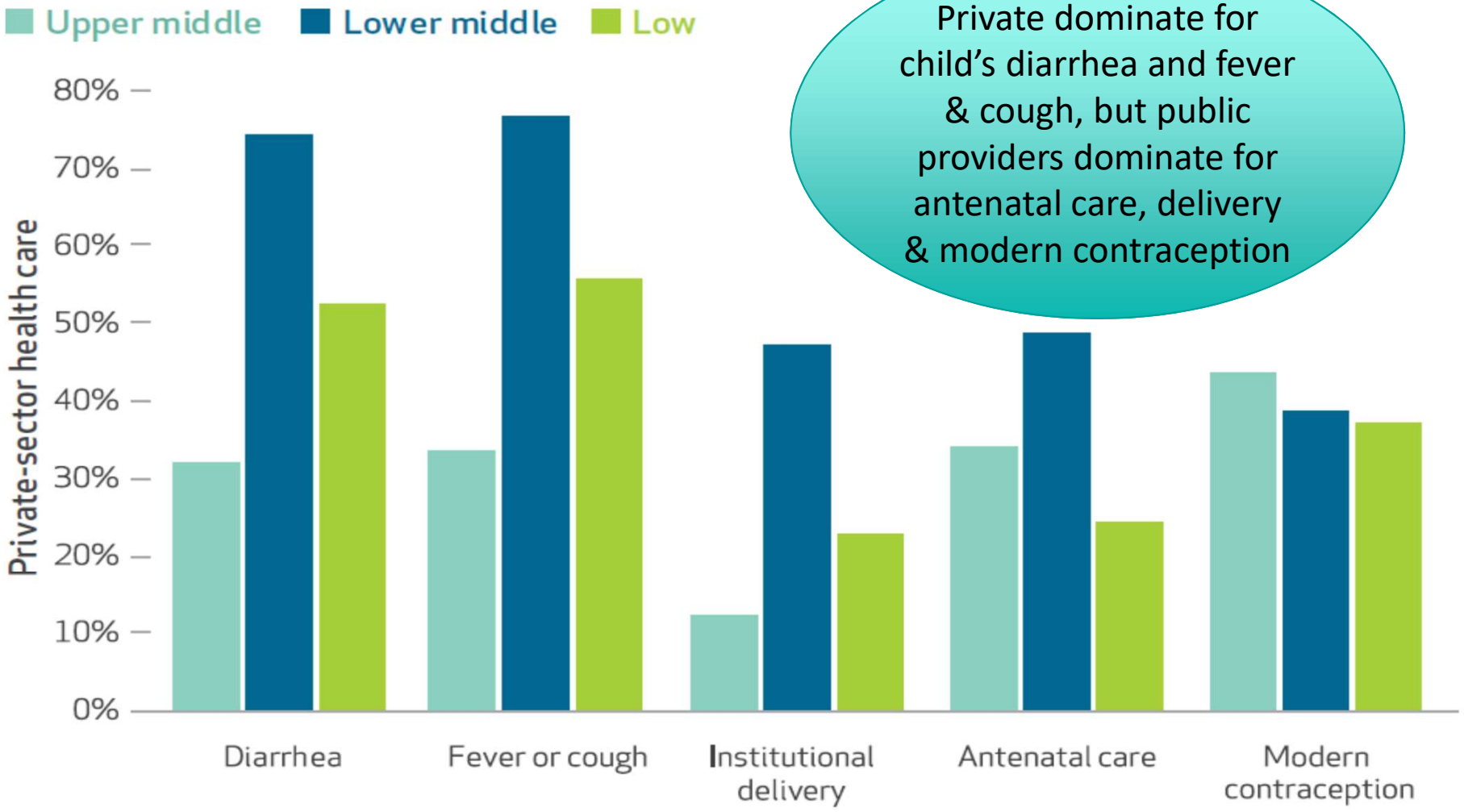
Only 6/26 OECD countries have predominantly public provision

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…

Average use of private-sector health care in seventy low- and middle-income countries, by country income group and service type

