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Information for and from Strategic Purchasing

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Why this topic?

- Strategic purchasing defined: allocations driven (at least in part) by **information** on provider performance and/or the health needs of the people that they serve
- A strong and useful information system is an **essential pre-requisite** for strategic purchasing
- So **there is no strategic purchasing without information**



2 key issues: for and from

- Unified information system **for** strategic purchasing is a key “governance for UHC” reform implementation step
- Information **from** strategic purchasing databases to serve future payment decisions and beyond



1. Information for provider payment

- Content: individual-level data with essential elements (e.g. patient and provider IDs, symptoms, diagnosis, procedures, etc. – will be subject of following presentation)
 - Anneke will describe in next presentation



Organization of information for provider payment as a step towards UHC

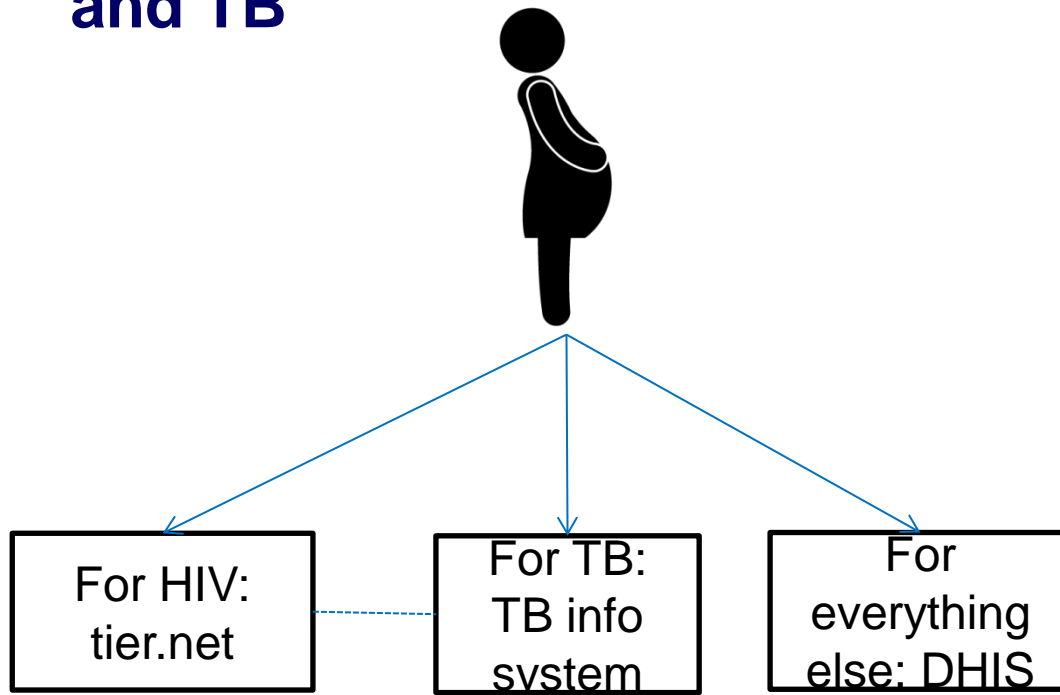
- Key issue of governance for UHC is to **embed schemes and programs within the overall system**
- Scheme- and program-level information systems may reinforce efficiency and equity problems associated with **fragmentation**
 - Also involves duplication of responsibilities, wasted time, effort...
- Unified information systems – even before funding is pooled – can be **critical early implementation step** in driving system change towards UHC

Problem in Ghana: data organized at scheme level

- One department of the hospital manages/inputs the patient activity data on NHIS claims forms for the insured population – for purposes of provider payment
- Another department of the hospital manages/inputs the patient activity data for all patients – for purpose of MOH statistical reporting
- But the content of the data is the same
- System-level governance gap – why not one form with a field that indicates the patient's insurance status?

