Reimbursement Mechanisms in Health Care

Policy and Fiscal Tools
Expected Impacts

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Demand and Supply Side Approaches for Cost Containment and Improving Efficiency

Supply side approaches

Indirect mechanisms

- Changing behavior via reimbursement mechanism
- Changing market structure and behavior by changing overall ownership (e.g., privatization of hospitals and facilities)
- **Using global budgets, possibly in combination with other efficiency targets (e.g., staffing)**

Changing care delivery

- **Adopting treatment protocols**
- Introducing performance management (e.g., setting targets for length of stay, promoting day surgery)
- Implementing business process reengineering
- Adapting cost-reduction and efficiency targets

Planning approaches

- Implementing hospital closure and reconfiguration programs

Demand side approaches

Indirect mechanisms

- Employing payment incentives to encourage treatment of patients in primary or ambulatory care
- Introducing user charges and co-payments

Demand management

- Initiating an appropriateness and utilization review
- Introducing "evidence-based purchasing", specifying explicit rationing of treatments, specifying a basic package of interventions
- Developing primary care substitutes
- Promoting social and domiciliary care
- Strengthening disease prevention activities
- Adopting managed care or disease management

Source: M. Henscher

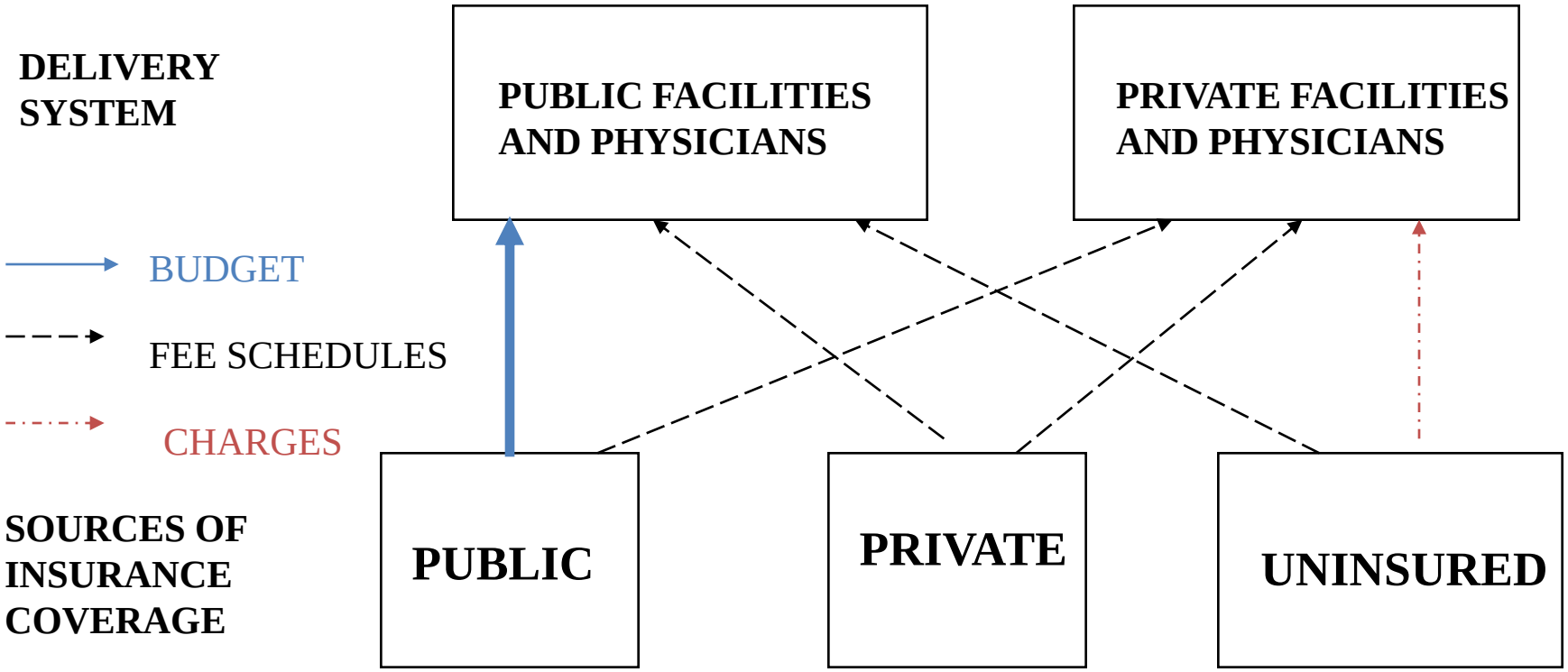
Health Financing Functions and Objectives