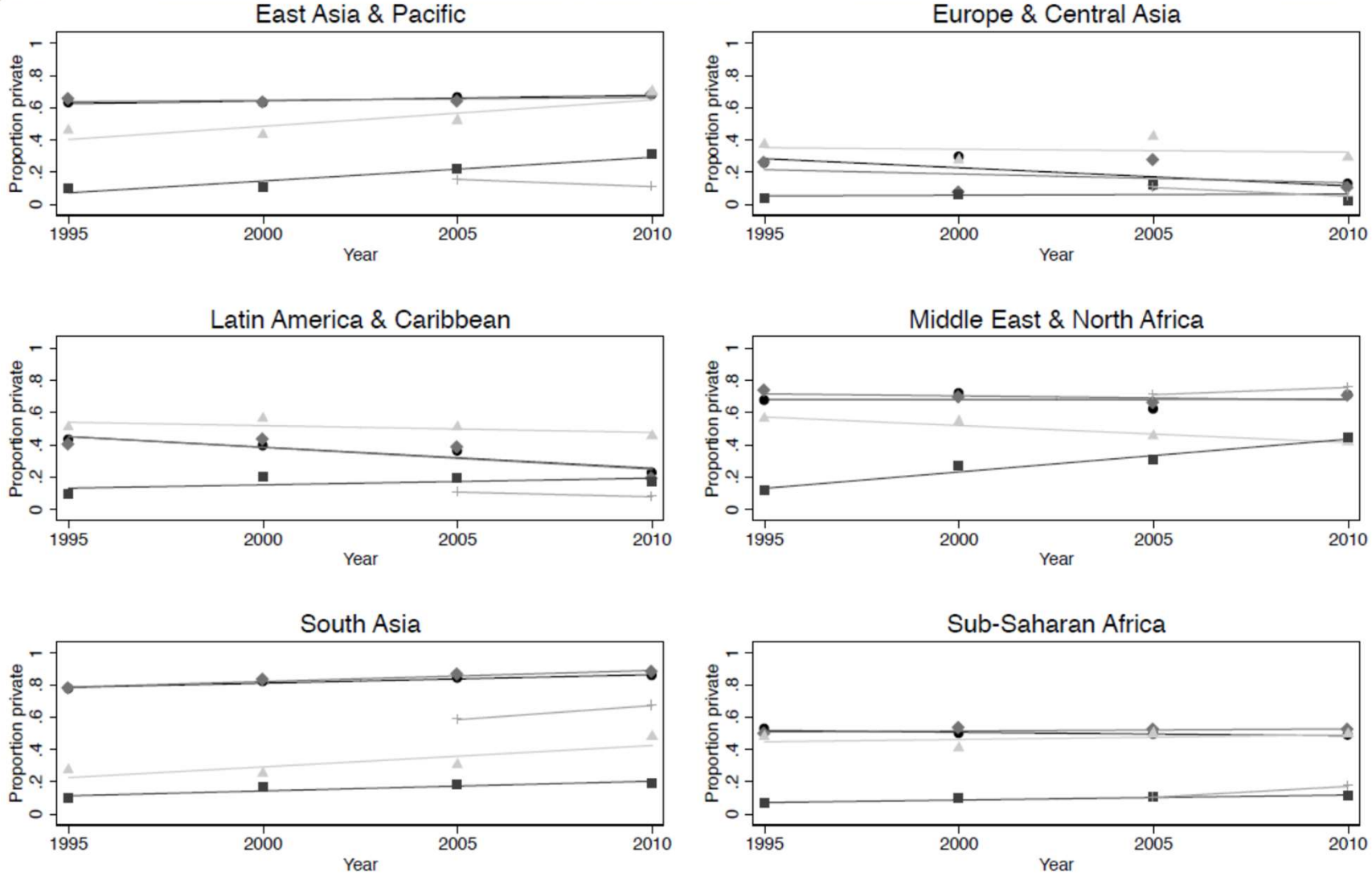


Private dominate for child's diarrhea and fever & cough, but public providers dominate for antenatal care, delivery & modern contraception

Source: Grépin (2016)

Author's analysis of data for the period 1990–2013 from 205 Demographic and Health Surveys. NOTE