Problems of information organized at program level in South Africa

Example: information systems for pregnant woman with HIV and TB



- Data entry is done separately
- Systems do not speak to one another
- No patient identification

Implications

- Information is used to **monitor and report**, not to manage patient care or provider behaviour
- **Incomplete picture** of individual patients, population health, efficiency, and quality of providers
- **Inability to coordinate or integrate** across levels of care
- HIV and TB **programs have better information** that is not coordinated across the system
- An **undue administrative burden**

Shared systems can provide foundation for universality: the Kyrgyz experience

- Plans to begin oblast (province) level provider payment reform in 1997, provincial ministry as the purchaser
- Late 1996, government decides to introduce new SHI fund
- Concern about two systems, lack of coordination (“we’re too poor to have two health systems”) leads to development of the “joint systems approach”
 - MOH and SHI jointly manage patient activity data
 - SHI managed a small amount of total spending, but all of the patient activity data...for 4 years
- 2000: gov’t announces that budget will be pooled in SHI fund over the coming years – applying SHI payment methods
 - SHI can simulate what hospitals will get under these systems
 - Works closely with each hospital on restructuring plan
 - SHI fund goes from managing 10% to 90% of prepaid money over coming 3 years, without major problems

2. Information from provider payment systems

- Individual level data from provider payment systems are a powerful and largely untapped resource for health policy decision-making
- Requires thinking ahead (for the governance agenda, again) about what we want to know, how to design forms appropriately, and keeping “UHC => unified systems” idea
- And also requires thinking, more generally (something we often undervalue in the quest for tools to answer our questions)

When you see a claims form...

- ...imagine a (powerful) database
 - It's not just for payment; it's a key source for applied policy research
 - and new support to help with how to use it

(to be filled by health care providers who have provided out or in-patient service)

NATIONAL HEALTH INSURANCE SCHEME
COMBONI HOSPITAL - SOGA KOFE

Claim Form
(Regulation 62)

Form no. 040103001
Health Facility Code* 040103001

Important! The form should be completed in CAPITAL LETTER using a BLACK or DARK BLUE ballpoint fountain pen. characters and marks used should be similar in the style to the following:
A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 1 2 3 4 5 6 7 8 9 0

Scheme Code* STG Month of Claim (Batch)* 10/2015

Client Information

Surname* [REDACTED] Gender ☒ Male ☐ Female

Other Names [REDACTED]

Date of Birth 05/02/2014 Age 2 Member Number 25794557

Hospital Record No. 457314 Card Serial Number 015120121479

Services Provided (to be filled all health care providers)

Type of Service* (a) select only one

☒ Outpatients ☐ In-patient ☒ Pharmacy

(b) ☒ All Inclusive ☐ Unbundled

Outcome*

☒ Discharged ☐ Died ☐ Transferred Out

☐ Absconded ☐ Discharged Against Medical Advice

Date(s) of Service Provision*

1st Visit/Admission 16/02/2016

2nd Visit/Discharge /

3rd Visit /

4th Visit /

Length of Duration (days) 17

Type of Attendance

☐ Chronic Follow-up ☐ Emergency ☒ Acute Episode

Specialty Code OPDC

Physician/Clinician Name* One Physician/Clinician ID

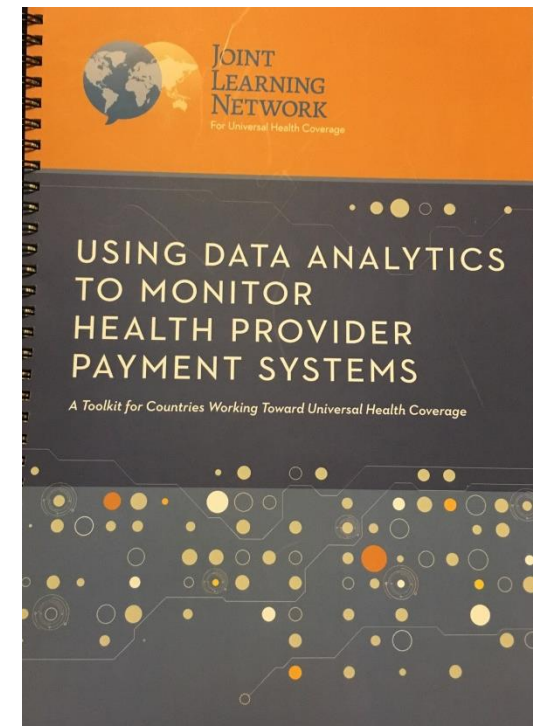
Procedure(s) (to be filled by health care provider who have provided out or in-patient service)

