



Paying for Health Services: Making Purchasers Accountable

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In all health systems, providers must be paid for their services. That payment can come from two sources: directly from the individual patient, or from an organization paying on behalf of the patient—or some mix of the two. This note focuses on the second type of payer, which I shall describe as a ‘strategic purchaser’ of health services, to distinguish it from the patient as a purchaser.

In both developed and lower income settings, strategic purchasing is one of the weakest functions of health systems. Many payers passively reimburse providers for services rendered, and make no systematic effort to limit the range, volume or quality of those services. Instead, providers are controlled (if at all) through crude mechanisms such as lists of approved services, global budgetary limits and various types of accreditation.

Accountability of organizations is key

A central requirement of all successful organizations is an accountability arrangement that measures achievement of organizational objectives, and that ensures remedial action is taken when needed. There are a number of basic requirements if accountability is to function effectively.

These include:

- Clarity about the organization’s objectives
- Organizational autonomy to make decisions in pursuit of those objectives
- Metrics to measure progress towards the objectives
- A system of governance to assure proper scrutiny of achievement
- Appropriate rewards or sanctions for management.

If one or more of these desiderata is not in place, it is unlikely that the organization can be held effectively to account.

The motivation for this note is the belief that improving the accountability of strategic purchasers of health services is

a fundamental requirement for securing improved effectiveness of the purchasing function. It therefore first examines the scope of strategic purchasing. The note then describes the various types of purchaser found in health systems. Finally, it examines the existing mechanisms by which strategic purchasers of health services are held to account, and concludes with some comments on purchaser autonomy.

What is strategic purchasing?

The World Health Report 2000 introduced the notion of strategic purchasing of health services, and argued that it had three principal components: What interventions to buy? From whom to buy them? And how to buy them? I consider each briefly in turn.

- Considerable analytic progress has been made in advising on what interventions to buy. The notion of cost-effectiveness enjoys widespread acceptance as an appropriate technical basis for priority setting, and some developed countries have put in place health technology assessment agencies to make the principle operational. However, setting health service priorities is an intensely political process, and many countries and their purchasers find it very difficult to make explicit the limits to the services being offered. When the national health basket is specified explicitly, local purchasers are rarely given a great deal of autonomy to alter it, except perhaps at the margin.
- There is a continuing debate about the appropriate role of competition amongst providers of health services. However, it is likely that some element of

contestability in the provision of services, carefully implemented, is likely to lead to better outcomes than monopoly supply. The purchaser therefore has a fundamental role in stimulating the market, assuring contestability, and putting in appropriate safeguards when competition in supply is not feasible. An important decision is whether to rely on patient choice as the driving force behind competition (with money following the patient), or to place directly, block contracts for specified levels of service from providers (in which case it is likely that some inhibition of patient choice will be required).

- In deciding 'how' to buy, the purchaser has a number of key decisions to make in the design of contracts and payment mechanisms. The objective should be to incentivize the required mix, volume and quality of services, at minimum overall cost, without impinging on the provider's managerial decision-making. To that end there have been numerous experiments with payment mechanisms (global budgets, fee for service, case payments). In general, none of these appears to secure satisfactory levels of quality, so attention recently has focused on explicit quality incentives, in the form of various forms of pay-for-performance mechanism.

What form do strategic purchasers take?

Although it is necessarily present in almost all health systems, strategic purchasing takes many different forms. It is possible to distinguish five broad categories of purchasing arrangements:

- Private health insurers
- Competitive social insurers
- Employment-based social insurers
- Local health authorities (implementing national health insurance)
- Local governments.

In practice, most health systems rely on a mix of such arrangements. However, it is usually possible to identify a dominant model in use. It is also important to note that in many low income settings, strategic purchasing sits alongside a very large market in individual purchase of health care, funded by out-of-pocket payments. Each of the five models is considered in turn in Table 1.

How can strategic purchasers be held to account?

