The World Bank Group
in collaboration with the
University of Edinburgh and
ACCESS Health International

MANAGING MARKETS FOR HEALTH

New Delhi,
Oct 26-30, 2015
Sub-markets covered in MM4H

Product markets

Product Retail

Markets in supply chain

Health services markets

Primary Care

Specialist

Hospital
SESSION 8
Managing Primary Care Services Markets

Mirja Sjöblom
The World Bank

The World Bank Group
in collaboration with the
University of Edinburgh and
ACCESS Health International
STEP 1: PRIMARY CARE SERVICES
STEP 2: BUILDING GOVERNANCE REGIMES (Swedish case study)
STEP 3: MARKET CHARACTERISTICS
STEP 4: DEVELOPING COUNTRIES
STEP 5: GROUP EXERCISE
Definition:
Primary Care Services Market

‘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 Services:
the Backbone of the Health System

Sustainability

Quality

Equity

Efficiency
STEP 1: PRIMARY CARE SERVICES

STEP 2: BUILDING GOVERNANCE REGIMES (Swedish case study)

STEP 3: MARKET CHARACTERISTICS

STEP 4: DEVELOPING COUNTRIES

STEP 5: GROUP EXERCISE
Swedish healthcare is the best in the world, but there are still lessons to learn

In December 2013, when the OECD released its overview of healthcare in Sweden, as part of its annual review of global health statistics the Swedish government was quick to call a press conference to celebrate the fact that the report rated the outcomes of treatment in Sweden among the best in the world.
Pre-1600 – Spontaneous Market

- **Operational Autonomy**
  - Administered: 0%
  - Market: 100%

- **Customer Competition**
  - Administered: 0%
  - Market: 100%

- **Price Influence**
  - Administered: Market

- **Entry Barriers**
  - Very High: 0%

- **Social Funding**
  - 100%: 0%

- **Contract Conditionality**
  - No Conditionality: No Conditionality
1600-1700 – Social Regulation

- **Ownership**: 0% (Administered) - 100% (Market)
- **Customer Competition**: 0% (Administered) - 100% (Market)
- **Price Influence**: Administered (663 Medical Faculties) vs Market (1797 National Board of Health)
- **Entry Barriers**: Very High (0)
- **Social Funding**: 100% (Administered) - 0% (Market)
- **Contract Conditionality**: No conditionality

Managing Markets for Health
The Government was quite effective in keeping unqualified providers out.

1888: Anders Wallström was sentenced to pay 75 SEK in fee for unlawfully practice medicine and 300 SEK for illegally selling pharmaceutical goods. (approx. 30K USD)
1890-1931 – Voluntary Health Insurance

- **Operational Autonomy**: Administered (0%) to Market (100%)
- **Customer Competition**: Very High (0%) to Market (100%)
- **Price Influence**: Administered (100%) to Market (0%)
- **Entry Barriers**: Low (0%) to Very High (100%)
- **Social Funding**: Subsidy for VHIs
- **Contract Conditionality**: No conditionality

Subsidy for VHIs 1891, 1919, 1931
1940-50s – Contracts/Market entry contracts – National Health Insurance

- **OPERATIONAL AUTONOMY**
  - Administered: 0%
  - Market: 100%

- **CUSTOMER COMPETITION**
  - Administered: 0%
  - Market: 100%

- **PRICE INFLUENCE**
  - Administered: Very High
  - Market: 0%

- **ENTRY BARRIERS**
  - Administered: Very High
  - Market: 0%

- **SOCIAL FUNDING**
  - Administered: 100%
  - Market: 0%

- **CONTRACT CONDITIONALITY**
  - Administered: No conditionality
  - Market: No conditionality

1947 NHS law enacted
1955 NHS law into effect
1960s – From steward to implementer: Step-wise elimination of private sector

- **Operational Autonomy**
  - 0% to 100%
  - 1959 Hospital law

- **Customer Competition**
  - 0% to 100%
  - 1969 Seven Crown reform

- **Price Influence**
  - Administered to Market
  - # of doctors + accreditation