	Description	Date	G-DRG
Procedure 1			
Procedure 2			
Procedure 3			

*Mandatory field

CF2009/V1

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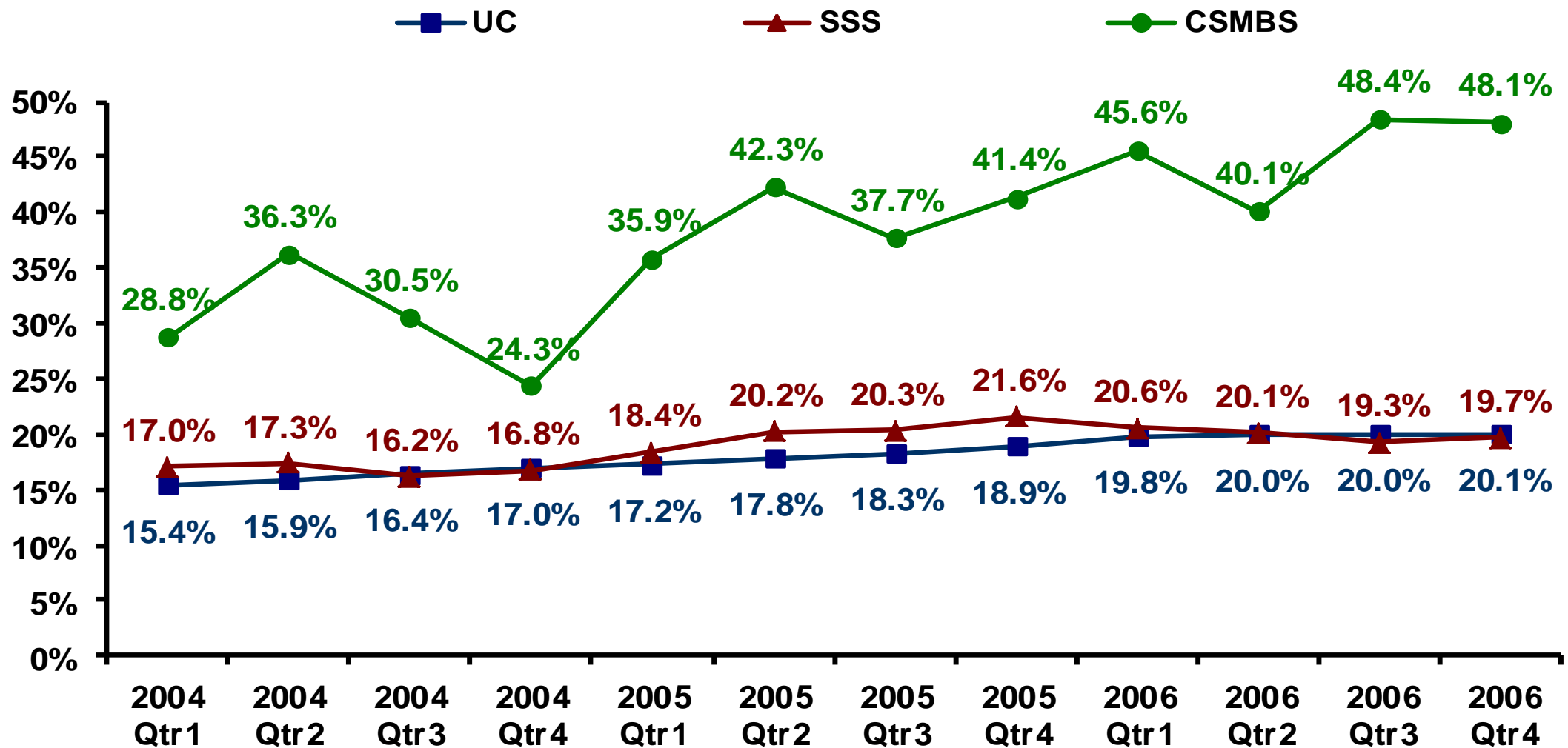


Another Kyrgyz example

- SHI fund managers review hospitalization data
 - “We have too many cases that could be avoided with good primary care”
 - Develop outpatient drug package, linked to clinical guidelines, for four conditions: bronchial asthma, hypertension, iron deficiency anemia, duodenal ulcer
 - Information system developed for this enables monitoring of treatment and prescribing practices for these conditions
- Message: they looked at their data, found a problem, developed a solution tailored to that problem, and monitored implementation (and later made further changes) – this reflects an adaptive system



Thailand: common data platform allows comparison of C-section rates across schemes



Source of slide: (Prakongsai, Limwattananon, Tangcharoensathien, Wisasa, presentation to Regional Forum on Health Care Financing in the Mekong countries, 2012)

Summary messages – reasons to elevate this issue on our agenda

No strategic purchasing without information

Unified (not scheme-level) information system facilitates reform for UHC

Implementation sequencing: pool the data before you pool the money

Use data to enable purchaser to develop its capacity (before going live)

When you see a claims form, imagine a database

Data analytics serve future decisions (not only for purchasing)