Functions	Objectives
Revenue Collection	raise *sufficient* and *sustainable* revenues in an *efficient* and *equitable* manner to provide individuals with both a *basic package of essential services* and *financial protection against* unpredictable catastrophic financial losses caused by illness and injury
Pooling	manage these revenues to *equitably* and *efficiently* pool health risks
Purchasing	assure the purchase of health services in an *allocatively* and *technically efficient* manner

Increased Pooling: cut administrative costs

- Minimize costs of premium collection and targeting
- Increase leverage and purchasing power
- Keep administrative costs < 15% at startup on new systems, <10% of existing systems
  - Exceptions…managed care organizations

If no Pooling…
set a Single Set of Payment Rules



Purchasing
The Capacity to Contain Costs (1)

- **Benefits Package: Design of the benefits package according to the resources available**
  - **reimbursement/funding of the only goods and services with proved medical effectiveness**
  - **benefits not included in the benefits package due to insufficient resources covered by voluntary health insurance or out-of-pocket payments**
  - **Ongoing Process: build-in analytic capacity: CEA, technology assessment, new protocols**

- **Contracts Well-designed contractual arrangements**
  - **include a set of rights and obligations for health care providers**

Source: Rahola, 2005

Contracting
"Easier Said than Done"

- **Eastern Europe and CIS region**
  - Soft relational contracts
  - Little or no "selective contracting"
  - Still most often excludes private sector
  - Issues: Lack of stable funding, Lack of good MIS Systems (non-standard, non-secure)
- **Latin America**
  - More aggressive with private providers (Soc Ins)
  - MOH contracting out of priority services (maternal and child health) e.g., Bolivia, Peru, Ecaudor
  - Issues: Overcomplexity, MIS, Management capacity

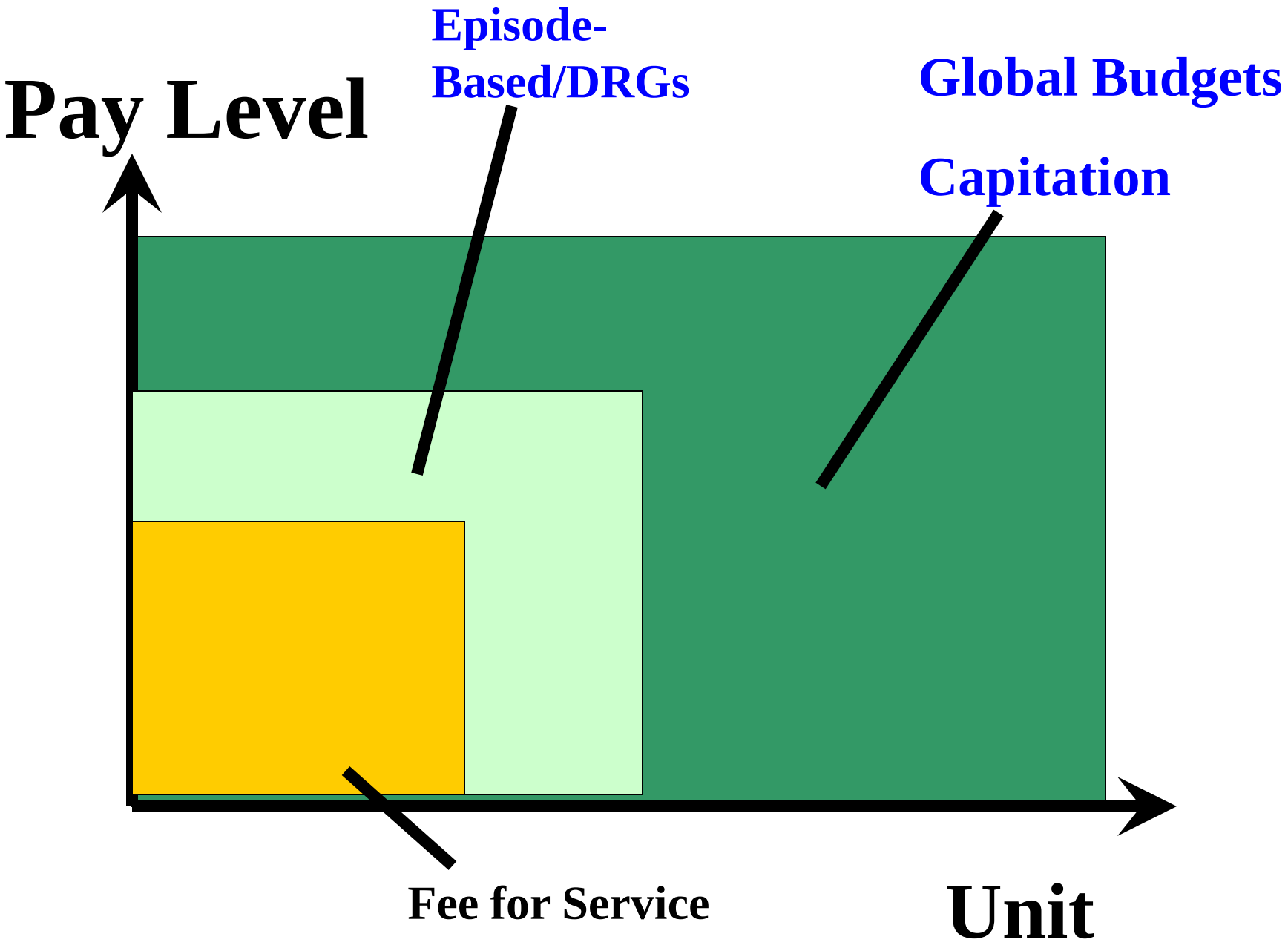
Purchasing
The Capacity to Contain Costs (2)

