Mixed provider payment systems: What are the issues?

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Dr Inke Mathauer
Department of Health Systems Governance and Financing

World Health Organization

Outline

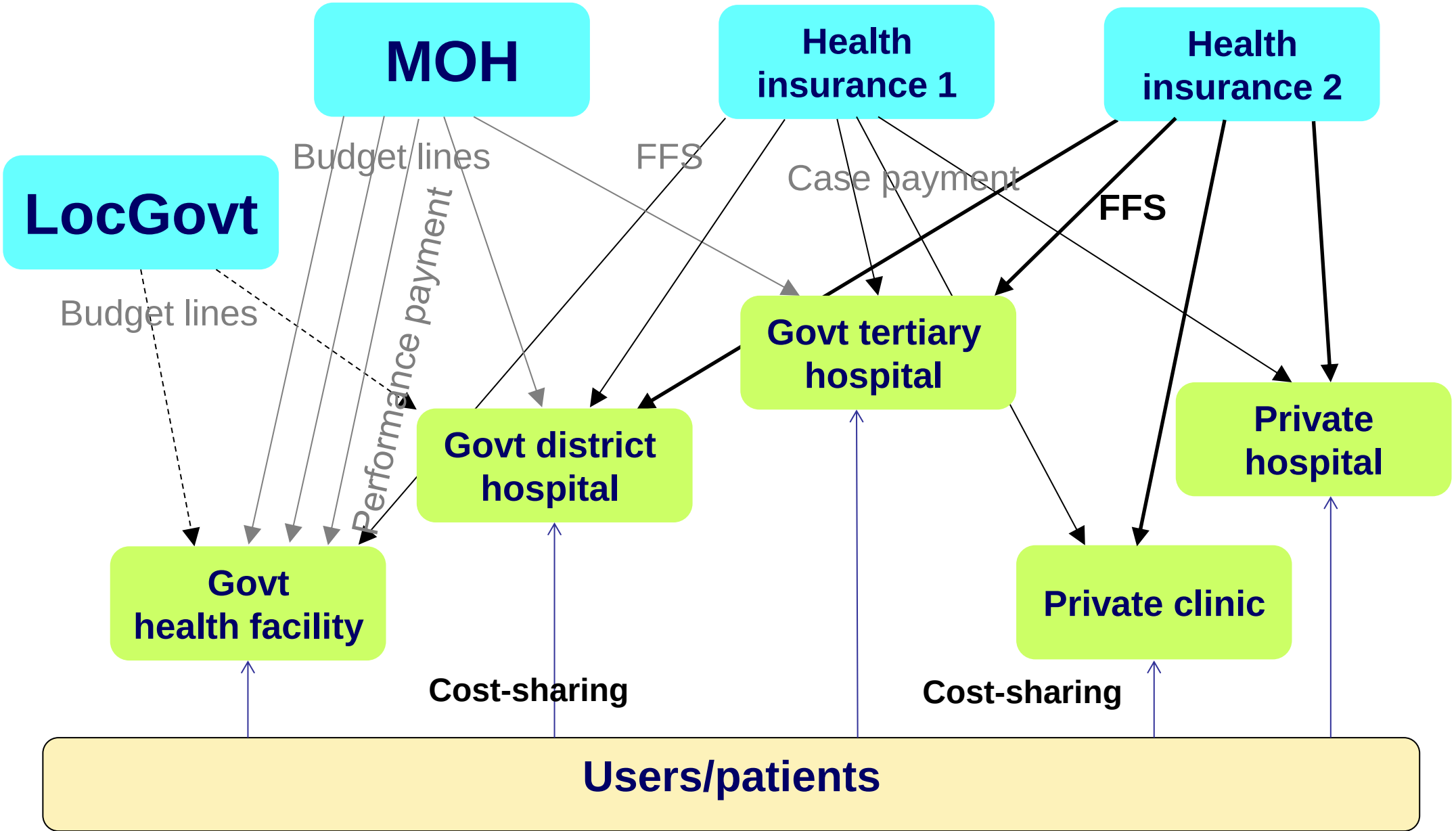
I. Seeing the ‘mix’ in mixed provider payment systems

