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Monitoring Quality and Performance

Contracting of Private Health Care Services in Nicaragua

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COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

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Commercial Market Strategies (CMS) is the flagship private sector project of USAID's Center for Population, Health, and Nutrition. The CMS project, in partnership with the private sector, works to improve health by increasing the use of quality family planning and other health products and services.

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Introduction

Contracting with the private sector to deliver health services can often pose issues for ensuring the quality of the services being provided and increasing their utilization. This is particularly true for expanding the use of reproductive health care, such as family planning, which is covered, but at times not actively promoted by providers. In Nicaragua, the Social Security Institute, or Instituto Nicaraguense de Seguridad Social (INSS), has implemented a health care financing and delivery model to provide health services to social security beneficiaries, which include most formal sector workers and government employees. The INSS contracts with private and public health care providers, known as Empresas Medicas Previsionales (EMPs), using a capitated payment system to deliver a defined package of health care benefits to thirteen percent of the population.

The USAID-funded Commercial Market Strategies (CMS) project has the mandate to expand the delivery of reproductive health care through the private sector in developing countries. In conjunction with its financing entity (know as the Summa Foundation), CMS provides financial and technical assistance to private providers to undertake new service delivery projects. Prompted by the innovative features of the INSS model, CMS is partnering with the INSS and two of the largest private EMPs to increase the utilization and quality of covered family planning benefits. The intervention utilizes specific benchmarks for measuring improvements in the quality and utilization of family planning services being provided by contracted providers.

Background

Nicaragua has been at the forefront of health care reform among Latin American countries. The INSS is responsible for providing formal sector workers and their families with health care insurance, including maternity coverage, and worker's compensation. Until 1978, INNS operated its own network of providers, including three hospitals and several outpatient facilities, located in urban areas. Under the Sandinista regime (1979 to 1990), the INSS facilities were transferred to the Ministry of Health (MINSA), and a unified health care system was created under MINSA. Due to a deterioration of health care services during the Nicaraguan conflict in the 1980's, there was widespread dissatisfaction with MINSA services among INSS contributors.

With the end of the Sandinista regime in 1990, reforms were undertaken to provide health care benefits to INSS beneficiaries using a market-based health care model. In 1994, a new system was created under which the INSS would utilize payroll and employer contributions to purchase services from private and public providers through capitated contracts. The new system began with eleven EMPs, including two public EMPs that enrolled mostly MINSA employees. By 2002, the number of EMPs had quadrupled to 48, of which ten were MINSA facilities.

Likewise, the new model grew in enrollment and coverage. Between 1994 and 2001, coverage increased by 182 percent, from 76,000 to 214,000 enrollees, covering between 85 and 90 percent of all INSS contributors. Just as important, the extended coverage of the INSS system in 2001 extended to 680,000 persons, consisting of the enrollees, their spouses/partners (133,000) and their dependent children up to the age of six (333,000.)

The "package" of services in the INSS model covers pre-defined curative care, surgical procedures, diagnostic tests and basic medicines. The insured's spouse or partner is eligible for maternity care, including deliveries; and dependent children to the age of six are also covered by the defined package. However, the coverage excludes a long list of expensive diseases (such as cancer, kidney disease, tuberculosis, AIDS) and procedures (dialysis, transplants, chemotherapy, radiotherapy). Most preventive services, (apart from immunizations, family planning and pre-natal care) are not covered; nor are dental and vision services. Enrollees must pay out-of pocket for those excluded services, or obtain them from MINSA facilities. It should be noted that MINSA provides a wide range of free health care services, both preventive and curative, to 70 percent of Nicaragua, a country where half the population lives below the poverty level.

Contracted EMPs are paid a specific monthly capitation payment per insured individual. In 2002, the capitation payment was increased to C$170, or about US$12, the first increase in over three years. The EMPs assume the contractual responsibility and financial risk for providing the covered services or outsourcing them to third-party providers. Additionally, the insured worker is entitled to sick leave, and maternity leave at 60 percent of salary, which must be paid by the EMP from the capitation payment.

The system, while providing a growing share of the population with access to private health care, also has created some imbalances. For example, there is anecdotal evidence that the MINSA does not recover charges for treating INSS clients at its facilities for covered hospitalizations and procedures, due to poor client referral systems, thereby subsidizing the INSS. Some EMPs admit that they avoid enrolling management employees, in order to minimize potential financial risks from higher worker's compensation payments or maternity leave. And there has been confusion over enrollment procedures, which in the past were designed to "protect" existing EMPs through automatic assignments. These issues are being addressed by the INSS, in an effort to expand and improve its coverage.