- **Incentives and Provider Payment Systems**
  Mechanisms used to 'pay' medical care providers/organizations for services rendered to their clients

- **In last 2 decades, new incentive-based systems emergent**
  - **money follows patients**

- **No Optimal Model…depends…"What's the Problem?"**

Source: Rahola, 2005


Episode-
Based/DRGs
Global Budgets
Capitation
Pay Level
Fee for Service
Unit

Payment Mechanisms for Physicians Financial Risk and Incentives

Payment mechanism	Basket of services paid for	Risk borne by		Provider incentives to			
		payer	by provider	increase no. of patients	decrease activity per consultation	increase reported illness severity	select healthier patients
FFS	each item of service and consultation	all risk borne by payer	no risk borne by provider	yes	no	yes	no
Salary	one week or one month work	all risk	no risk borne by physician	no	n/a	n/a	yes
Salary and bonus	bonus based on no. of patients	salary portion	bonus portion	yes	n/a	n/a	yes
Capitation	all covered services for one person in a given period	amount above 'stop-loss' ceiling	all risk borne by provider up to a given ceiling (stop-loss)	yes	no	no	yes

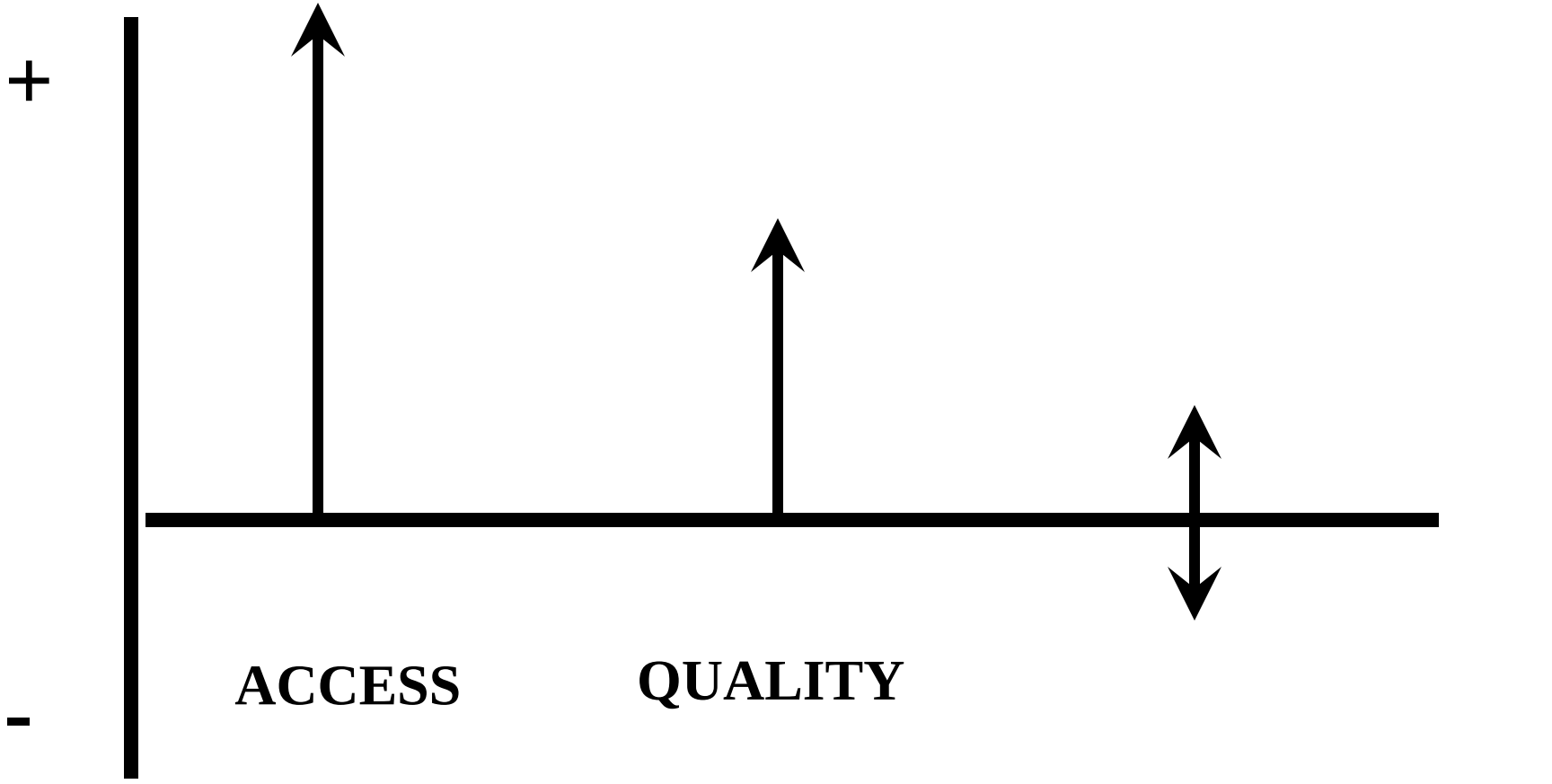
Source: Maynard and Bloor

Hospital Payment Mechanisms: Financial Risk and Incentives

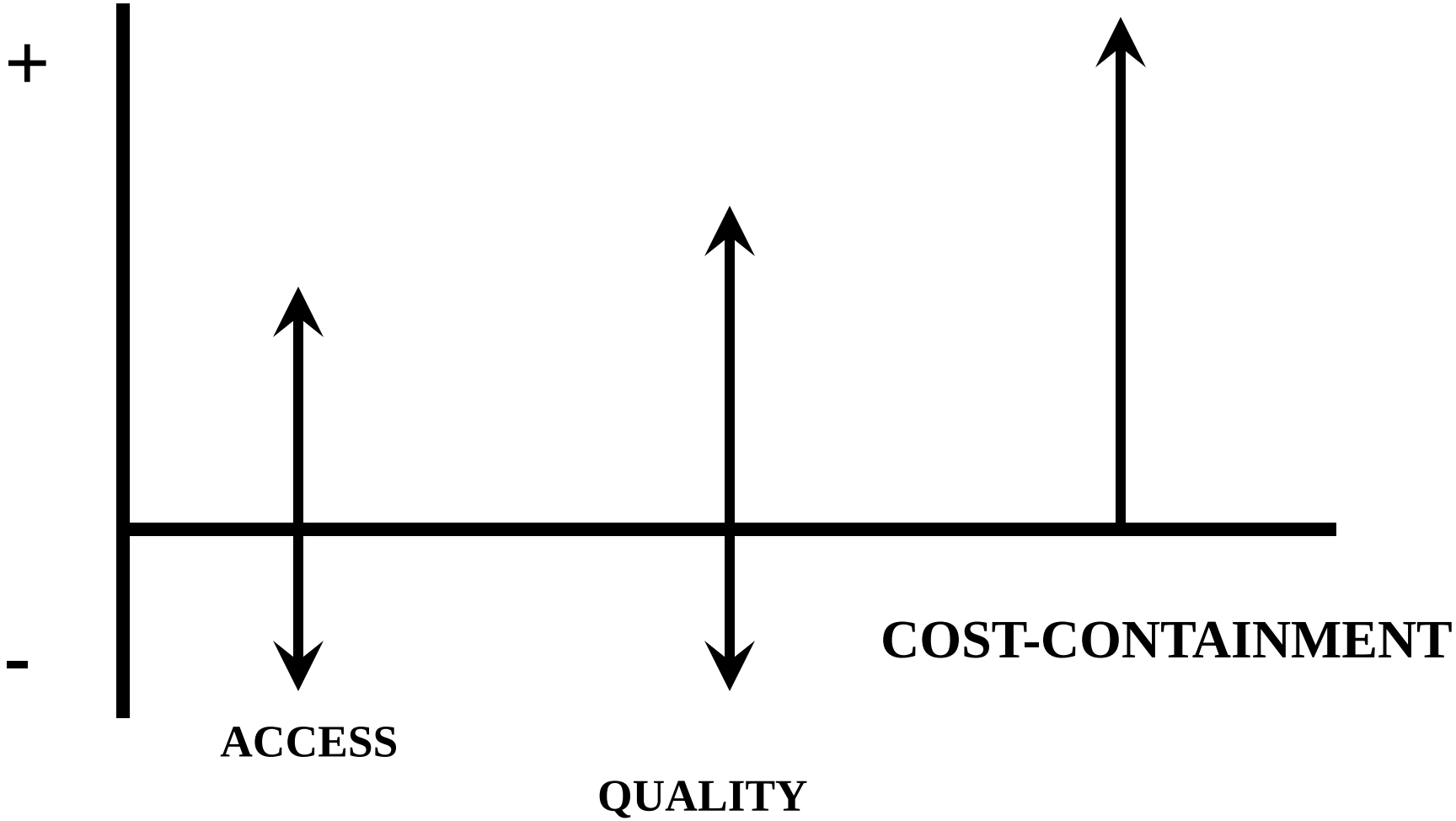
Payment mechanism	Basket of services paid for	Risk borne by		Provider incentives to			
		payer	by provider	increase no. of patients	decrease activity per consul-tation	increase reported illness severity	select healthier patients
FFS	each agreed item of service and consultation	all risk borne by payer	no risk borne by provider	yes	no	yes	no
Case payment (e.g. DRG)	payment rates vary by case	risk of no. of cases and severity classification	risk of cost of treatment for a given case	yes	yes	yes	yes
Admission	each admission	risk of number of admissions	risk of no. of services per admission	yes	yes	no	yes
Per diem	each patient day	risk of number of days	risk of cost of services per day	yes	yes	no	no
Capitation	all covered services for one person in a given period	amount above ‘stop-loss’ ceiling	all risk borne by provider up to a given ceiling (stop-loss)	yes	n/a	no	yes
Global budget	all services provided by an institution in a given period	no risk borne by the payer	all risk borne by provider	no	n/a	n/a	yes