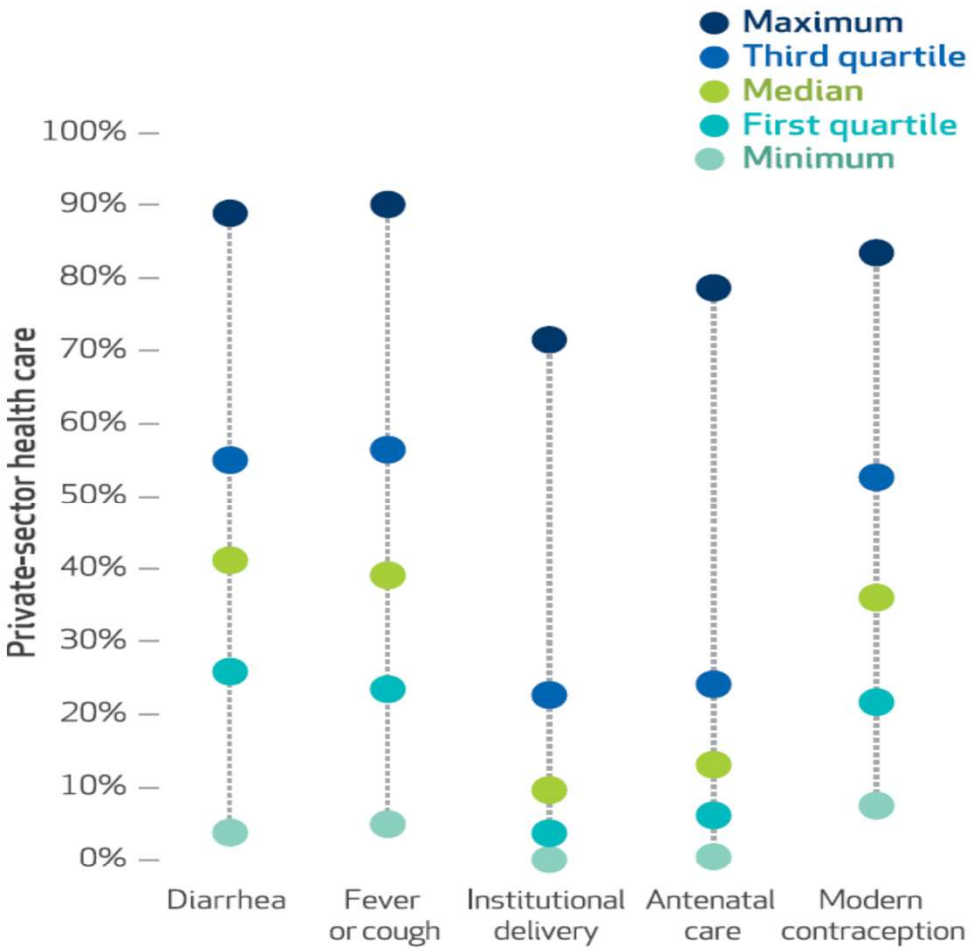
Large differences between countries and regions



Source: Grépin (2016)

Where people seek care depend on socio-economic status

Private-sector health care use in selected low- and middle-income countries, by service type



Author's analysis of data for the period 2009–13 (round 6) from forty-three Demographic and Health Surveys. **NOTES** Countries included are those with recent surveys. Median, interquartile, minimum, and maximum values of all surveys in the sample are depicted in the graph.

