ORGANISATIONAL MATTERS

Purchaser strategies to influence quality of care: from rhetoric to global applications

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The potential of purchasers to influence the quality and safety of care has captured the attention of health sector leaders worldwide. Quality based purchasing explicitly seeks to hold providers accountable for the quality and safety of care. Three strategies are available to purchasers: (1) selective contracting based on quality; (2) payment differentials based on quality; and (3) sponsorship of comparative provider report cards. Examples are given to illustrate each of the three strategies. Governments, employers, social insurance funds, community based insurance organizations, health plans, donors, and other buyers of health services are encouraged to explore and debate these purchaser strategies within the context of an overarching national or local quality framework. Public and private funders of operations research are encouraged to support and disseminate evaluations of purchaser efforts to improve quality. This paper is designed to highlight and frame purchasers' strategies explicitly crafted to enhance the quality and safety of care. The ultimate aim is to encourage thoughtful discussion about whether or not one or more purchaser strategy might support a particular country's goals to improve care. Experiences from both developed and developing countries are included to facilitate the exchange of ideas and provide the broadest of perspectives.

FRAMING PURCHASER STRATEGIES TO IMPROVE QUALITY OF CARE

Purchasing, as defined by WHO, is "the process by which pooled funds are paid to providers in order to deliver a specified or unspecified set of health interventions".¹

Quality based purchasing, a particular form of what WHO refers to as strategic purchasing, seeks to hold providers accountable specifically for the *quality* of care they deliver. The WHO defines quality as the "proper performance of interventions that are known to be safe, that are affordable to the society in question, and have the ability to produce an impact on mortality, disability and malnutrition".⁴ Purchaser strategies to improve quality are distinguished from those designed to enhance access or increase utilization without regard to the "proper performance of interventions".

Three optional and potentially overlapping strategies are available to purchasers interested in using their power as a payer to promote quality: (1) quality based selective contracting; (2) payment differentials based on quality; and (3) public domain information on comparative provider performance. Each of these three approaches seeks to identify and reward high quality providers either directly with higher payment rates or indirectly with a greater volume of patients.

PREVALENCE OF QUALITY BASED PURCHASING

Quality based purchasing is in its infancy in developed countries. According to a leading expert on European health systems, the concept of using purchasing to improve healthcare delivery is far from the agenda of health policy makers in many countries; the role of purchasers is largely confined to that of financial intermediary. With few exceptions, European purchasers are content to take a passive role.⁵ Similarly, most US analysts agree that US purchasers as a group are not acting as quality drivers.⁶ But there are some exceptions. The US Centers for Medicare and Medicaid Services (CMS) and certain large employers such as General Electric have been active quality based purchasers.

In developing countries, too, quality based purchasing is the exception to the rule. Public payers and donors typically pay salaries and recurrent costs rather than seek to ensure that consumers actually receive high quality services.⁷ A review of 82 health insurance schemes for people outside formal sector employment in a number of developing countries found that the

The global purchaser community knows little about the quality of health goods and services it buys, but this is slowly starting to change. The potential of purchasers' power is capturing the attention of global health sector leaders. In 2000 the World Health Organization (WHO) recommended that countries move from passive purchasing to strategic purchasing. Passive purchasing implies following a predetermined budget or simply paying bills when presented. In contrast, strategic purchasing involves a continuous search for the best ways to maximize health system performance.¹ In 2001 the US Institute of Medicine called on purchasers to use their market power to promote quality.² The US Agency for Healthcare Research and Quality (AHRQ) published an evidence review and synthesis on quality based purchasing in 2004,³ following a series of agenda setting meetings specific to quality based purchasing in 2001–2003.