- **Entry Barriers**
  - Very High to 0

- **Social Funding**
  - 100% to 0

- **Contract Conditionality**
  - No conditionality
Post 1970-80s – more restrictions on private practice

- **Operational Autonomy**: Administered (0%) to Market (100%)
- **Customer Competition**: Administered (0%) to Market (100%)
- **Price Influence**: Administered (Very High) to Market (0%)
- **Entry Barriers**: Administered (Very High) to Market (0%)
- **Social Funding**: Administered (100%) to Market (0%)
- **Contract Conditionality**: No conditionality to No conditionality

1982 Dagmar reform

Restrictions on private providers go back and forth
Trends in governance of OECD primary care systems 1800 to 1990s

- **Operational Autonomy**: 0% to 100%
- **Customer Competition**: 0% to 100%
- **Price Influence**: Administered to Very High
- **Social Funding**: 100% to 0%
- **Contract Conditionality**: No conditionality to No conditionality

**Semashko & Nordic & Southern “NHS” countries 1800 - 1990**

**Most other European countries 1800 – 1990**

MANAGING MARKETS FOR HEALTH
So where did this take us….

- Publicly owned health centers employing a multidisciplinary workforce
- Providers responsible for population health within a geographical area
- Resources was allocated based on a yearly budgets
# Governance Regimes: Exclusive

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<th>Main features</th>
<th>Publicly owned and financed facilities deliver on service-related goals. Private clinics operate in the periphery of the system and rely on OOPs expenditure. Private providers are often under regulated.</th>
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| Areas of performance issues | Access  
Responsiveness  
Productivity/Efficiency |
Creation of a separate governance regime for private providers

1975-1995: legislation allows a restrictive number of GPs to establish private solo clinics and get reimbursed by the state on a fee-for-service basis.
- Dual practice is not allowed.
- The market share of private GPs is kept small.

Some people, particularly in urban areas, were not happy with the public monopoly of primary health care.
National tariff regime

- Ownership: 0% to 100%
- Customer Competition: 0% to 100%
- Price Influence: Administered to Market
- Entry Barriers: Very High to 0%
- Social Funding: 100% to 0%
- Contract Conditionality: No conditionality to No conditionality
# Governance Regimes: Selective

<table>
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<th>Main features</th>
<th>Resembles Exclusive regime, but the Government buys services from the private sector to either fill temporary gaps or specific needs.</th>
</tr>
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<tr>
<td>Policy tools</td>
<td>Internal Tools of Government (mainly direct delivery)+ contracting for specific services</td>
</tr>
<tr>
<td>Physicians payment</td>
<td>Salaried civil servants + GPs reimbursed with FFS</td>
</tr>
<tr>
<td>Implementation network</td>
<td>Public</td>
</tr>
<tr>
<td>Accountability mechanism</td>
<td>Public: Through budget allocations like any public agencies or department. Private: Through contracting or entry contracts</td>
</tr>
<tr>
<td>Prevalence</td>
<td>Rare in OECD, but exist in developing countries, e.g. contracts with NGOs for delivery to specific target group or hard to reach areas</td>
</tr>
<tr>
<td>Areas of performance issues</td>
<td>Access&lt;br&gt;Responsiveness&lt;br&gt;Productivity/Efficiency&lt;br&gt;Growth/ Investment</td>
</tr>
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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 retarded children.

**Contract for services to specific geographical area:**
The Government of Haiti contracts with an NGO to provide services in one of the regions in the country.
Key performance issues: Limited access

Doctor's visit per capita is low in Sweden compared to OECD.
Gate-keeping role of PC limited

<table>
<thead>
<tr>
<th>Country</th>
<th>Primary care physicians/capita</th>
<th>PHC physicians/all physicians</th>
<th>Visits to primary care/capita</th>
<th>Visits to specialist care/capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>0.71</td>
<td>0.22</td>
<td>3.65</td>
<td>0.78</td>
</tr>
<tr>
<td>Finland</td>
<td>0.71</td>
<td>0.34</td>
<td>1.28</td>
<td>1.28</td>
</tr>
<tr>
<td>Norway</td>
<td>0.91</td>
<td>0.24</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Sweden</td>
<td>0.53</td>
<td>0.17</td>
<td>1.18</td>
<td>1.37</td>
</tr>
</tbody>
</table>
But at least it was equitable....NO!?!
More people were not happy (including politicians)
The Swedish Choice Reform