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

Decentralized

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

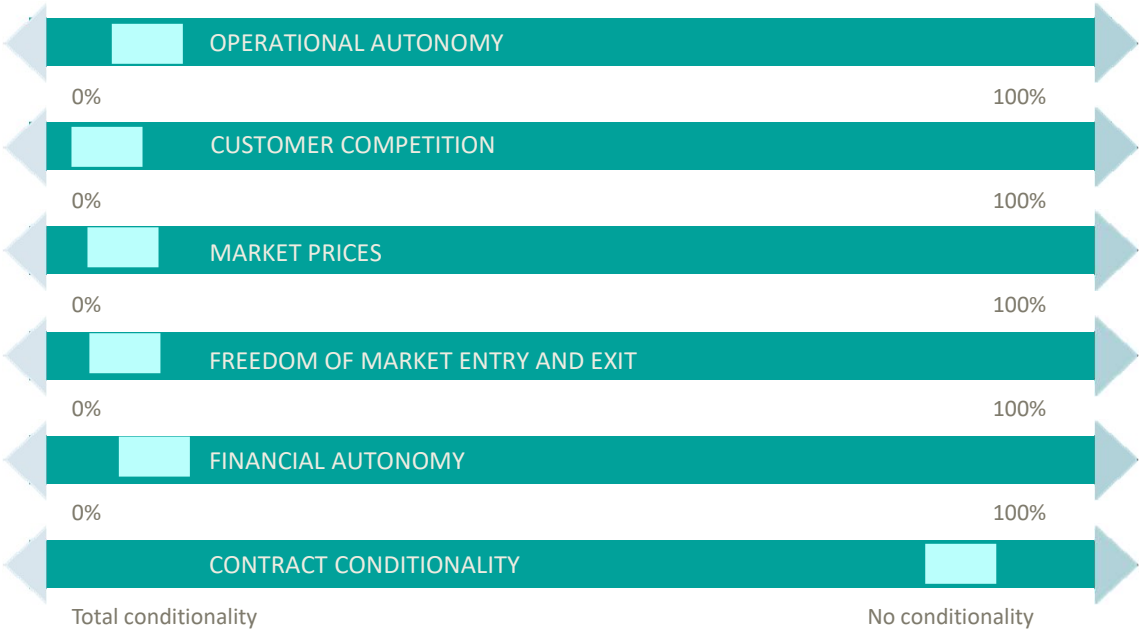
Publicly financed

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

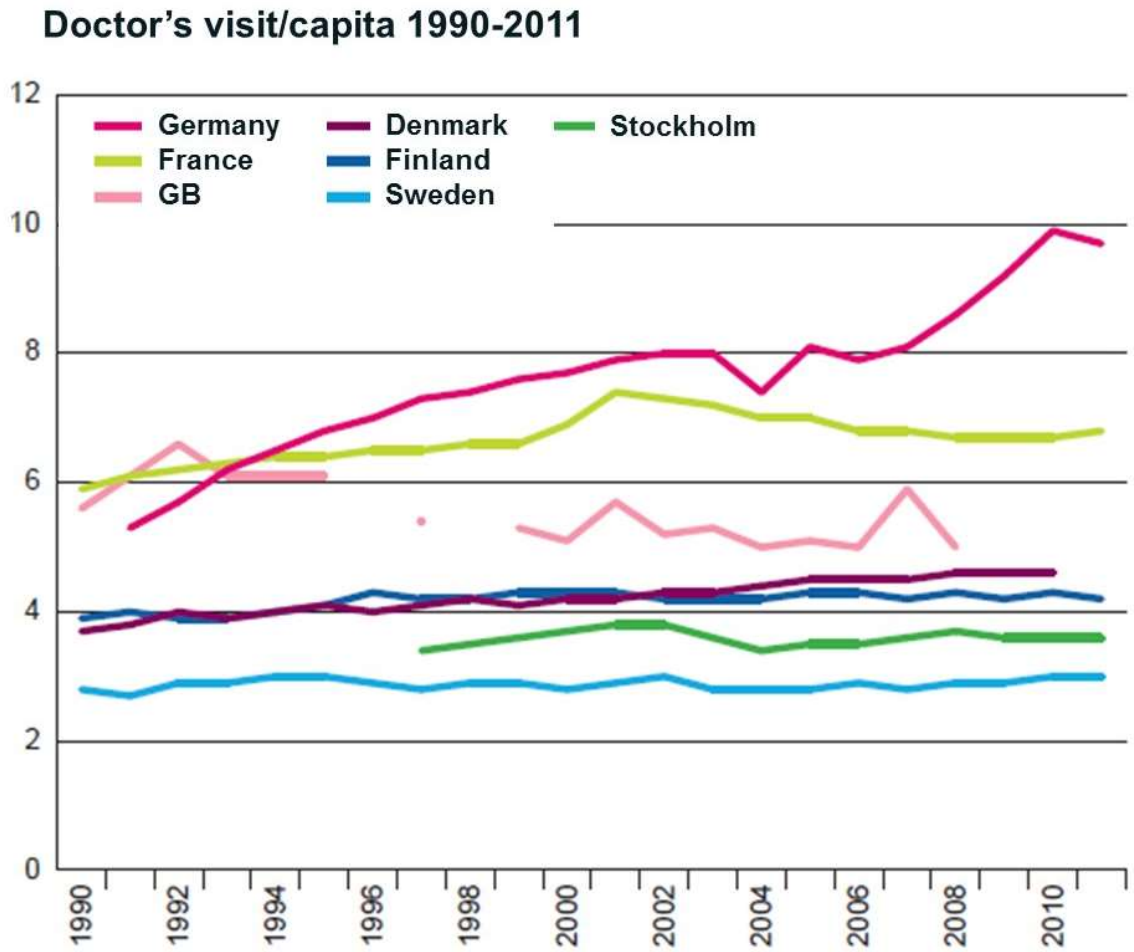
Primary care system before reform