The effectiveness of purchaser accountability arrangements depends on two fundamental elements: performance information, to support proper scrutiny of the purchaser; and mechanisms for taking action to hold the purchaser to account.

The breadth and quality of performance information is central to the effectiveness of accountability arrangements. Without extensive, high quality and timely performance information, it is rarely possible for citizens, patients, governments or regulators to hold strategic purchasers to account. At the very least, public reporting of performance offers the prospect that the media, patient groups, healthcare professionals, researchers and individual citizens can scrutinize and comment on the effectiveness of purchaser arrangements. Comparative performance information should also act as the fundamental tool with which those charged with governing the purchaser are able to hold management to account. In practice, of course, the availability and quality of many performance data are often poor.

The three main external mechanisms for holding strategic purchasers to account come from markets, electoral processes, and national governments and their regulators. None of these is without difficulties.

The pressure from markets arises when individuals, employers or other collectives have the option of changing purchaser when they are not happy with the incumbent. Whilst such contestability is likely to offer important pressures for quality and efficiency improvement, experience has shown that excessive reliance on markets can lead to adverse unintended consequences. In particular, in the absence of good clinical outcome data, insurers may place a low emphasis on clinical quality, instead focusing on visible characteristics (such as the availability of high technology equipment) likely to attract the target membership. Competition has also led to widespread evidence of insurers seeking to 'cream skim' healthier insurees, and to avoid higher risk patients, even in social insurance systems. Furthermore, the short time horizon associated with the enrolment period can militate against integrated care and preventative interventions.

Local electoral processes can also contribute towards independent scrutiny of purchasers. Countries have ex-

Table 1: Forms of strategic purchasing

<p>Private health insurers</p>	<p>These compete for business from individuals or organizations, such as employers. Ultimately, private insurers are responsible to their owners, such as shareholders, and will usually seek to maximize long run profits. However, the immediate accountability is to their insurees, whom they must seek to attract and retain by offering satisfactory services at reasonable prices. The key characteristic of private insurers is that—in general—they are unable to cross-subsidize from one individual or group to another, so they must charge premiums in line with the expected costs of each insuree, or group of insurees.</p> <p>The major obvious example of widespread use of private insurance occurs in the United States.</p>
<p>Employment-based social insurers</p>	<p>This is the traditional Bismarck model. Such purchasers are closer to a mutual model, in which the collective ‘owners’ are the employers and their employees. Individual premiums are based on ability to pay, rather than expected expenditure. The key characteristic is—in contrast to a competitive social insurance—a lack of immediate contestability for insuree business. The accountability of the purchaser therefore depends crucially on the governance arrangements put in place to assure effectiveness and efficiency.</p> <p>Employment-based health insurance remains the dominant arrangement in countries such as Austria and Japan.</p>
<p>Competitive social insurers</p>	<p>This variant of the Bismarck model introduces competition into the social insurance market. Whilst (in contrast to conventional private insurance) premiums remain independent of health status, patients are periodically free to enrol with an insurer of their choice. A central risk adjustment mechanism seeks to compensate insurers financially for any resulting variations in the risk profile of their insured populations. This approach therefore introduces social insurers to more direct competitive pressures. The recent development of this policy in a number of social insurance countries suggests that in some countries the governance of the traditional Bismarck model was perceived to be weak.</p> <p>Competitive social insurance is in place in Belgium, Germany, Israel, the Netherlands and Switzerland.</p>
<p>Local health authorities (implementing national health insurance)</p>	<p>National health systems funded out of general taxation require local, geographically defined health authorities to implement nationally agreed health policies. These are usually (although not always) given fixed annual budgets within which they must seek to offer an agreed package of services. The voice of local patients and citizens is traditionally weak in such systems, and the principal accountability of the purchaser is to the national government, which provides finance and sets national policies. National governments might put in place independent regulatory agencies to assure citizens that health authorities are performing satisfactorily.</p> <p>National health insurance is in place in Denmark, New Zealand, Norway, Portugal and the United Kingdom. It is also in widespread use within devolved states, provinces and regions in countries such as Canada, Italy and Spain.</p>
<p>Local governments</p>	<p>In local government systems, responsibility for statutory health care is also devolved to a local level (although ‘local’ could take any form from a huge province to a tiny municipality). The key differentiating characteristic is accountability to local people through some sort of electoral process. The national government often sets certain minimum standards, and finances a proportion of health services. However, local government may have the ability—within limits—to vary local policies, user charges and taxation from national norms. There is therefore usually a mixed accountability, in part to the national government, and in part to local voters and patients.</p> <p>Reliance on local government has traditionally been strong in Scandinavia, and remains in place in Finland and Sweden. There is also reliance on democratic devolution to regions, states and provinces in Australia, Canada, Italy and Spain, although those devolved entities often use local health authorities to implement regional policies.</p>