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purchasing function tended to be weak, with scheme managers focused on raising revenue rather than assuring efficient delivery of quality care.⁸ In a survey of community based health organizations, at most 16% considered quality of care in their purchasing activities.⁹

APPROACH 1: QUALITY BASED SELECTIVE CONTRACTING

Taylor¹⁰ defines contracting as “a purchasing mechanism used to acquire a specified service of a defined quantity *and quality* at an agreed-on price from a specific provider for a specified period”. *Selective* contracting based on quality therefore seeks to identify and contract with that subset of available providers judged to provide better care. Contracting cannot be selective unless the purchaser is committed *not* to contract with every bidder.¹¹

Recent articles about contracting in developing countries tend to focus on contracts between public purchasers and private providers, in parallel to privatization trends perhaps. It should be noted, however, that contracts for healthcare services also exist between private purchasers and private providers, private purchasers and public providers, and even public purchasers and public providers.

Illustration of quality based selective contracting

The CMS, a public payer and the single largest purchaser in the US, covers care for senior citizens only from providers who meet the CMS standards. Collectively referred to as Medicare Conditions of Participation, this set of standards includes minimum requirements related to quality. For example, hospitals must meet technical and interpersonal quality standards such as 24 hour nurse coverage and a system for prompt resolution of patient grievances.¹² Nearly all US hospitals meet Medicare’s Conditions of Participation; given that Medicare pays for approximately 44% of the nation’s hospital bill, hospitals are not in a position to exclude Medicare patients (HCUPnet 2002). A more dramatic example of selective contracting by CMS—which results in winners and losers—can be found in the Medicare organ transplant program.¹³ Facility requirements for heart transplants, for example, include far more restrictive standards; facilities must meet minimum volume thresholds of cardiac transplants per year and specified 1 and 2 year actuarial survival rates.¹⁴ Only nine US hospitals have been approved as Medicare Heart Transplant Centers.¹⁵

While the contract literature is voluminous, not many examples of contract provisions specific to technical quality were found. In the US, with its large number of private purchasers, the dearth of publicly available information may be due, in part, to the proprietary nature of contracts between private payers and private providers. Another potential explanation for this deficiency is that contract provisions specific to technical quality are, indeed, rare. A review of UK National Health Service contracts in use prior to 2004 found them to be broadly focused, informally worded, and vague about risks and responsibilities. Many were incomplete and deficient in terms of specification of quality performance and how to deal with failure.¹⁶

APPROACH 2: PAYING PROVIDERS DIFFERENTIALLY BASED ON QUALITY

The logic of paying more for high quality and less for low quality is presumed in most sectors yet, in the health care sector, differential payment based on quality is illusive.¹⁷ The resulting signal to healthcare providers is that quality doesn’t matter.

Financial incentives for quality can be incorporated into each type of underlying payment system (budget transfer, capitation by person or episode of care, and fee for service).

Incentives take the form of bonuses, penalties, and combination bonus-penalty schemes.¹⁷ Quality based payments can be advanced to providers to permit quality related infrastructure investments or can be paid upon attainment of performance goals.

Illustration of differential payment based on quality

Nicaragua is a pioneer of quality based payment.¹⁷ The Ministry of Health developed a set of reforms to increase health sector accountability. Reforms included financial incentives for performance. Six public hospitals participated in a pilot program that provided bonus payments for achieving performance targets including quality related standards. Quality related standards include technical and interpersonal indicators such as re-infection rates and rates of complaints, respectively. The maximum bonus available to participating hospitals was considerable, averaging 17% of revenue.¹⁸

A recent review by Rosenthal and colleagues¹⁹ of quality based payment schemes by US purchasers including health plans found that 30 are paying more for high quality care. A later analysis by the Leapfrog Group identified 77 incentive schemes.²⁰ HealthPartners, a Minnesota based health plan, provides a unique and bold example of quality based payment with its decision in 2005 to stop paying hospitals for care that involves one of a set of 27 medical errors referred to as *never events*. Never events are deemed by the National Quality Forum as errors so severe that they should never happen to any patient, such as surgery performed on the wrong body part or leaving a foreign object in a patient during surgery.²¹

APPROACH 3: PURCHASER LED PUBLIC REPORTING OF PROVIDER PERFORMANCE

A lack of comparative information on provider performance contributes to a persistent belief that quality is not a serious problem,²² and that quality is relatively uniform across providers. Making information about providers’ differential performance publicly available is a third way for purchasers—and other stakeholders—to attempt to influence quality of care.