- 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

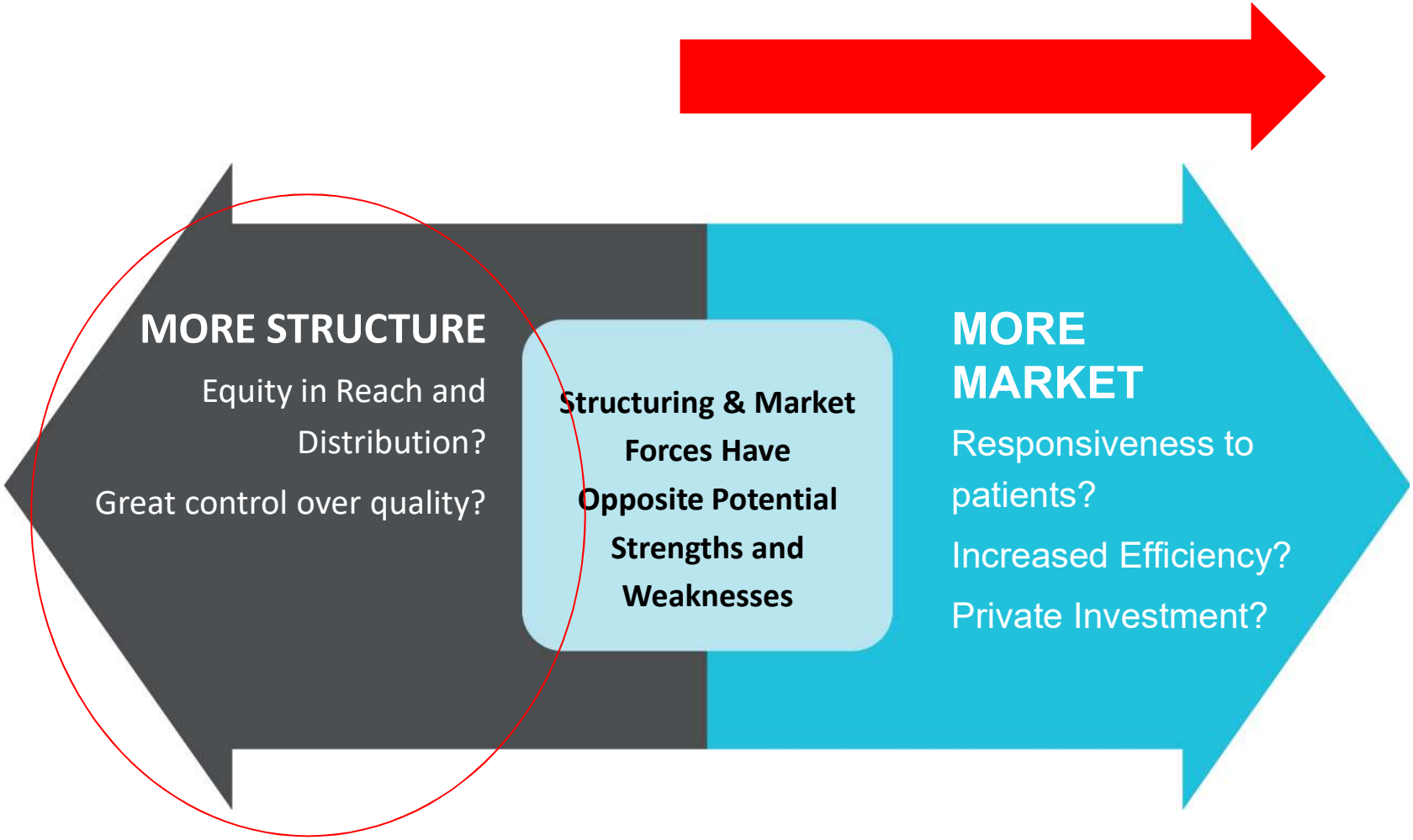
Primary care BEFORE the Choice Reforms



Challenges – limited access & responsiveness to patients



Goals of more structure vs. more market reforms



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 intiative 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