II. Provider behaviour reactions and effects through multiple payment mechanisms

III. Various “types” of mixed payment systems

IV. Where to go? Taking on a system perspective

I. Seeing the 'mix' in multiple provider payment systems



I. Provider payment methods and incentives

Payment Method	Definition	Incentives
Line-item budget	Providers receive a fixed amount to cover specific input expenses (e.g., staff, drugs, …).	Under-provision
Per diem	Hospitals are paid a fixed amount per day that an admitted patient is treated in the hospital.	Extended length of stay, reduced cost per case; cream-skimming)
Case-based (“DRG”)	Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics.	Increase of volumen, reduction of costs per case, avoidance of severe cases
Global budget	Providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. Budget is flexible and not tied to line items.	Under-provision, also in terms of quality
Fee-for-service	Providers are paid for each individual service provided. Fees are fixed in advance for each service or group of services.	Over-provision
Capita-tion	Providers are paid a fixed amount in advance to provide a defined set of services for each individual enrolled for a fixed period of time.	Under-provision

I. From the analysis of one provider payment method and its incentives…

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I. … to the analysis of multiple provider payment methods and combined effects on incentives

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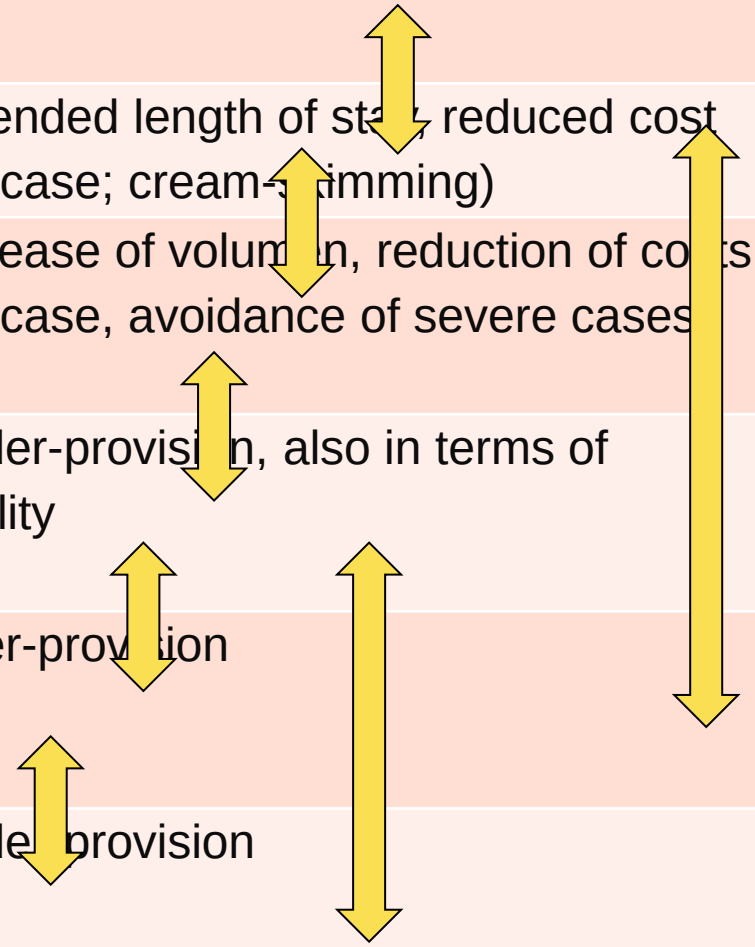

I. … to the analysis of multiple provider payment methods and combined effects on incentives

Payment Method	Definition	Incentives
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Case-based ("DRG")	Hospita admiss charac	f costs ses
Global budget	Provide certain Budget	
Fee-for-service	Provide provide service	
Capita-tion	Provide to prov individ	

Multiple payment methods can be complementary & compensatory.

But if not aligned, they may create contradictory incentives.