Overall goals:

- Improve access
- Improve responsiveness
- Improve quality of care
- Strengthen the role of primary care
Video:
Professor Anders Anell
06:46
Reform process

- Started as a local initiative in Holland (2007) and replicated by other county councils e.g. Stockholm (2008)
- Mandatory national regulation in 2010
  - Money should follow the choice of patient
  - Freedom of establishment for private providers that fulfill local requirement
- The 21 county councils defined the rest of the reform
  - Responsibilities, requirements & payments of providers were defined locally
Examples of new functions that were created:

- **The Swedish Competition Authority** evaluates the competitive conditions of the 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 monitors the quality of care and operations
- **SKL (employer interest organization)** offers legal advice, process support, and organizes conferences for local authorities that are implementing/tinkering with the Choice reform
INCLUSIVE GOVERNANCE REGIME

REIMBURSEMENT MECHANISM
Reimbursement levels & permitted co-pay stipulated
“Money follows customer” based allocation

ELIGIBILITY MECHANISM
Entry contract to operate in primary care market
Eligibility monitoring process

SOCIAL REGULATION
PUBLIC INFORMATION about performance of providers
PROFESSIONAL LICENSING professional capability criteria & operationalization process

FINANCE

Providers

Consumers

REGULATION

S

D

ECONOMIC REGULATION
OWNERSHIP RESTRICTIONS for physicians and providers

MANAGING MARKETS FOR HEALTH
Health policymakers deploy two distinct approaches to contracting

<table>
<thead>
<tr>
<th>HAITI</th>
<th>SWEDEN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional contracting</strong> is a contracting process where.....</td>
<td><strong>Institutional contracting</strong> is a contracting process where.....</td>
</tr>
<tr>
<td>the <em>identity</em> of contractual partners <em>changes</em>;</td>
<td>the <em>identity</em> of contractual partners is <em>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 <em>the focus</em> of negotiation and agreement; and,</td>
</tr>
<tr>
<td>This form of contracting <em>enables</em> <em>exchange of services/goods</em> between contracting parties.</td>
<td>This form of contracting <em>crafts a governance structure</em> among contracting parties.</td>
</tr>
</tbody>
</table>
INCLUSIVE GOVERNANCE REGIME

**INFLUENCES**

**FINANCE**
- Providers
- Consumers

**REGULATION**
- Social Regulation
- Economic Regulation
- Public Information about performance of providers
- PROFESSIONAL LICENSING
- Professional capability criteria & operationalization process
- Low intensity of profit focus
- Avoid Penalties
- Maintain Prof. Recognition
- Maintain Eligibility
- Protect Clients

**ELIGIBILITY MECHANISM**
- Entry contract to operate in primary care market
- Eligibility monitoring process

**REIMBURSEMENT MECHANISM**
- Reimbursement levels & permitted co-pay stipulated
- “Money follows customer” based allocation

**MANAGING MARKETS FOR HEALTH**

**OWNERSHIP RESTRICTIONS**
- for physicians and providers
Supplier induced demand
INCLUSIVE GOVERNANCE REGIME

INFLUENCES

REIMBURSEMENT MECHANISM
Reimbursement levels & permitted co-pay stipulated
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ECONOMIC REGULATION
OWNERSHIP RESTRICTIONS for physicians and providers

REGULATION

PROFESSIONAL LICENSING
Low intensity of profit focus

MANAGING MARKETS FOR HEALTH
Trust Based Strategy

Only trusted providers are allowed in the implementation network
INCLUSIVE GOVERNANCE REGIME

REIMBURSEMENT MECHANISM
Reimbursement levels & permitted co-pay stipulated
“Money follows customer” based allocation

ELIGIBILITY MECHANISM
Entry contract to operate in primary care market
Eligibility monitoring process

FINANCE
Providers
Consumers

SOCIAL REGULATION
PUBLIC INFORMATION about performance of providers
PROFESSIONAL LICENSING professional capability criteria & operationalization process

INFLUENCES
CONSUMERS
Please Clients

REGULATION

MANAGING MARKETS FOR HEALTH
Professional Self-Regulation

Rather than direct regulation by the state, in professional self-regulation schemes, rulemaking, supervision and enforcement are all undertaken by the professionals subject to regulations.