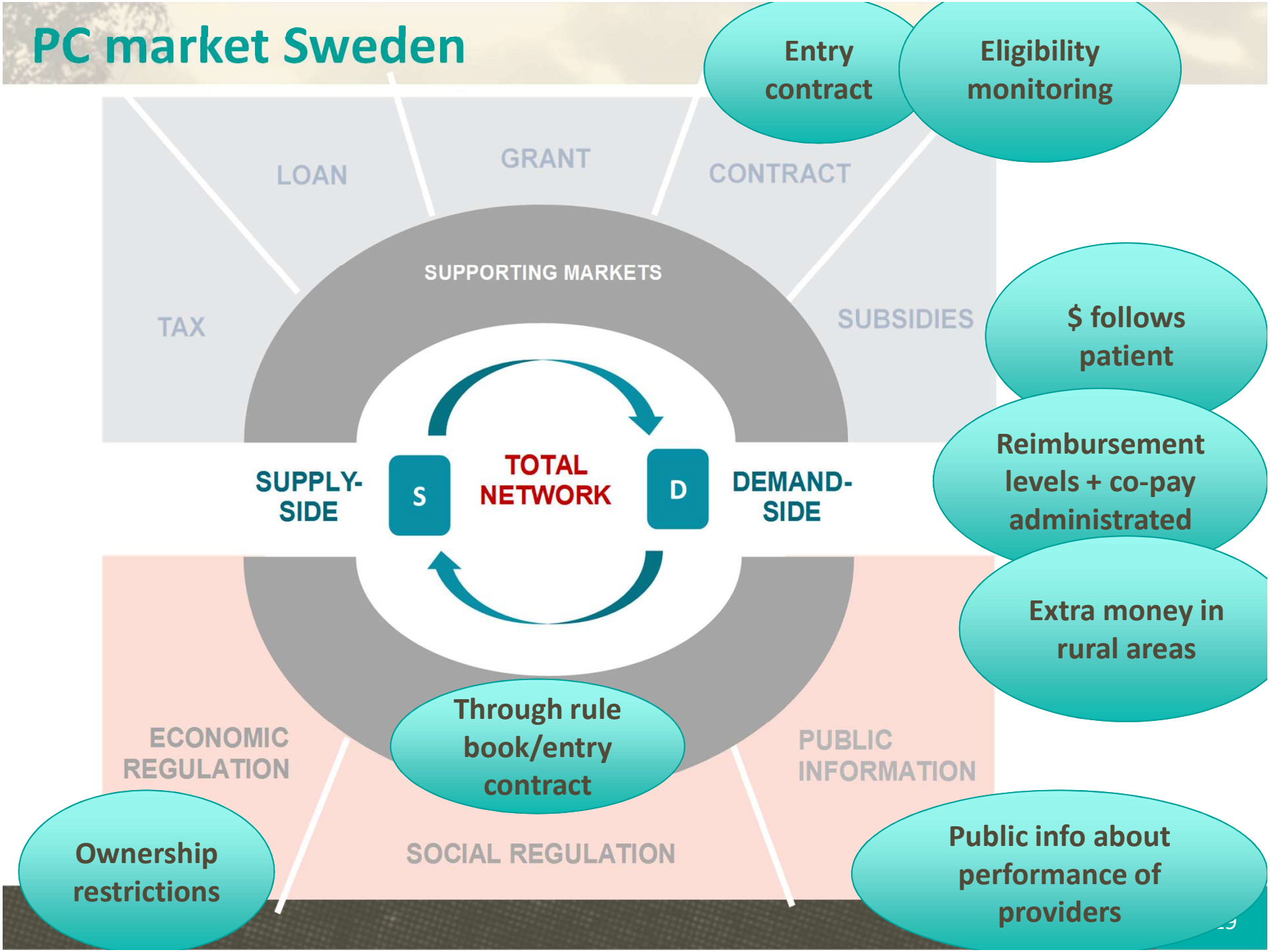
  Patient choice (money follows the patient)