Source: Maynard and Bloor

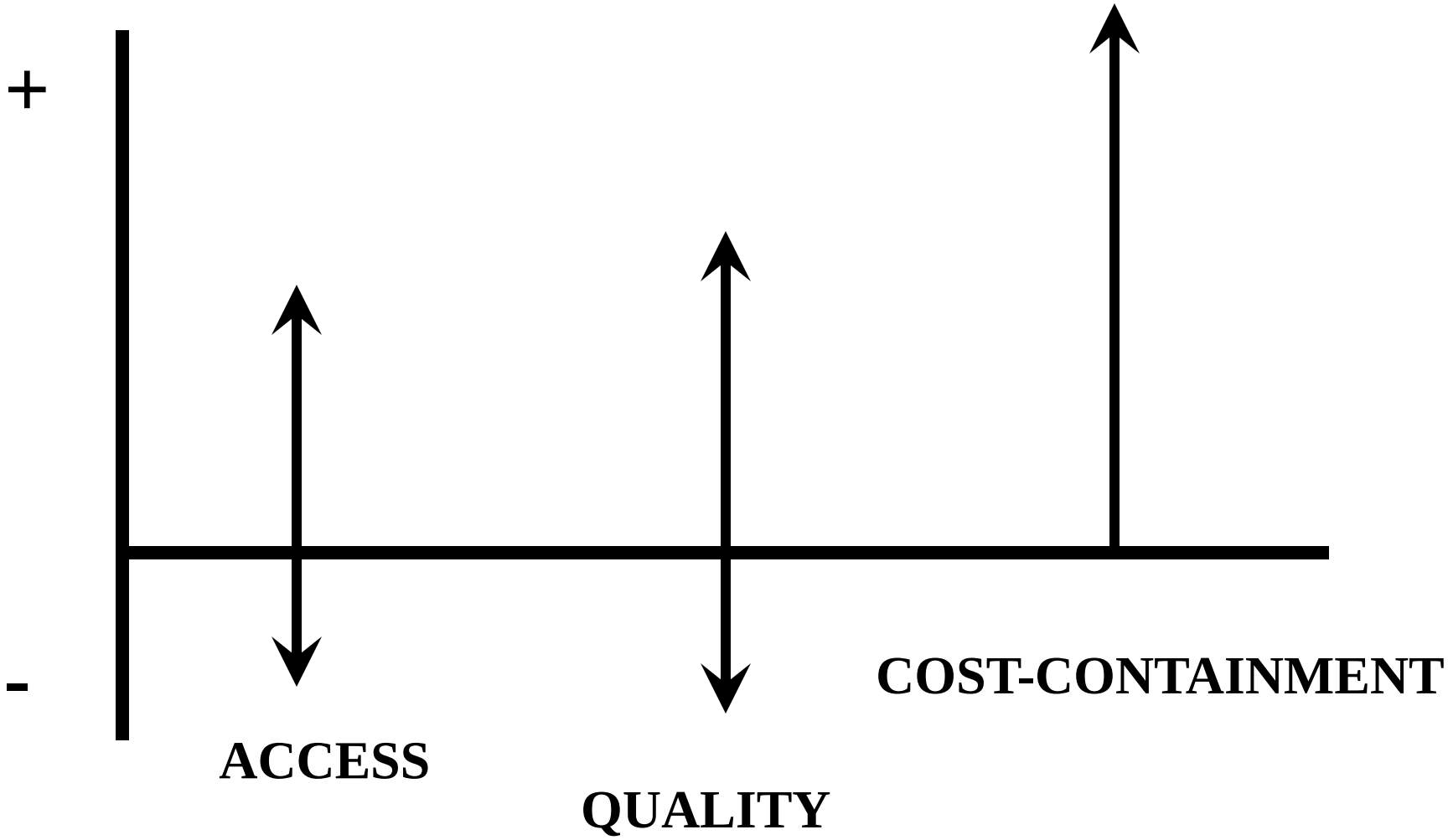
FEE-FOR-SERVICE



EPISODE-BASED e.g., DRGs



CAPITATION

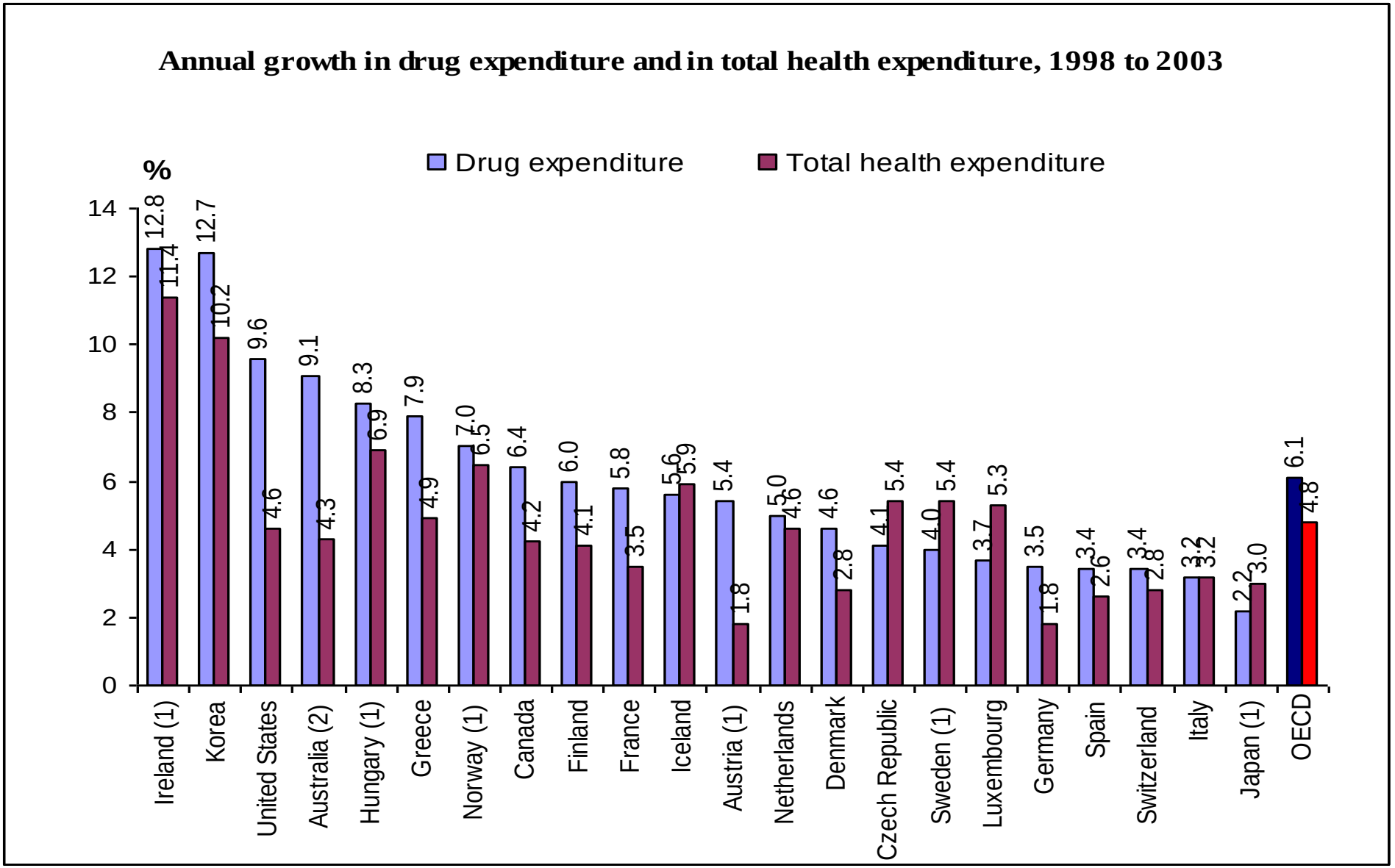


Containing Costs (3)
Pharmaceutical Sector

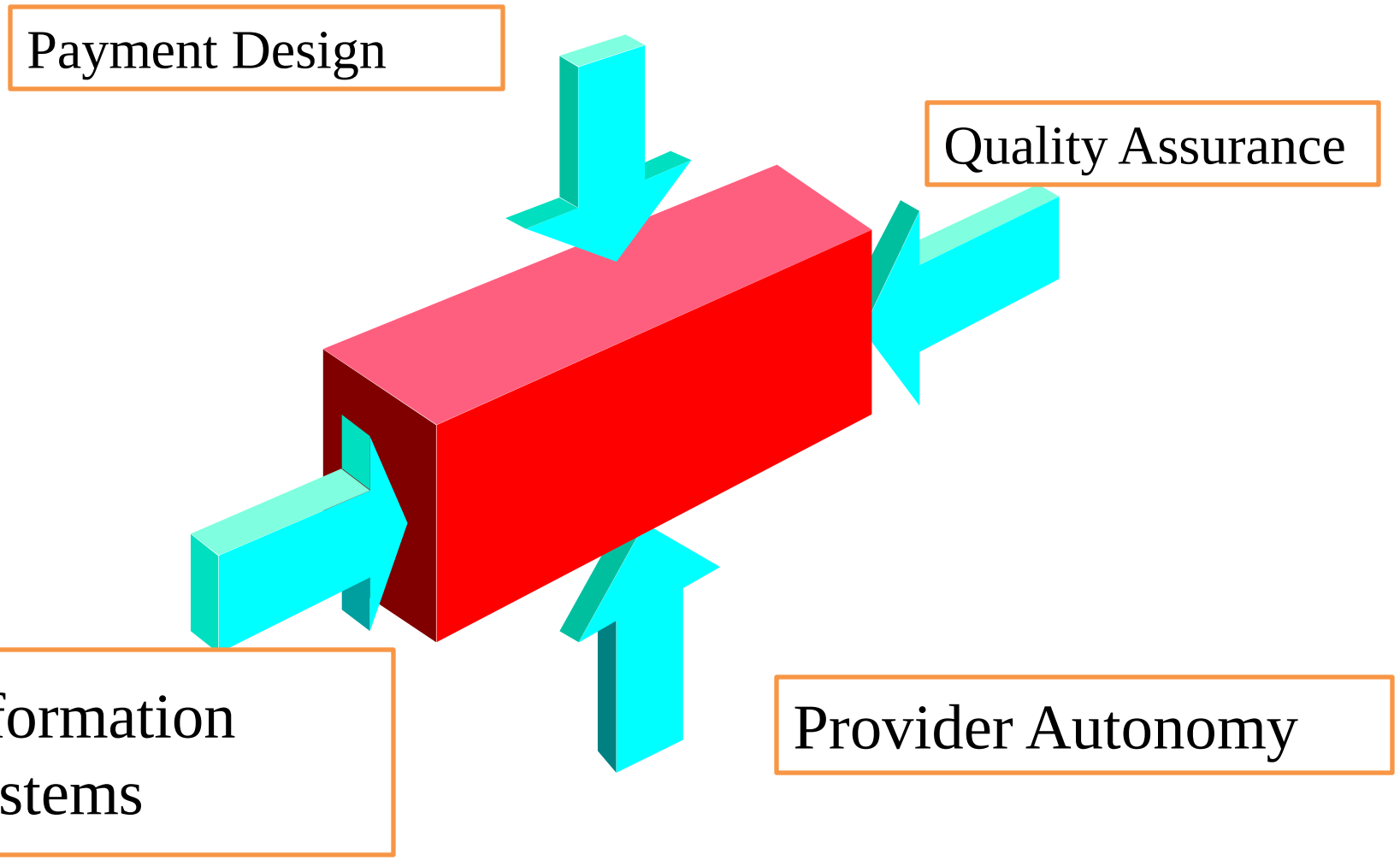
- **Often largest part of health care spending – 25-40 percent of health spending in ECA and MENA countries**
  - **generally largest item of household medical expenditures**
- **Cost control requires control of price and volume of prescribing**
- **Efficiency requires demand and supply side regulation**
- **Equity may be reduced by user charges**

Source: Maynard

The rising costs of pharmaceuticals is *not* a problem in MICs and LICs only…..