This will positively or negatively affect cost containment, efficiency, equity, quality and financial protection.

II. Rather undesired provider reactions and effects through a mixed, non-aligned payment system

Providers change behaviour to benefit more from financially more attractive payment methods:

1. Shifting to “preferred” patients: Cream-skimming of patients + over-provision (and less attention to others + under-provision) => may affect equity, efficiency, quality

2. Shifting resources (staff, beds, supplies, drugs): over-provision of some services with more attractive remuneration, under-provision of other services

   E.g., resources are moved from the public to the private wing in a public hospital

   => may affect equity, efficiency and quality

Adapted from draft paper “mixed provider payment systems”, W. Yip et al.

II. Rather undesired provider reactions and effects through a mixed, non-aligned payment system (cont.)

3. Shifting (or avoiding) service provision (and hence costs)
   - Shift patients from outpatient care to hospital admission
   - Unnecessary referral of patients to higher levels

   => may affect efficiency

4. Shifting costs: charge higher rates to patients that can pay/remunerate more (e.g. OOP or through insurance)
   - Over-billing of insured patients => issues of cost-containment
   - “balance” billing => increases out-of-pocket expenditure
   - But also allows for cross-subsidization: patients with lower capacity to pay or covered by lower payment rates can also be treated

III.

There is a continuum of mixedness:
…from messy to mix by design…

- "Messy" payment system: Different payment methods with no coherence, contradictory incentives at the provider level
  - Usually the result of a highly fragmented system with multiple purchasers and different benefit packages for different groups
- Alignment of provider payment methods within a purchaser or across purchasers
  - helps to make incentives of different provider payment methods more coherent to meet health system objectives

III.

There is a continuum of mixedness:
… to blended payment methods…

- Intentional mix of several payment methods to pay for a specific service or a provider
  - to increase desired incentives (and minimize undesired incentives) of each payment method
- e.g., capitation payment for PHC + (small amount of) fee-for-service (FFS) for priority interventions
- specifically for episodic care: e.g., FFS + P4P, DRGs + global budget

III.

There is a continuum of mixedness:

… and to bundled payment…

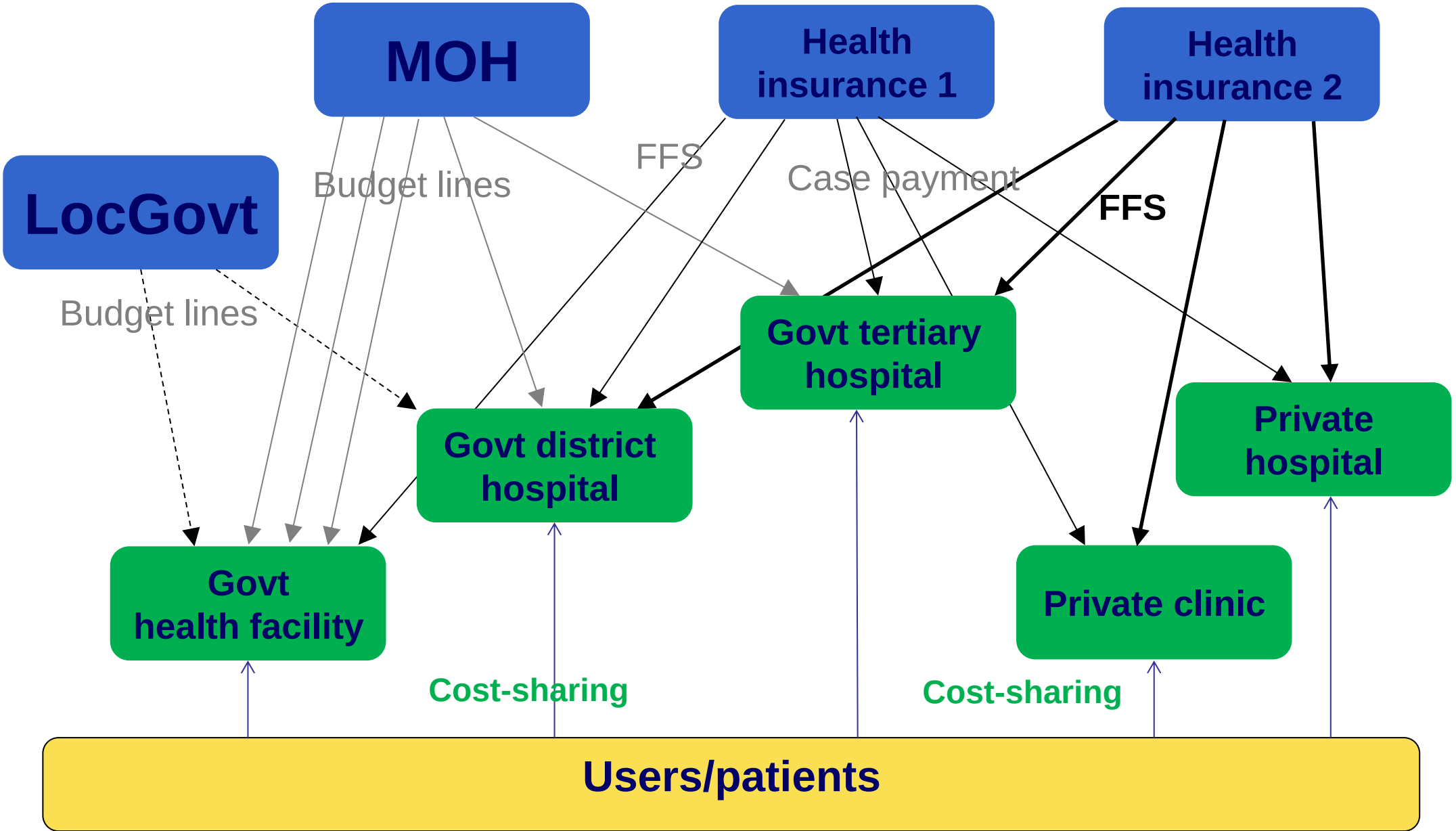
- fixed payment per patient per period or for a package of care to cover costs of the package/bundle
  - e.g., consultation, diagnostic tests, case management, drugs, procedures and probabilistic costs of hospitalisations
- to manage the interface and continuum between primary, secondary and tertiary care
- especially for continuous and coordinated care (chronic conditions)

IV.