  Other aspects of reform defined locally

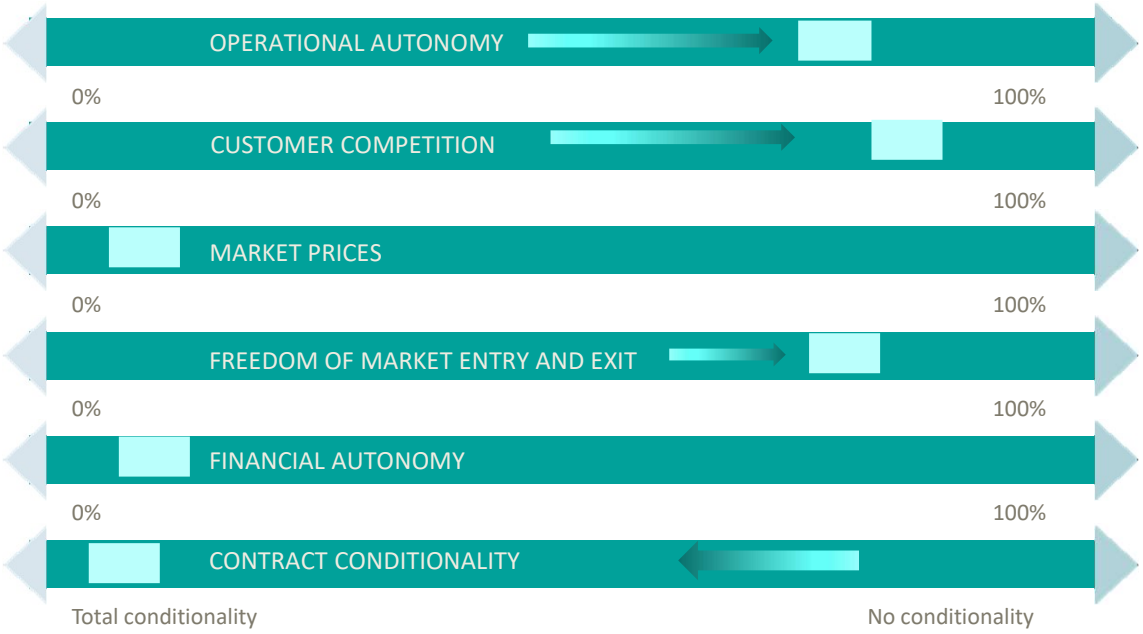
The reform

- 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

PC market Sweden



Primary care AFTER the Choice Reforms



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)

"First we're going to run some tests to help pay off the machine."

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

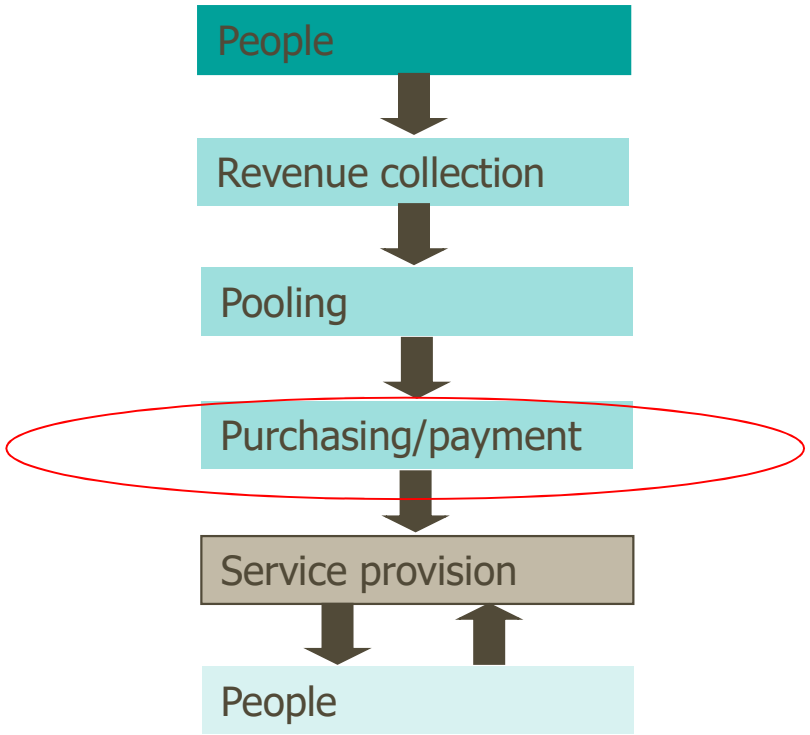
Traditional contracting is a contracting process where…..	**Institutional contracting** is a contracting process where…..
the *identity* of contractual partners *changes*;	the *identity* of contractual partners is *stable* over time;
the *exchange* of services and/or goods for payment *is the focus* of negotiation and agreement; and,	the *process* of interacting and means of *coordinating is the focus* of negotiation and agreement; and,
This form of contracting *enables exchange of services/goods* between contracting parties.	This form of contracting *crafts a governance structure* among contracting parties.