perimented with democratic involvement in health services at various levels, such as large regions in Italy and Spain, counties in Sweden, and small municipalities in Finland. However, the contribution these processes have made to the performance of health services is not clear. Given

economies of scale and scope, it is often natural to seek to organize health services at a regional level. Yet regional purchasers will often seem remote to voters. In contrast, it is easy for very local democratic processes to be subverted by local provider interests, preventing purchasers from

rationalizing local services, or introducing more competition into the provider market.

Whatever the design of the health system, national governments have an important stewardship role to play in assuring proper governance of all aspects of the system. They may therefore put in place regulators to monitor the performance of strategic purchasers. Whilst this function is necessary in most types of health system, it is especially important when those purchasers are local agencies of national government. It is likely that the most effective regulation occurs when the regulator has genuine independence of government, as it will at times have to report poor performance by the government's own agencies.

Purchaser autonomy

Whichever accountability model is in place, it is important to note that it can operate meaningfully only if the purchaser has some real autonomy over the actions it takes. The major dimensions of autonomy relate to the three main purchasing functions: the freedom to specify the benefits package (or at least make significant amendments to the nationally agreed package); the freedom to place contracts with a range of providers, and to influence the providers used by patients; and the freedom to amend payment schedules and user charges, and to put in place incentive schemes relevant to local circumstances.

Examples of limitations on the purchaser's autonomy include:

- Traditional systems of social insurance in which patients have complete freedom over which providers from whom to seek care, inhibiting the ability of purchasers to direct patients to preferred providers
- Systems of local government in which all health service expenditure is funded by the national government, and there is effectively no discretion over local taxation
- Systems of competitive social insurance in which the package of care and insurance premium is set by the national government. Purchasers may then be able to complete only on relatively marginal aspects of services
- National health systems in which purchasers are required to direct services to specified government providers (in the extreme, purchasing and provision

are combined into a single organization—a common organizational form in many developing countries)

- Systems of any sort in which provider payment schedules are specified by the national government, inhibiting the scope for using local payment variations to incentivize service changes.

Of course, some of these constraints on purchasers may serve useful purposes, and may therefore be appropriate in some settings. However, if pursued to excess, the autonomy of purchasers is inhibited to the point where it has little meaningful scope to promote improved health system performance.

Concluding comments

This discussion suggests that it may be feasible to assess the strength of purchaser accountability along a number of dimensions, such as:

- The clarity of the purchaser's role
- The quality of the purchaser's governance arrangements
- The quality of information available to assess the purchaser's performance
- The freedom of the purchaser to set priorities
- The freedom of the purchaser to contract selectively with providers
- The freedom of the purchaser to amend provider payment mechanisms
- The quality of independent scrutiny of the purchaser
- The extent to which the purchaser is exposed to real market forces.

Strategic purchasing is a cornerstone of the health system. Implementation of system reforms will therefore usually be futile if weaknesses in the accountability of strategic purchasers are not addressed. This note has suggested that it may be feasible to develop a framework for assessing the quality of accountability arrangements, and for identifying where improvements can be secured.