Where to go?
Let's take on a system perspective

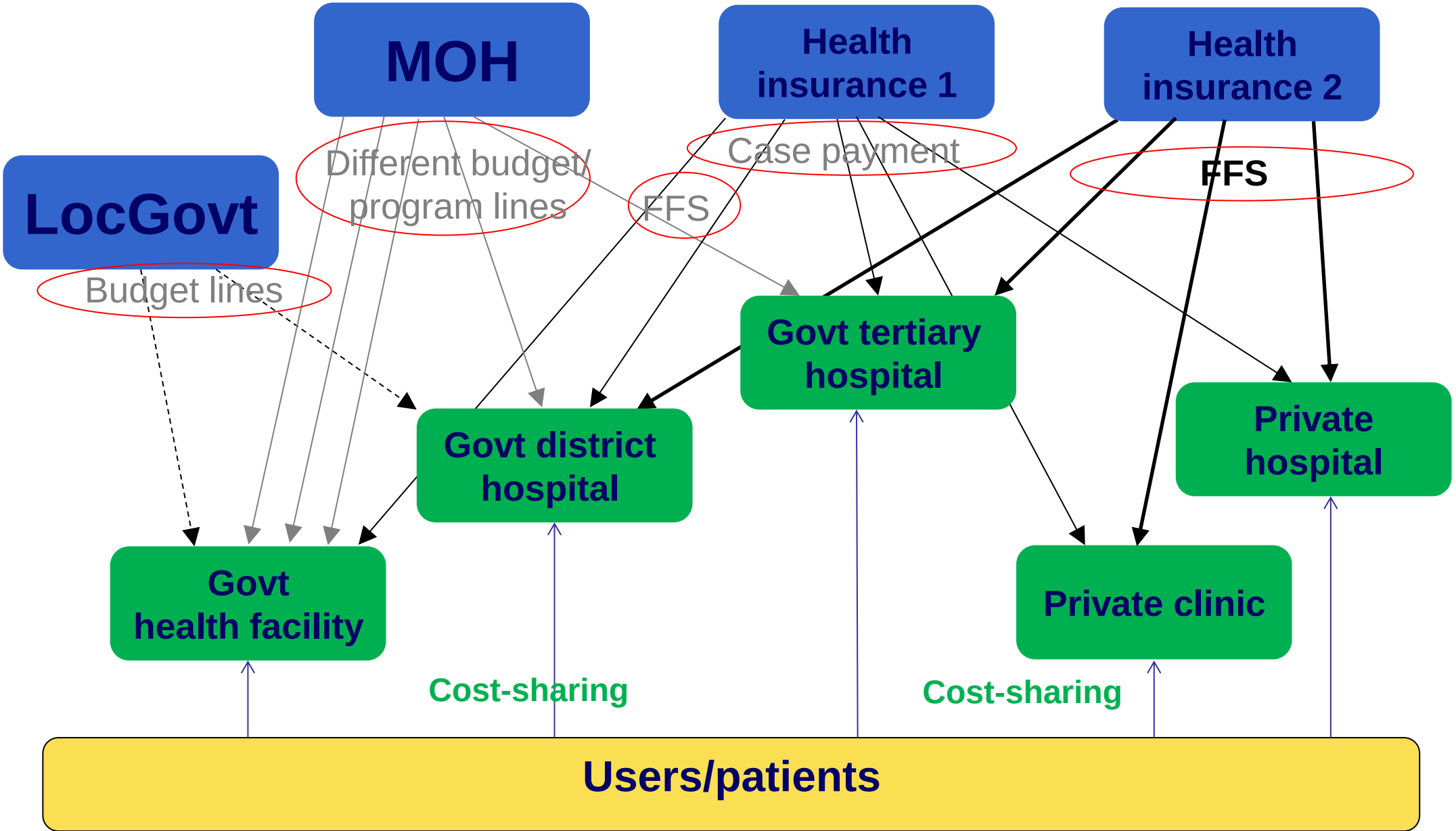
- SP links payment to incentives on provider performance and population health needs, while managing expenditure growth
- Shift focus to system perspective that looks at all PPMs jointly
- With this perspective, the question is no longer how to optimize a "PBF program" or a specific payment method, but
  - **How to align it with the overall provider payment system?**
  - **Spending wisely => How to mix wisely?**
- Work towards a mix of various payment methods with a coherent set of incentives across the system and for each provider to provide a strategically defined benefit package