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



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

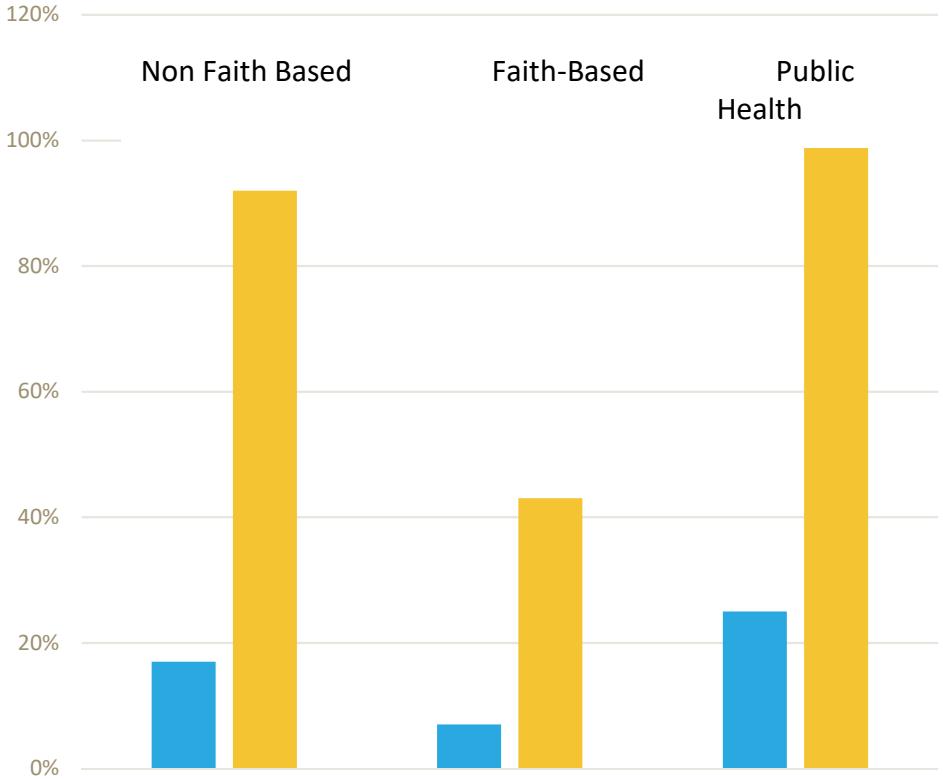
Source: Cashin 2016 "Provider payment reforms as a driver of the efficiency agenda: What have we learned?"

Example of contracting in Cameroon

- 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…

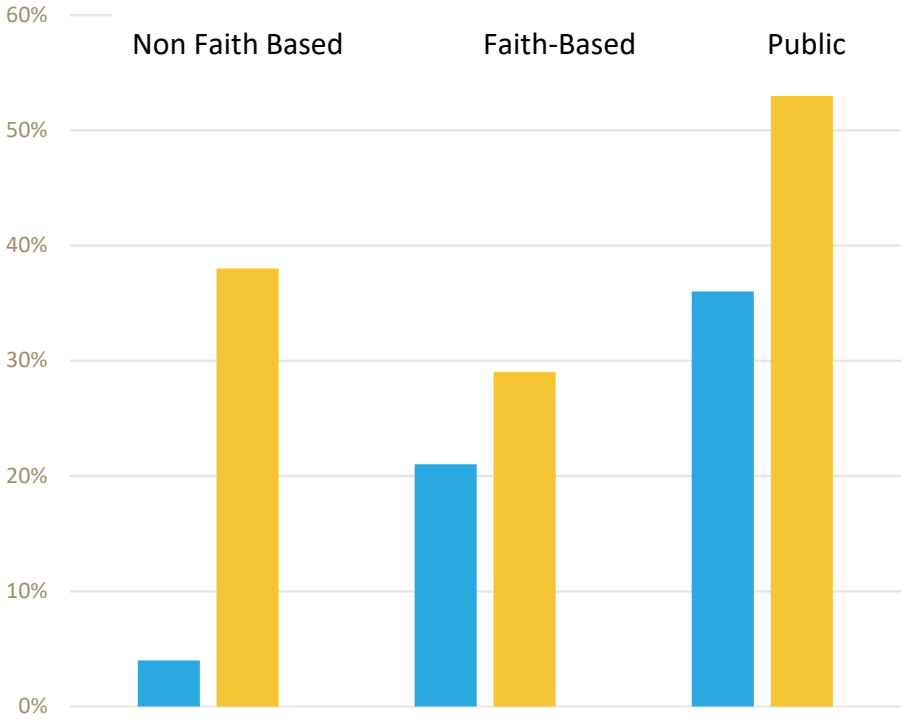
% of health facilities providing FP at the start of PBF and during the ten following quarters



% of health facilities offering FP at the start of PBF

% of health facilities offering FP during the ten months following PBF

% of health facilities providing PMTCT at the start of PBF and during the ten following quarters



% 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?