

Appendix 4: Purchaser-Provider Split



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Health Care Financing

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Health financing is a necessary, but not a sufficient component of any health reform program. Health financing cannot be addressed in isolation, but must be integrated with restructuring of the health delivery system, changes in medical practice, increasing the capabilities of medical workers, the development of information systems, and the involvement of the population. It is not effective to address each piece separately; rather all elements of health reform must be integrated into one comprehensive program.

Issues of health care financing are fundamentally related to how a country's resources are allocated between competing uses in the economy as a whole, and between competing uses within the health sector. Health financing reforms are oriented toward creating the institutional conditions and economic incentives to allocate resources to their highest valued uses. "Highest valued use" is in part a political determination, reflecting the collective values of society about the importance of health and health care relative to other outputs of the economy, and in part determined by more objective measures of the value of outputs relative to inputs.

Resource allocation decisions are made at five different levels of the system, from the decision about the overall level of government resources allocated to health care down to the decision of a health care facility about how to allocate its budget. Health care financing policy determines which institutions make the resource allocation decisions at each level, and how these decisions are made. In the Soviet system, health financing policy was inefficient in how resource allocation functions were distributed among purchasers and providers of health care, and in how resource allocation decisions were made. Many health financing reform efforts in Central Asia have therefore focused on establishing an appropriate split between the resource allocation functions of health purchasers and providers, and changing the mechanisms by which resources are allocated at all levels of the system.

Resource allocation decisions related to health care begin with the decision about the overall level of government resources to allocate to the health sector, which is a political decision. In addition, the fixed amount of government health care resources must be allocated geographically across regions, which is also a political decision. In the Soviet system, all of these functions were, and often still are, largely carried out by the national and oblast political leadership together with the Ministry of Finance.

Once the overall pool of resources available for health care is established in each geographic area, the resources must be allocated across levels of the health care system: primary health care, outpatient specialty care and diagnostic tests, inpatient care, public health, education and research, capital, and administration. Resources must also be allocated across health facilities within each of those parts of the system, and then across inputs and outputs within the health facilities. In the Soviet system, all of these decisions were carried out by the MOH, but greatly influenced by the Ministry of Finance budgeting process based on physical normatives.

Thus, in the Soviet system, the health purchaser, which was a combination of the political leadership, the Ministry of Finance and the MOH, made all of the resource allocation decisions. The providers of health care had no control over health care resources, and therefore had no incentive or capability to change the way they delivered services to be more effective and efficient. The following section outlines how resource allocation functions can be split between the purchaser and providers of health care services to create appropriate economic incentives to make the best use of limited health care resources.

Purchaser-Provider Split

Purchaser-provider split is the division of authority in the process of distributing and using health resources between the health purchaser (national or regional) and health providers. The purchaser-provider split may be achieved through several different policy options, for example, establishing a health insurance system to serve as an independent health care purchaser, or increasing the autonomy and independence of health care providers and reducing MOH control over their internal activities.

With an appropriate purchaser-provider split, the purchaser has the authority to determine how much total funding should be allocated to the health care system, how that funding should be allocated

geographically, and how the funding should be allocated among types of health services. The allocation of resources across types of health services may be an administrative decision, with the purchaser establishing separate pools of funds for each level of the health care system based on administrative criteria. Or the decision may be driven more by market forces, with resource pools set more broadly, and competition between parts of the health care system determining the final resource allocation.

The health purchaser also has the function of determining the system of health provider payment, which is the mechanism by which the purchaser sets the incentives for providers in making their resource allocation decisions. Provider payment systems are the point at which the authority of the purchaser with respect to the allocation of health care funds ends and the authority of the provider begins, or the point at which authority is transferred from purchaser to provider.

First, the health care purchaser determines the level of health care resources in the system and how resources are allocated across each part of the health care system. The next level of decisions involves the allocation of resources across providers within each type of care, for example how to distribute the pool of inpatient funds across hospitals. At this level, the health purchaser is only a passive distributor of funds. The purchaser has already set the payment systems, so now it must simply distribute the funds that providers have earned by delivering services in response to the incentives of the purchaser. By competing with each other for these funds, the health care providers in effect determine the allocation of resources across institutions within one sector of the health care system.

The final level of resource allocation decisions is how health care providers allocate the funds that they have earned across inputs, such as staff, medicines, and equipment, and outputs, which is the mix of services provided. At this level, the provider allocates funds according to the needs of the organization, which are driven by a desire to respond increasingly well to the incentives of the purchaser in order to compete better and qualify for more funding.

Health Care Resource Allocation

Purchaser Decisions
Level one is the decision about how much state (national and local) resources to allocate to the health sector.
Level two is the decision about how resources, collected at the national level, are distributed geographically, or across the oblasts, rayons and cities.
Level three involves the allocation of resources among types of health services – primary health care, outpatient specialty and diagnostic tests, inpatient care, public health, education and research, capital, and administration.
Provider Payment Systems
Provider Decisions
Level four is the distribution of funds among providers within each level of the health care system.
In level five, the health provider allocates funds across inputs and outputs.

Thus, the purchaser-provider split *divides the authority* with respect to allocation and use of health funds, but *preserves the unity* of the process of allocation and use of health funds through the provider payment systems. The purchaser-provider split is a horizontal split between the third and fourth levels of the health financing functions. It is not a vertical split where two government health purchasers, such as an insurance fund and the MOH, implement all five health financing functions or levels. The vertical split is inefficient and ineffective, as there is a duplication of functions. The purchaser-provider split is a technical element in the process of allocation and use of resources. However, it is an absolutely crucial prerequisite to the success of the national health care reform.

Why is the purchaser/provider split important? There are a number of reasons, a few of which include:

- it encourages competition among providers by offering incentives to those providers achieving better results;

- it allows providers to control the results of their work, and by delivering the results desired by the purchaser they can increase the level of their funding; and
- it allows the purchaser to control providers and hold them responsible for the delivery of desirable results.

Financing reforms aimed at more appropriately distributing resource allocation functions between the purchaser and provider will improve the efficiency and effectiveness of the system, or allocate scarce health care resources to their highest valued uses, only if the appropriate conditions are in place to allow resources to move more freely throughout the system. In the CCA, the ability to move health funds is limited for both health purchasers and health providers.

The health purchaser's flexibility in resource allocation decisions is hindered by fragmented health care budgets that are formed at the level of the rayon, city and oblast. This limits the purchaser's ability to allocate funds geographically and across levels of health care in the most efficient and effective way. Health purchasers should have the ability to pool health care funds at the oblast level to use their resource allocation decisions to improve equity, rationalize the health delivery system and implement effective health provider payment systems.

The health providers' flexibility in resource allocation is limited because they receive their financing and must execute their expenditures according to fixed budget line items, or chapters. The health facilities have limited flexibility to reallocate expenditures across these budget chapters, which means they have little capability to respond to the incentives of the payment systems of the health purchaser. New provider payment methods and stronger economic incentives for providers must be accompanied by greater authority to decide how to adapt their operations and spending their resources according to their needs.

Next Steps

In summary, there are three important directions that health financing policy reform in the CCA have begun and should continue to follow to improve the efficiency and effectiveness of their health care systems.

- First, is establishing a split between the resource allocation functions of the health purchaser and provider, with new payment methods as the point of intersection.
- Second, is the pooling of health care funds at a geographic level not smaller than an oblast. This means that all rayon, city, oblast, and republican funds must be pooled into one unified budget.
- Third, is giving greater financial autonomy to health care providers, and allowing the health purchaser to distribute and health providers to spend funds without budget chapter restrictions.