Quality and performance standards

In order to operate as an EMP, providers must first meet operational and legal requirements, and standards for medical facilities prescribed by MINSA. The medical review by MINSA involves a one-time physical inspection of an EMP's facilities, equipment, fixtures and medical supplies, to ensure it can deliver proper medical services. Once MINSA verifies the EMP's infrastructure, the EMP must be "certified" by the INSS, as having adequate financial, management and technical capabilities to perform as an EMP.

Traditionally, the INSS certification process has emphasized the financial and administrative capability of the EMPs. For example, the INSS requires that an EMP submit a feasibility study, based on market projections and likely enrollment of INSS clients, so as to ensure that EMPs are financially viable. EMPs must also provide a bank guarantee with the INSS equal to one month's revenues, as a safeguard against financial difficulties. Most observers of the INSS model readily point out that these standards have been fairly easy to meet, thereby facilitating the rapid growth of the EMP market, particularly among private providers. This may also have been an explicit strategy to expand coverage, and to stimulate the market when the model was first developed.

On the other hand, EMPs have not been contracted on the basis of specific quality assurance requirements. The contracts between the INSS and the EMPs do not specify any performance benchmarks. The EMPs are required to report monthly service statistics, which quantify the services provided to enrollees and their beneficiaries. INSS regulations include potential sanctions or fines for a range of infractions, some of which are directly related to clinical issues, such as incapacitation or death due to poor treatment. However, the bulk of the sanctions are for administrative infractions or for not meeting their financial obligations to beneficiaries. A number of EMPs have suffered contract terminations, largely due to financial and procedural irregularities.

In an effort to improve the current system, the INSS recently embarked on a new process to "re-certify" the EMPs. The intent of the INSS is to discard firms that are financially or managerially weak, or unable to deliver most services through their own infrastructure. Another goal may be to reduce the number of providers in the system, particularly those at financial risk, due to limited enrollment. In April 2002, the INSS began conducting thorough reviews of all EMPs, starting with those headquartered in Managua. The certification process involves a review of the financial, administrative, and technical capacity of each EMP and its track record. The table below highlights key aspects of the new certification standards, which quantify the EMPs' ability to provide services.

Areas (700 points)	New Certification Requirements (2002)
Financial Liquidity (150 points)	Liquidity Debt Acid test ("quick ratio") Net working capital
Administrative Strength (150 points)	Management structures Operational systems Information systems
Technical Strength (350 points)	User contact and information Enrollment systems In-house service delivery network Contracted services Control systems
Experience (50 points)	Years delivering health services

Only those firms that receive a minimum of 530 on a scale of 700 points are deemed to have passed the certification, although the technical components account for less than 40 percent of the criteria. Further, only 140 points relate directly to service delivery capabilities. Those who score between 400 and 530 points are given a certain time (3 to 6 months) to remedy their deficiencies. Those who score below 400 points are barred from continuing as an EMP. Reportedly, at least five EMPs would be closed for not meeting the new certification requirements. The INSS has a stated objective of continuously certifying all firms on an annual basis, although meeting the objective will be difficult due to the large number of EMPs in the system.

Another quality monitoring mechanism being employed by the INSS is to place a physician who performs supervisory functions at each EMP. Although this mechanism was in place before, the supervisors were until recently paid by the EMP, thereby potentially impacting their ability to objectively supervise EMPs. The supervisor (now paid by the INSS) is charged with ensuring that INSS enrollees are properly registered with the EMP, and to address any complaints or problems filed by users. In addition, the supervisor monitors whether the EMP has adequate pharmaceutical stocks on hand to meet enrollees' needs, and reviews a certain number of medical files each month (20 per each medical area) using case review protocols prescribed by MINSA. This is one instance where the INSS attempts to monitor the quality of services being provided.