Assessment of a mixed provider payment system

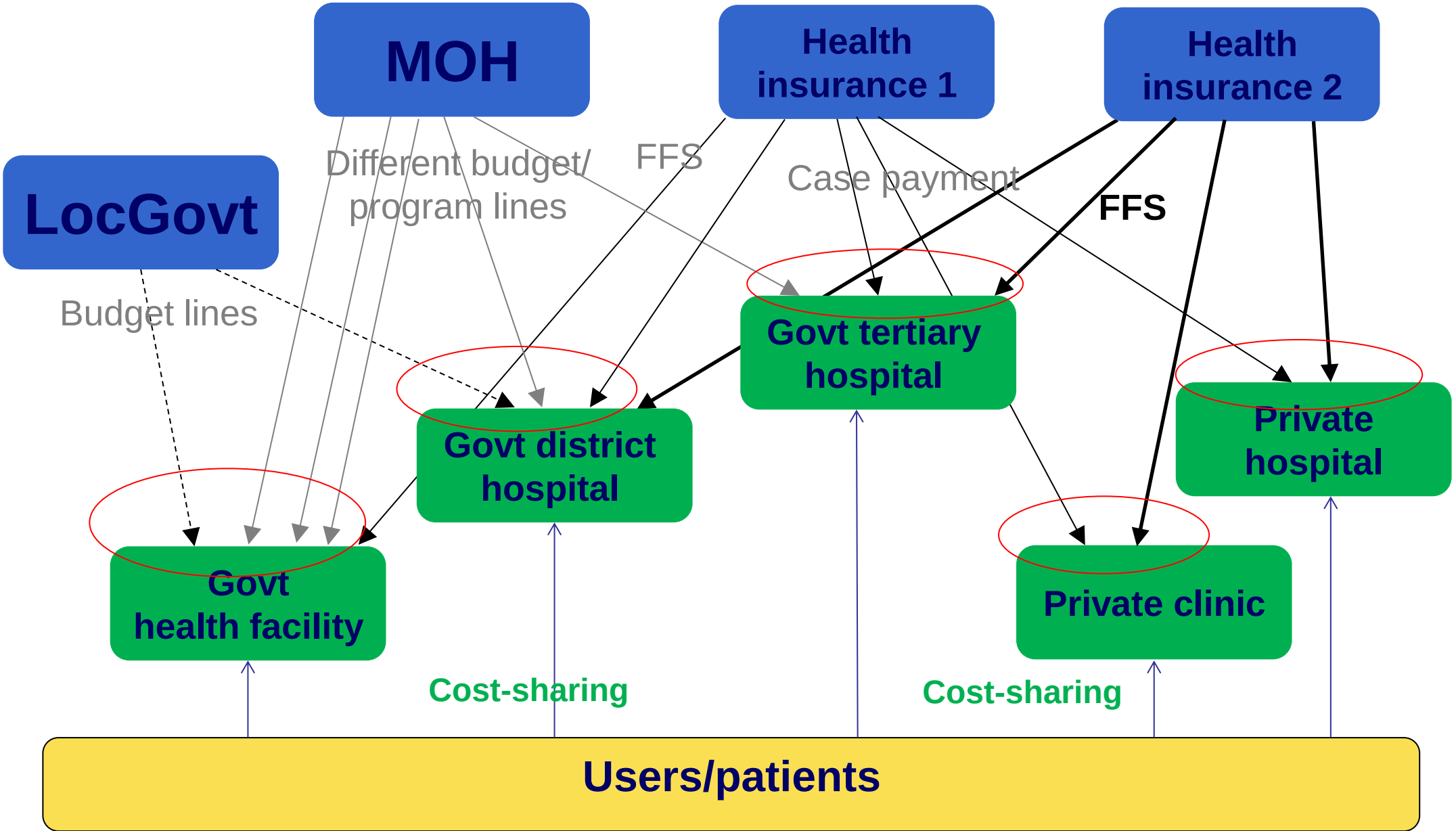


Purchaser level:

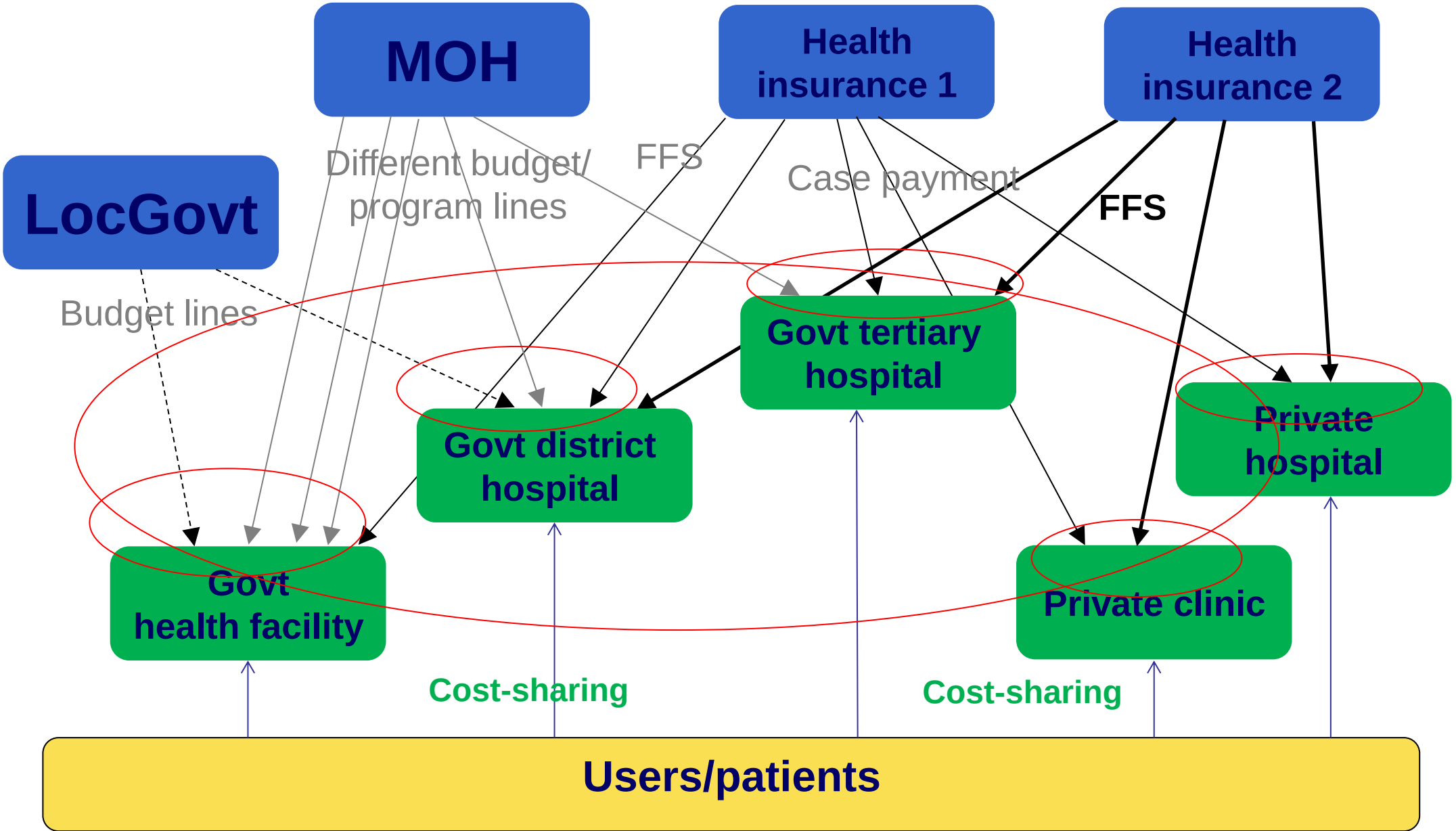
different payment methods/rates for different services and different providers



Provider level:
incentive mix
through different provider payment methods



System level:
Interaction of incentives and effects across the payment system



IV. How to go from a ‘mess’ to a mix by design?

Challenges:

- Limited evidence for design and implementation, very country specific
- Political economy: Resistances from providers

Options: Build upon conducive design and implementation factors

- Unified information management systems
- Leadership and governance of purchasing markets: defragmentation, policy setting, harmonisation of packages and PPMs
- Stakeholder/provider involvement

Thank you very much for your attention

II. There is also need to align PPMs with cost-sharing

- Cost-sharing mechanisms and referral rules also affect patients' use of services
- Optimal deliver/use of services requires alignment of provider and patient incentives.
  - For example, PPMs that incentivize delivery high co-payment for PHC does not lead to optimal PHC utilization.
- Cost-sharing is part of benefit package policy (needs to be aligned with this) and is one source of revenues of providers (= another form of "provider payment method")
- Regulation of balance billing, informal payments, etc.

Synthesis study: lessons

- Difficulties to measure impacts on expenditure growth, efficiency,
- The findings of this review suggest that the effects and implementation of a particular MPPS are highly context-specific, requiring considerable adaptation and continued research based on population needs and resources available.
- Planners and policymakers should consider the existing system, specific goals of reform, and feasibility in realizing implementation when designing an MPPS.