Purchasers who pursue this approach realize that individual consumers are not in a position to obtain performance data merely by asking for it. They use their purchaser clout to ensure comparative information on provider performance is in the public domain. Individual consumers are thus enabled to judge quality and exert their own quality preferences.⁶

Illustration of purchaser led, provider specific quality reporting

Employer Healthcare Alliance, an employer-owned, not-for-profit health care cooperative in Wisconsin, US, represents 160 employers with more than 100 000 employees and dependents. The Alliance makes information publicly available on the quality and safety of care in the 24 hospitals in south-central Wisconsin with which they contract for care. This report compares how often mistakes, complications and deaths happen with how often they can be expected to occur, given how sick patients were. While these negative outcomes cannot always be prevented, there is much that hospitals can do to reduce them. Patient satisfaction data are also made available.²³

A number of US examples were identified. The CMS is a leader of performance reporting. In 2001 CMS began publicly reporting dialysis facility quality ratings, adding nursing home ratings in 2002 home health provider ratings in 2003, and hospital ratings in 2005. Quality ratings for each provider group are posted on the agency’s website for use by consumers (T Haywood, unpublished presentation at

meeting of Employer Health Care Alliance Cooperative, Madison, Wisconsin, 5 May 2004). Examples of purchaser led, provider specific report cards in developing countries can be found in Uganda, for example, but are rare.²⁴

DISCUSSION

At the center of each of the three strategies is the measurement of a set of provider attributes thought to be indicative of quality. Quality measurement is one on a long list of technical, administrative, and political barriers to selective contracting, quality based payment, and provider report cards.^{17–24} Implementation is not for the faint of heart.

Depending on the purchasing context, one strategy might be preferred over another. For example, two of the three strategies are feasible in communities with limited provider choice. A purchaser in such a community could initiate a bonus program that would, for example, reward its only hospital for improvements along certain measured attributes. Similarly, a purchaser could publish quality ratings for its only hospital along with a normative standard or national benchmark. Selective contracting, in contrast, would not be a realistic option.

Similarly, in some contexts strategies that increase direct payments to high quality providers are more appropriate than those that promise a greater volume of patients. For example, hospitals with chronic bed shortages might not find the prospect of an increase in patient volume resulting from a high score on a report card to be particularly appealing.

While the three strategies are separated for the purpose of discussion, in practice they are not mutually exclusive. Some purchasers such as the US CMS simultaneously pursue the three approaches. To the extent that strategies share a common measure set, the strategies are mutually reinforcing and presumably have the potential for a greater impact.

Research has not kept pace with real world applications of quality based purchasing.^{2–3, 6, 11–25} There is little published research evaluating quality based purchasing, in particular contracting and payment innovations. As a consequence, little is known about the impact of quality based purchasing in absolute terms and relative to (and in combination with) other quality improvement policies. Nor do we know much about contextual factors associated with the success of alternative quality based purchasing approaches. We can only speculate about unintended consequences such as the potential displacement of providers' professional or personal motivation by external drivers, decreases in quality for care that is not the focus of a quality based purchasing strategy, and decreases in quality as a result of potential redirection of resources that previously supported medical training and continuous quality improvement activities. As funders of operations research contemplate competing research priorities, consideration should be given to evaluations of quality based purchasing schemes and their potential to improve quality on a global scale.

In the absence of a persuasive body of empirical findings, logic suggests that efforts by purchasers to communicate that quality and safety matter in their transactions with providers can only help to focus attention on quality and quality improvement. As governments, employers, social insurance funds, community based insurance organizations, health plans, donors, and other buyers of health services worldwide consider or reconsider their quality agendas, they are encouraged to explore and debate selective contracting, quality based payment, and sponsorship of provider report cards within the context of an overarching national or local quality framework alongside more traditional methods such as provider training, continuous quality improvement programs, and accreditation.

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