Perceived Quality

Due to an absence of baseline data and benchmarks, it is difficult to quantify whether service quality within the INSS model has improved since its inception in 1994, or how the health outcomes of enrollees have changed. The INSS has conducted a number of user satisfaction surveys, in which INSS enrollees appear generally satisfied with a number of attributes related to the delivery of care they receive. The last such survey, conducted in 2000, indicated the following results among INSS enrollees:

- 80 percent were satisfied with the their services
- 76 percent felt their medical problems were resolved
- 84 percent did not have to purchase additional medicines
- 80 percent had their prescriptions totally filled
- 90 percent were satisfied with pre-natal services
- 91 percent were satisfied with admission processes

These results were largely consistent with those reported in 1999 survey, where 73 percent of INSS patients ranked their overall satisfaction with EMPs as “good” or “excellent”.

Also in 2000, the INSS reported that of the 45 EMPs in the system, 35 of them (82 percent) had received “good” or “excellent” ratings from the INSS in terms of meeting INSS standards for maternal/child services during supervisory visits. Further, the INSS noted that the review of medical records for these EMPs resulted in a ranking of “excellent” or “good” for 37 EMPs (82 percent).

The CMS Initiative

The INSS model, while not covering all preventive services, does cover reproductive health, including family planning counseling and specific contraceptive methods (pills, IUD insertions, and surgical contraception.) According to EMP service statistics, however, very few INSS patients utilize the EMPs for family planning. Given the growing number of enrollees, particularly among women and female spouses, there is the potential to expand utilization of these services, if beneficiaries are informed and educated about their availability, and if they are properly delivered. In addition, an incentive exists for EMPs to inform their clientele about the benefits of family planning in order to reduce costs of peri-natal services and deliveries, and related maternity leave, for which EMPs are financially responsible.

The CMS Project, which has the mandate of expanding the delivery of family planning services through the private sector, is partnering with the INSS to improve the EMPs' capacity to deliver quality family planning services to INSS clients. A new initiative between CMS and two of the leading private EMPs (Salud Integral and SuMedico) was formulated this year to pursue this objective. In collaboration with its financing entity (the Summa Foundation), the CMS Project is providing access to credit through loans of $250,000 and $225,000 to these two EMPs to upgrade their medical facilities and to improve their capacity to deliver quality services, with a focus on maternal/child and reproductive health care.

The CMS initiative aims to expand the capability of the two EMPs to deliver a defined package of health care services, with a focus on reproductive health care, including family planning. The initiative is supported through a program of technical assistance with the following features:

- Improving the quality of services by training EMPs' staff in accordance with prescribed guidelines and protocols, including proper family planning counseling and provision of modern contraceptives;
- Ensuring or expanding the availability of covered contraceptives, to include temporary, long-term, and permanent methods at their facilities;
- Increasing the EMPs' service delivery capacity by providing Summa Foundation funding to upgrade facilities and equipment;
- Strengthening the supervisory function within the EMPs to ensure that family planning services comply with principles of informed choice and consent; and
- Improve the EMPs' information systems, so as to properly track and measure the utilization of family planning services among INSS clients.

CMS will also assist the two EMPs to inform their clients about reproductive health care, including family planning, through an IEC campaign that will:

- Promote the availability of services and benefits covered under the INSS package; and
- Educate clients about the benefits of family planning.

Measuring the Health Outcomes of CMS's Quality Improvement Initiative

The CMS initiative with the INSS and the two EMPs is based on achieving measurable outcomes against specific benchmarks for health and financial indicators. In order to establish health indicators, CMS is conducting a needs assessment with the two EMPs to determine their current level of utilization of family planning services, and to arrive at targets that will be monitored, reported and analyzed with the participation of the EMPs' management. The key service delivery indicators include:

- Number of family planning visits per month
- Number of modern methods provided to patients
- Awareness of family planning service coverage among clients
- Increased staff knowledge in FP counseling
- Adherence to protocols for family planning visits

To track these indicators, a number of collection tools and systems are used:

- Review of EMPs' service statistics
- On-site monitoring visits
- Facility audits of contraceptive supplies
- Client-exit interviews
- Observation of client-provider interactions

As a direct result of the technical assistance, the INSS and CMS expect to achieve important outcomes. First, CMS seeks to increase the utilization of reproductive health care through private EMPs, thereby alleviating the burden on the public sector for delivering this important health service. Second, the methodological approach for establishing benchmarks and monitoring service quality will be available to be replicated, with the collaboration of the INSS, for use by other EMPs to track the utilization of family planning services. Last, the methodology can be adapted to monitor the delivery of other MCH services. Such a step would contribute to the efforts of the INSS to improve the technical quality of services being provided through EMPs.