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Superior technical expertise</td>
<td>Anti-competitive behavior</td>
</tr>
<tr>
<td>Enhanced efficiency</td>
<td>Exclusion of public interests</td>
</tr>
<tr>
<td>Decreased cost to state</td>
<td>“Soft” regulation mechanism</td>
</tr>
</tbody>
</table>
Example of Self-regulation

Danish Healthcare Quality Program. Develops standards for professional accreditation, clinical guidelines and carries out regular accreditation based on annual self-assessment and external evaluation by a professional accreditation body. Members are primarily medical professionals, that are overseen by a quasi public institute.
Results of Choice Reform

Video: Professor Anders Anell
Key outcomes of Choice Reform

**Results**
- Better access
- # of primary care providers rose with 20%
- # contacts with primary care and GPs per capita increased
- Phone and visiting availability has increased
- Quality and efficiency of public and private providers similar

**Challenges**
- Has the reform mostly benefited patient with minor care needs?
- Continuity of care still an issue
- Limited innovation
- National comparisons challenging
- Measurements of quality of care

**Constant tinkering process**
- Constant monitoring of leveled playing field
- Can we do more for chronically/comorbidity patients?
- Which reimbursement mechanisms yield best results?
Sweden – after the Choice Reform

- **Operational Autonomy**: 0% (Administrated), 100% (Market)
- **Customer Competition**: 0% (Non-conditioned), 100% (Conditioned)
- **Price Influence**: Administered (Very High), Market (0%)
- **Entry Barriers**: Administered (Very High), Market (0%)
- **Social Funding**: Administered (100%), Market (0%)
- **Contract Conditionality**: No conditionality (No conditionality)

MANAGING MARKETS FOR HEALTH
## Governance Regimes: Inclusive

<table>
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<th>Main features</th>
<th>Self-employed doctors or private organizations under contract with public or social insurance organizations deliver primary care.</th>
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<tr>
<td>Policy tools</td>
<td>External tools of Government</td>
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<tr>
<td>Physicians payment</td>
<td>Fee-for-service, capitation</td>
</tr>
<tr>
<td>Implementation network</td>
<td>Public and Private</td>
</tr>
<tr>
<td>Accountability mechanism</td>
<td>Money follows the patient Institutional contracting</td>
</tr>
<tr>
<td>Prevalence</td>
<td>Common in OECD countries rare in developing countries</td>
</tr>
</tbody>
</table>
| Areas of performance issues | Cost Containment  
Equitable Distribution  
Financial protection (if copay not regulated)                                                                                 |
A movement back to the middle…

- **Ownership**
  - 0%
  - 100%

- **Customer Competition**
  - Administered
  - Market
  - Very High
  - 0%
  - 100%

- **Price**
  - 0%
  - 100%

- **Social Funding**
  - No conditionality
  - No conditionality
  - 100%
  - 0%

- **Contract Conditionality**
  - No conditionality
  - 100%

- **Countries**
  - EST, POL, CZ, SLO, Sweden, Finland 1990 - present
  - Semashko & Nordic & Southern “NHS” countries 1800 - 1990
  - Most other European countries 1800 – 1990

- **A movement back to the middle…**
Characteristics of primary care services markets

- **High contestability**
  low/medium barriers to enter and less potential for monopoly

- **Low measurability**
  medium subjective measurability (patient can judge the quality of care but doesn't necessarily want optimal care) but low objective measurability (difficult to know what happens in the meeting between provider and physician)

Primary care services markets benefit from market forces
Primary care in the structure vs. market spectrum

MORE STRUCTURE

Acute Inpatient (Hospital)