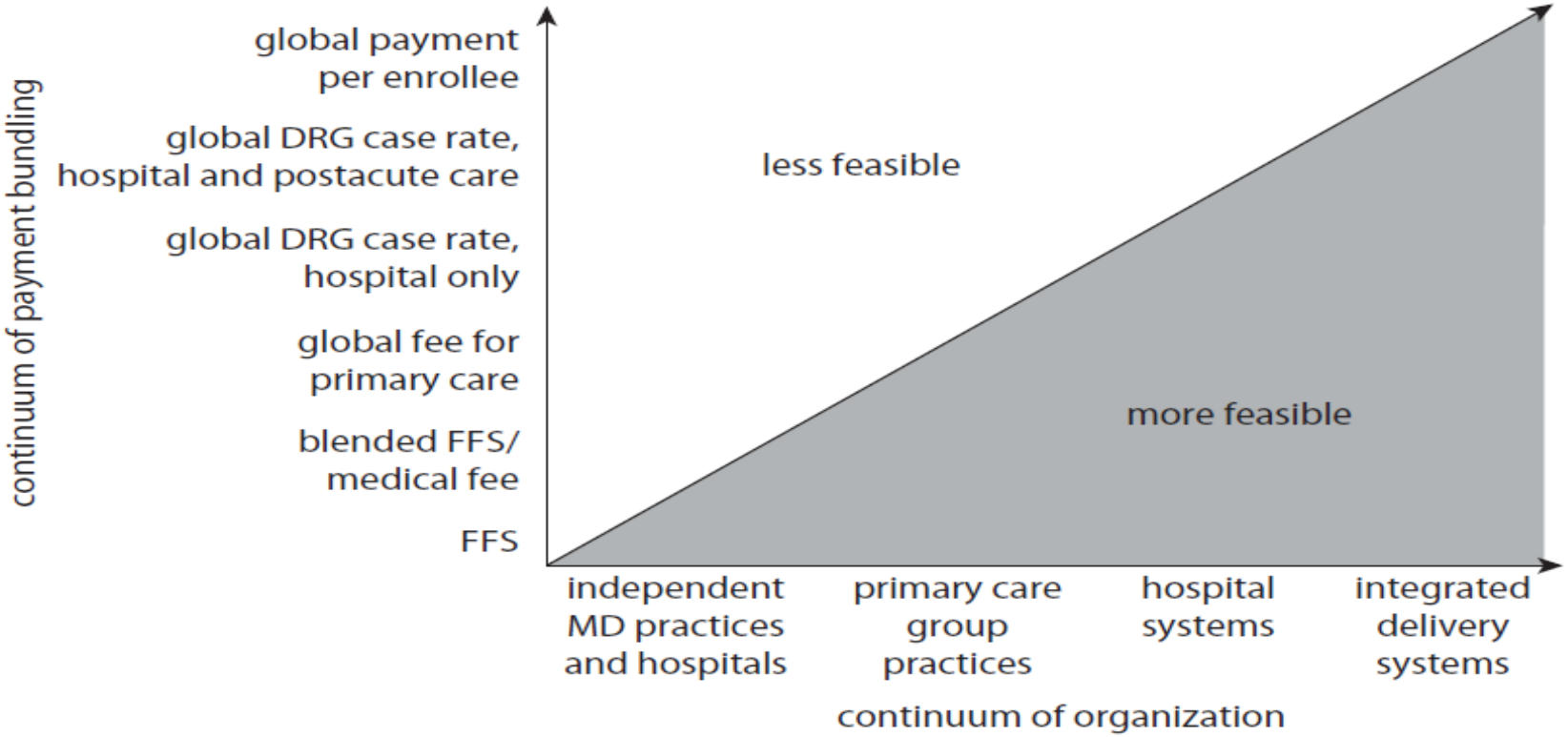


Implementation Issues



The Relationship between Payment mechanisms and provider organization

Figure 5.6 Provider Payment Mechanisms and Health System Organization



Source: Guterman et al. 2009.
Note: DRG = Diagnosis-related group; FFS = fee for service.

Supply Side Regulation: Licensing and Reimbursement

- **Registration procedures broadly similar: evidence of safety and efficacy**

- **Many countries restrict reimbursement by positive lists or negative lists**
  - **Increasingly, governments are encouraging provision of economic data and evidence of cost-effectiveness (RCTs and actual practice)**

Source: Maynard

Supply Side Payment and Regulation: Price Controls

- Reference price systems: patients pay any difference between the brand price and a reference price (for generics or same therapeutic group)
- Direct cost-plus pricing
- External comparison pricing, e.g., across markets and countries
- To achieve cost containment, essential to control not just price but also volume

Source: Maynard

Supply Side Regulation: Retailers and Wholesalers

- **Fixed profit margins to facilitate cost control**
- **Require generic substitution**

Source: Maynard

Demand Side Regulation and Payment: Influencing Patients

- **Cost sharing – deductibles, copayments, coinsurance**
- **Reference prices**
- **Caps on volume**
- **Consumer education**

Source: Maynard