Diagnostics, Elective Surgery, Specialist Services

Primary Care; Pharmacy Production & Distribution

Retail, OTC Pharmacy

MORE MARKET

MANAGING MARKETS FOR HEALTH
<table>
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<tr>
<th>Country</th>
<th>Predominant form of service provision (% of dominant share)</th>
<th>Choice of GP/family physician</th>
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<tr>
<td>Austria</td>
<td>Private (&gt;80%)</td>
<td>Limited</td>
</tr>
<tr>
<td>Belgium</td>
<td>Private (75%)</td>
<td>Free</td>
</tr>
<tr>
<td>Denmark</td>
<td>Private (N/A)</td>
<td>Limited</td>
</tr>
<tr>
<td>Finland</td>
<td>Public (88%)</td>
<td>Limited</td>
</tr>
<tr>
<td>France</td>
<td>Private (65%)</td>
<td>Free</td>
</tr>
<tr>
<td>Germany</td>
<td>Private (76%)</td>
<td>Free</td>
</tr>
<tr>
<td>Greece</td>
<td>Private (60%)</td>
<td>Free</td>
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<tr>
<td>Ireland I/II</td>
<td>Private (N/A)</td>
<td>Free</td>
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<td>Italy</td>
<td>Private (65%)</td>
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<td>Netherlands</td>
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<td>Norway</td>
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<td>Portugal</td>
<td>Public (100%)</td>
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<td>Spain</td>
<td>Public (97%)</td>
<td>Free</td>
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<tr>
<td>Sweden</td>
<td>Public (50%)</td>
<td>Free</td>
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<td>Switzerland</td>
<td>Private (N/A)</td>
<td>Free</td>
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<tr>
<td>UK</td>
<td>Private (100%)</td>
<td>Limited</td>
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<tr>
<td>US convent/man.care</td>
<td>Private (N/A)</td>
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STEP 5: GROUP EXERCISE
Primary care services in developing countries

- Comparable data on primary care services delivery network and institutional characteristics of health system in developing countries are lacking.
- Demographic and Health surveys show where people access care (e.g. delivery network):
  - Large share of care is accessed in private clinics/drug sellers. Share of private delivery varies between services and countries/regions.
It is challenging to regulate a market that you don’t have information about.
Delivery network in Kenya by ownership
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Responsiveness  
Productivity/Efficiency                                                                                                           |
Diverse providers, little provider accountability in public sector, unregulated private sector & poor quality of care

Quality and Accountability in Healthcare Delivery: Audit Evidence from Primary Care Providers in India, Jishnu Das et al. 2015

- Use standardized patients to measure quality of care in Madhya Pradesh
- Quality of care is low overall and patients have few good options for healthcare (public or private)
- Private providers are mostly unqualified, but exert more effort with patients than public providers, while being no different in their diagnostic and treatment accuracy.
- Public providers though theoretically staffed by qualified providers, are characterized by lower provider effort.
- Public doctors in private practices exerted high effort and were more likely to provide correct treatment in private practices.
- Market-based accountability in the unregulated private sector may be providing better incentives for provider effort than administrative accountability in the public sector in this setting.

THE GOVERNANCE REGIME SEEMS TO MATTER MORE THAN THE OWNERSHIP OF THE PROVIDER
STEP 1: PRIMARY CARE SERVICES

STEP 2: BUILDING GOVERNANCE REGIMES (Swedish case study)

STEP 3: MARKET CHARACTERISTICS

STEP 4: DEVELOPING COUNTRIES

STEP 5: GROUP EXERCISE
What are you doing in primary care services markets?

- Operational Autonomy
- Customer Competition
- Price Influence
- Entry Barriers
- Social Funding
- Contract Conditionality

Marketizing reforms

Structuring reforms

No conditionality

MANAGING MARKETS FOR HEALTH
Group exercise/discussion

1. Name a primary care service reform that you are currently implementing?
2. Show how it changes the red bars in the market forces framework.
3. Is it a “marketizing” or a “structuring reform”?
4. Are you using any tools of government in this reform effort? Which ones?